East Sussex Healthcare NHS Trust

# East Sussex Healthcare NHS Trust Board Agenda

**Date:** Tuesday 12th December 2023

**Time:** 09:30 – 12:30

**Venue:** Horntye Park Sports Complex, Bohemia Road, Hastings, TN34 1EX

| | Item | Lead | Action | Time |
|---|---|---|---|---|
| 1 | **Welcome and apologies** | Chair | Information | 09:30 |
| 2 | **Staff Recognition** | Chair | Information | |
| 3 | **Declarations of Interest** | Chair | Information | |
| 4 | **Minutes of Trust Board Meeting in public 10/10/2023** | Chair | Approval | 09:35 |
| 5 | **Matters Arising** | Chair | Approval | |
| 6 | **Chief Executive's Report** | CEO | Information | 09:40 |
| | **Quality, Safety and Performance** | | | |
| 7 | **Integrated Performance Report, Month 7 (October)**<br>1. Chief Executive Summary<br>2. Quality & Safety<br>3. Our People<br>4. Access and Responsiveness<br>5. Financial Control and Capital Development | <br>CEO<br>CNO/CMO<br>CPO<br>COO<br>CFO | Assurance | 09:55 |
| 8 | **Maternity Overview Q2** | DOM | Assurance | 10:40 |
| | **Break – 15 minutes** | | | |
| | **Strategy** | | | |
| 9 | **Winter Preparedness 2023/24: Update** | COO | Assurance | 11:05 |
| | **Governance and Assurance** | | | |
| 10 | **Mortuary Security (verbal)** | CMO | Assurance | 11:15 |
| 11 | **Establishment of Inequalities Committee** | COS | Information | 11:25 |
| 12 | **Speak Up Guardian Update** | CPO | Assurance | 11:30 |
| 13 | **Violence and Aggression SBAR report** | CPO | Information | 11:40 |
| 14 | **Delivering Improving Lives Together: Partnership Working Update** | CEO | Information | 11:55 |
| 15 | **Board Committee Summaries** | Committee Chairs | Assurance | 12:00 |

| Items for Information | | | | |
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| **16** | **Infection Control Annual Report** | CNO | Information | 12:05 |
| **17** | **Use of Trust Seal** | Chair | Information | |
| **18** | **Questions from Members of the Public** | Chair | | 12:15 |
| **19** | **Date of Next Meeting**<br>Tuesday 13th February 2024 | Chair | Information | |
| | **Close** | Chair | | |

**Steve Phoenix**
Chairman

| 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**

Please be aware that there are a number of things that we know contribute to productive meetings and show respect to all members in the room. If you are attending the meeting then we would be grateful if you would consider the following:

- 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: 2024**

| Month | Location | Timing | Any other information |
|---|---|---|---|
| 13th February | Eastbourne District General Hospital | 09.30 – 12.30 | |
| 9th April | Bexhill | 09.30 – 12.30 | |
| 11th June | Conquest – Lecture Theatre, Education Centre | 09.30 – 12.30 | |
| 13th August | Eastbourne District General Hospital | 09.30 – 12.30 | |
| 10th September – Annual General Meeting | Bexhill – The Relais Cooden Beach | 14.30 - | |
| 8th October | Bexhill | 09.30 – 12.30 | |
| 10th December | Conquest – Lecture Theatre, Education Centre | 09.30 – 12.30 | |

East Sussex Healthcare NHS Trust

# Staff Recognition

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| **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** | Presented to the Trust Board only | | | | | | |

| **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 |
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**Executive Summary**

**Hero of the Month**

**<u>August 2023</u>**

**Winner – Neil Maskell, Waste Porter - Estates and Facilities**

'I wish to nominate Neil because he highlights what our Trust is all about.

He is always full of smiles, greets everyone when walking along the corridor and is very polite. Nothing is ever too much trouble, and he clearly takes a huge amount of pride in his work representing the waste portering team. This was showcased to me more than ever when I was working with a colleague on the floor archiving documents. He noticed me sitting there whilst he was going about his normal day and without being asked returned with a chair for me to sit on. This was a magic moment for me and my colleague! Random acts of genuine kindness like this make ESHT a great place to work and doing that extra bit is always worth doing.

Neil is a shining example of the Trust's values in every way and a huge asset to his team/hospital. He is an unsung hero of the DGH.'

Neil receiving his certificate from Steve Phoenix, Chairman

**September 2023**

**Winner – Melanie Southwood, Midwife, Buchanan Delivery Suite – Women, Children and Sexual Health Division**

A Service user of ESHT Maternity has recently reached out via the Maternity Voices Partnership in the hope to track down the midwife who cared for her during labour and birth over 12 years ago. With the help of the senior midwife team and some digging we managed to identify Labour ward lead Melanie Southwood and arranged a meeting to reconnect them after all these years. The Service User had been thinking about this for some time and wanted to get in touch to pass on her gratitude for the kindness Melanie showed her as she was unable to do that at the time.

The Service User told us that at 8 months pregnant she sought asylum in the UK with only the clothes she was wearing and a small bag. She was young, without her family and unable to speak English. It was common in her country for there to be little or no antenatal education or care during the first pregnancy and she was scared of the unknown.

She had been told to ring an ambulance as soon as she felt pain and that is what she did one month after arriving in the country. The ambulance crew were kind and considerate and took her straight to ESHT Labour ward where she was cared for throughout labour and birth, predominately by Melanie until shift change the following morning.

The Service User told us how kind and caring Melanie was and quite what that meant to her. In her culture the first person to hold a newborn child is held in very high regard and now she can tell her daughter all about the woman who helped her into the world.

The Service User recalled how challenging those initial few years were. In her country households are typically large and multigenerational with family matters being kept strictly private. Reluctant to share personal issues with non-family members, as community knowledge can bring shame on the household, she only went out once a month to get her food shopping. Although parent and baby groups were signposted to by her Health Visitor she did not want to attend.

When her daughter reached two years of age she was able to access childcare at a nursery and went to college to learn English. This then enabled her to get a part time job and save for 10 years. Working seven days a week she now has her own thriving

local business. Her daughter is doing well at school and has aspirations of becoming a doctor.

Melanie is an inspirational leader who has shown herself as a true ambassador for the Trust and the midwifery profession. By sharing her story, this service user has highlighted how Melanies dedication, kindness, empathy and compassion, has had a profound impact on her birth experience, and her first impressions of the NHS and the people who work in our organisation.

It is wonderful to hear that she has settled here in Hastings and is part of a thriving community.

Melanie receiving her award from Steve Phoenix, Chairman

## Long Service Awards

| Sep-23 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **10 Years Service** | | | **25 Years Service** | | | **40 Years Service** | |
| Hugo | Carreira Da Silva | | Kirsti | Bennett-Koster | | Alan | Raby |
| Lauren | Coe | | Linda | Graham-Scott | | | |
| Jennifer | Douthwaite | | Nidhal | Jabbur | | | |
| Marjorie | Fianza Parkins | | Trudi | Kitcher | | | |
| Nawarl | Hassan | | Carole | Lewis | | | |
| Samatha | Malapatti | | Mette | Lundorf | | | |
| John | Chrizsostham | | | | | | |
| Joel | Newman | | Davina | Piper | | | |
| Christophe | Richardson | | Joanne | Thomas | | | |
| Lisa | Robison | | | | | **50 Years Service** | |
| Jann | Silerio | | | | | | |
| Julie | Spashett | | | | | | |
| Ashley | Townsend | | | | | | |
| Hayley | Tuck | | | | | | |

| Oct-23 |
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| 10 Years Service | | 25 Years Service | | 40 Years Service |
|---|---|---|---|---|
| Nicola | Godin | Rebecca | Carr | |
| Harriet | Hughes | Caroline | Driver | |
| Rebecca | Hutchinson | Jane | East | |
| Charlotte | Jones-Strong | Dean | Edwards | |
| Louise | Lawson | Nikki | Frankis | |
| Charlotte | Lecheminant | Tracy | Hennebry | |
| Wendy | MacLean | Nathan | Ling | |
| Nilima | Mahat | Terry | McCormick | **50 Years Service** |
| Helen | Peterken | Sally | Muggridge | |
| Tracy | Taylor | Nikhil | Patel | |
| Rick | Veasey | Kerl | Power | |
| | | Linda | Usherwood | |

Caroline Driver, Bereavement adviser, receiving her 25 year Long Service certificate

| **Next steps** | None applicable |
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East Sussex Healthcare NHS Trust

# East Sussex Healthcare NHS Trust Board Minutes

**Date:** Tuesday 10th October 2023

**Time:** 09:30 – 12:30

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

| | | Actions |
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| | **Attendance:**<br>Mr Steve Phoenix, Chairman<br>Mrs Vikki Carruth, Chief Nurse & Director of Infection Prevention and Control<br>Mrs Jackie Churchward-Cardiff, Vice Chair and Non-Executive Director<br>Mrs Karen Manson, Non-Executive Director<br>Dr Simon Merritt, Chief Medical Officer<br>Mrs Charlotte O'Brien, Chief Operating Officer<br>Mr Paresh Patel, Non-Executive Director<br>Mr Damian Reid, Chief Finance Officer<br>Ms Carys Williams, Non-Executive Director<br><br>Non-Voting Directors<br>Mrs Ama Agbeze, Associate Non-Executive Director<br>Mr Steve Aumayer, Deputy Chief Executive and Chief People Officer<br>Mr Richard Milner, Chief of Staff<br>Mr Frank Sims, Associate Non-Executive Director<br><br>In Attendance<br>Mrs Alison Newby, Head of Midwifery<br>Mrs Lisa Forward, Assistant Director of Clinical Governance<br>Mr Peter Palmer, Board Secretary (minutes) | |
| | **Apologies:**<br>Mrs Joe Chadwick-Bell, Chief Executive<br>Mrs Amanda Fadero, Associate Non-Executive Director<br>Ms Brenda Lynes, Director of Midwifery<br>Mrs Nicola Webber, Non-Executive Director | |
| **67 / 2023** | **Chair's Opening Remarks**<br>Mr Phoenix welcomed everyone to the meeting, noting that Mrs Newby was deputising for Ms Lynes. He explained that the way in which Board Committee updates were presented had been enhanced for this meeting, and that these now appeared in the governance section. The updates were not formal minutes of the meetings, but contained everything that was not considered to be otherwise confidential. This was the closest that the Trust could get to presenting full minutes in public without redactions.<br><br>Hero of the Month<br>Mr Phoenix reported that June's winners had been Claire Wyse, a member of the Intermediate Care team and Kevin Piper, a Radiology Housekeeper. July's winner had been James Banks, a member of the Emergency Department Security Team. He explained that neither Kevin or James had known about their nomination or winning the award in advance, and that their whole teams had celebrated their success on the day. He had spent some time with the whole security team and praised them for the extremely challenging work that they did in the Trust. | |

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| **68 / 2023** | **Declarations of Interest**<br>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. | |
| **69 / 2023** | **Minutes**<br>The minutes of the Trust Board meeting held on 8th August 2023 were considered. No amendment to the minutes were noted and they were agreed as an accurate record, and were signed by the Chair and would be lodged in the Register of Minutes. | |
| **70 / 2023** | **Matters Arising**<br>There were two formal matters arising from the meeting on 8th August 2023:<br><br>*Patient Involvement in Electronic Record Programme (EPR)*<br>An update was provided which explained that as the EPR programme progressed, patient representation would be included on the EPR Board; patient engagement would increase as the go-live period for EPR approached.<br><br>*Multi-professional Leadership Academy*<br>An update was provided noting that access to the multi-professional Leadership Academy was available to all Trust staff and not just clinical staff. | |
| **71 / 2023** | **Chief Executive's Report**<br>Mr Aumayer noted that the day's agenda included a paper that provided assurance for the Board following the Letby case, but felt that it was important to note the impact that the case had had on Executives and all staff in the Trust. Executives had reflected on the leadership approach taken in the Trust and on Speak Up activities. October was Speak Up month, and the opportunity would be taken to reinforce the importance of speaking up within the organisation. In addition, an external well led review was being commissioned to look at wider governance within the Trust.<br><br>He reported that Dr Simon Dowse had recently joined the Executive Team as Director of Transformation, Strategy and Improvement.<br><br>Industrial action had continued during September, and Mr Aumayer thanked staff for the way that they had responded to the strikes, which had included the first combined consultant and junior doctor strike. The Trust had worked hard to mitigate any risks to patient safety during the actions, but elective activity had been significantly disrupted. The recent events in the Middle East had personally impacted on a number of colleagues with Trust leaders and health and wellbeing teams supporting those affected.<br><br>Mr Sims asked how potential harm to patients who had waited for more than a year for an appointment was being managed. Mrs O'Brien explained that a clinical harm review process was undertaken to identify any potential harm to patients as a result of long waiting times. Dr Merritt noted that the clinical harm review process was due to change shortly following a recommendation from NHSE, with patients who had not been seen being proactively assessed for harm when they had their appointment. The current clinical harm review process had not identfied any significant harm in any patients.<br><br>Mr Patel asked about the quantum of patients who had been reviewed, and Dr Merritt reported that all specialities apart from gynaecology had reviewed 70% or more of patients. Reporting and investigations of any harm that was identified would continue under the revised process.<br><br>*The Board noted the report.* | |
| **72 / 2023** | **Taking organisational assurance post R v Letby**<br>Mr Phoenix explained that the Letby case had had a profound effect on staff throughout the organisation. The paper that was presented to the Board had been written jointly by himself and Mr Milner, emphasising that the Trust's response to the case was the responsibility of the whole Board. A public inquiry was due to be held which would lead to recommendations | |

for the Trust, but areas where processes could be strengthened had already been identified, including some HR processes and Fit and Proper Person Testing (FPPT).

He emphasised the importance of having a strong Speak Up culture, noting that the Trust's Speak Up Guardians regularly presented to the Trust Board and to the People and Organisational Development (POD) Committee. The Trust Board, along with senior managers and staff, had undergone Speak Up training which emphasised the importance of speaking up, listening up and acting when concerns were raised. Mr Phoenix explained that he held regular meetings with Executives and Clinical Chiefs in an informal, unminuted environment which allowed him to connect and triangulate written assurance with the personal experience of colleagues in the Trust. He explained that he felt that the Trust was good at listening to, and acting upon, issues when they were raised, but noted that it was important not to be complacent. Colleagues should continually challenge themselves and each other to ensure that they were doing the right things in the right way.

Dr Merritt explained that what had taken place had been truly awful. The purpose of the paper presented to the Board was to emphasise the effective speak up culture that already existed at the Trust. However, there was more that could be done, including ensuring that the different forms of data available were utilised effectively in real time to allow concerns to be identified as soon as possible.

Mrs Carruth explained that the level of personal malevolence seen in the Letby case was thankfully very rare, noting that people who wished harm on others could choose occupations that allowed them to access vulnerable people. The impact of what had happened and damage to the reputation of every healthcare worker would be felt for some time. She explained that any issues should be identified at an early stage through the use of robust governance processes along with data. She anticipated that the introduction of the Patient Safety Incident Response Framework (PSIRF) in the Trust would change the way in which incidents were responded to. It was important that individual members of staff were held to account for their actions when this was appropriate.

Ms Williams reported that the POD Committee received regular updates from the Speak Up Guardians, which gave her personal assurance about the open speak up process in the Trust. The Trust's Speak Up Guardians were fantastic, well trusted and raised concerns when they identified issues. It was important to ensure that they continued to be well supported and visible in the organisation. She noted that there were improvements that could be made, emphasising the importance of not being complacent. Dr Merritt reported that a recent medical leadership afternoon had been held where the Speak Up Guardians had made a presentation to attendees, who had emphasised their continued support for them.

Mrs Manson reported that the Quality and Safety (Q&S) Committee would review listening up to ensure that maternity staff, patients and families were reassured about the processes that were in place to ensure that safe care was provided. Mr Phoenix noted that the listening up process used by the maternity team had worked well when recent improvements to the service had been made, ensuring that staff and patients were heard when they raised concerns.

Mrs Churchward-Cardiff noted the important role that the Speak Up Guardians had in supporting colleagues to raise concerns; it was vital that feedback was provided to those raising concerns once these had been investigated in an open manner. Mrs Carruth agreed, explaining that punishing colleagues for making genuine mistakes would deter the reporting of issues. However, if there was any suggestion of deliberate harm the this would need to be dealt with appropriately. She hoped that the implementation of PSIRF would help to support the correct balance being found.

In response to a query from Mrs Agbeze, Dr Merritt reported that the Trust had a high level of no harm incident reporting, demonstrating an open reporting culture. Mrs Carruth noted that all near misses were subject to discussion at weekly patient safety summits.

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| | Ms Williams noted that it was important that the Board reflected on what could be done better, asking whether enough was being done to look at potential patterns in patient complaints and how this could be reported to the Board. Mr Milner explained that emerging issues were triangulated with divisions, with any issues identified discussed at weekly patient safety summits. Complaints were considered to be high impact events by the Trust with regular reports provided to Q&S. Mrs Carruth noted that all complaints received Executive oversight when they were received. The complaints team were adept at identifying patters or areas of concern when they arose and a dashboard was being developed which would improve the way that data was presented to Q&S.<br><br>Mr Reid asked whether mortality trends should be reviewed in more detail, noting that in the Letby case clinicians had identified concerns but had not been listened to. Dr Merritt explained that the Trust already reviewed detailed mortality data. A deep dive was being undertaken into level two incidents where there was minimal harm, which would be reported to Q&S. He explained that the roll out of Datix Cloud in November would put more of the Trust's data into a single place, allowing for improved triangulation.<br><br>Mr Sims agreed about the importance of effective triangulation of information, use of data and listening to colleagues; he felt that consistent investigations of incidents and of how learning was used were also important. He recognised that challenges of triangulating complicated data in a consistent and effective manner, and hoped that the introduction of PSIRF would be of positive benefit in doing this.<br><br>Mr Phoenix explained that the Board would continue to discuss the implications of the Letby case. Areas where improvements could be made would be addressed, including working with staff, strengthening policies and reflecting on governance processes. The Trust would await further guidance once national reviews of the case had been completed.<br><br>*The Board noted the report.* | |
| **73 / 2023** | **Integrated Performance Report, Month 5 (August)**<br>Mr Aumayer reported that August had been an exceptionally challenging month for the Trust, particularly for the Emergency Departments (EDs). Bed occupancy had increased which had caused challenges to patient flow and cancer and elective care performance, enhanced by ongoing industrial actions. The Trust had continued to focus on improving performance with some key areas of success. Performance had been challenged across the region during the month, and the Trust had been recently received praise from a regional director for maintaining performance levels during the challenging period with the Trust performing well in comparison to other organisations.<br><br><u>*Quality*</u><br>Mrs Carruth reported that, following validation, nine cases of clostridium difficile (c.diff) had been reported during August. Five had been health care related, with one due to a possible lapse in antibiotic usage; none were related to cross infection. A deep dive was being undertaken by the infection control team which would be presented to Q&S. A robust action plan had been developed but the number of cases was of concern. Four c. diff cases had been reported during September.<br><br>Seven cases of Meticillin-sensitive Staphylococcus Aureus (MSSA) had been reported in August, five of which were healthcare related. Three were considered to be unavoidable, one possibly avoidable and one avoidable. The cases would also be discussed by Q&S. A notable increase in MSSA had been seen across the region and the Trust was working closely with system colleagues and the infection control team to fully understand the increase.<br><br>Interim project support had been secured to support the work being undertaken on reducing Violence and Aggression, with an 8% increase in assaults on staff reported during September. Good progress had been made in progressing actions, but there was more work to do. Sustained pressure from complex patients attending the Trust with mental health needs was being seen. The situation was not anticipated to improve in the short term, but discussions were taking place across the system about what could be done to | |

improve the situation. Mrs Carruth reported that she had recently spent a morning with the community frailty team, and was proud and inspired by the work that they did.

Mrs Churchward-Cardiff noted that a couple of weeks previously there had been 70 patients in the region who had been waiting for an inpatient mental health bed. She asked whether the system recognised the ongoing mental health emergency that was taking place and accepted that EDs were not the right place for these patients to receive treatment, from both a patient and staff perspective. Mrs Carruth noted that not all patients with mental health issues required a bed; some needed housing or more complex support. Discussions were taking place across the system about flow through mental health beds and whether more beds were required. There was a huge reliance on the independent sector to support the NHS, with some of the highest risk patients receiving treatment in their own homes. Some patient behaviours in hospital were extremely challenging for staff and other patients. Mrs O'Brien noted that work was being undertaken with Sussex Partnership Foundation Trust colleagues to co-locate liaison teams into EDs which would enable patients to be redirected at the front door to the most appropriate place for their care.

Mrs Williams noted that the Board had previously discussed the importance of information about the Trust's community services being presented in more detail in the IPR. She asked when it was anticipated that this would be undertaken. Mr Milner explained that a programme for reviewing the whole IPR had been started, and hoped that IPRs would provide a more helpful focus for the Board, including additional data on community services from April 2024. **RM**

Dr Merrit explained that the Summary Hospital-level Mortality Indicator (SHMI) and the Risk Adjusted Mortality Index (RAMI) measured mortality in different ways, with the SHMI including patients who had died up to 30 days after discharge. The SHMI at ESHT was exacerbated due to the Trust's provision of community services. The increased SHMI seen since October 2022 had previously been discussed by the Board, and had been seen in trusts across the South East, and could not be explained. A deep dive into mortality was scheduled to be presented at the November Board Seminar.

Deaths due to Covid had previously been removed from SHMI and RAMI, but would be included in the data in the future. Dr Merritt anticipated that this recalculation would lead to improved figures for the Trust. During August, 4-5 more patients died from sepsis than had been anticipated but 3-4 less patients died from pneumonia. The figures tended to even out over time, and the Trust's adherence to best practice for the treatment of sepsis remained good. A deep dive had been undertaken to look at the increase in the elective SHMI which had found that this was linked to patients with terminal conditions being admitted for procedures and subsequently dying. There had been no increase in deaths from elective surgical activity.

In response to a question from Mrs Churchward-Cardiff, Dr Merritt explained that he did not think that patients in virtual wards would be included within mortality data. Mrs Churchward-Cardiff asked why medical examiner reviews had fallen to 55% and Dr Merritt explained that he was unsure, but that the reduction was unacceptable. He had discussed the matter with clinical chiefs, emphasising the importance of undertaking the reviews in a timely manner.

Mr Patel asked whether the integrity of the data used to calculate SHMI and RAMI was subject to checks. Dr Merritt explained that the data for the mortality metrics came from Hospital Episode Statistics (HES) which used data produced by the Trust. Issues with the date were corrected by the Trust when identified, and work was undertaken to ensure clinical coding was as accurate as possible. Mr Phoenix noted that getting coding wrong could cause issues for Trusts for a long time, explaining that the good quality of coding seen at ESHT was a credit to the clinical coding team. Ms Williams noted that she had recently enjoyed a visit to the clinical coding team, and asked Dr Merritt to ensure that the thanks of the Board were passed on to the team, reflecting the positive discussion that had taken place.

Mr Sims asked whether it was possible to be given more information about the processes in

the Trust used to review mortality data, accepting that the information presented to the Board was only a summary of all the work that was done. Dr Merritt explained that greater detail would be included in the presentation to the Board Seminar.

*Workforce and People*
Mr Aumayer reported that continuing industrial action in August had seen 6.3% of the Trust's consultants taking part in strike action, along with a significantly higher percentage of junior doctors. He thanked clinical colleagues who had provided cover during strike actions, ensuring that emergency services were covered and that safe care continued to be offered to patients. The industrial actions had impacted on lengths of stay for patients and waiting lists for elective care.

People metrics had remained broadly positive during August, with a continued reduction in turnover and vacancies, and stable, low level sickness rates. Mr Aumayer anticipated that sickness rates would increase moving forward as there had been a recent increase in the number of staff unwell with Covid to around 50 during the previous week. Pay expenditure had increased during August due to it being a five week month and due to industrial action.

Mandatory training rates had reduced having been impacted by industrial action, but would be recovered moving forward. Appraisals rates continued to improve, meeting the four year recovery trajectory. A flu vaccination programme for colleagues had commenced; due to a decline in local provider sites, Covid vaccination hubs had been set up for to patient facing colleagues. All colleagues were able to access the national booking system to receive a Covid vaccination.

Mrs Churchward-Cardiff asked whether the appetite for striking was changing and whether any doctors were striking in order to take agency work in other organisations. Dr Merritt reported that the consultant body at ESHT did not had a large appetite for strike action, but that appetite remained high amongst junior doctors. Mr Aumayer explained that both the Trust and unions were passionate about ensuring that striking doctors did not work elsewhere and were working closely together to ensure that this did not happen. Unions were reinforcing this message with their members.

*Access and Responsiveness*
Mrs O'Brien reported that despite increased challenges in ED during August, particularly during industrial action, the Trust had seen a small increase in performance against the four hour emergency access clinical standard to 75.1%, placing the Trust 31st in the country. A comprehensive action plan had been developed to reduce the number of non-admitted breaches, along with work with system partners around timely support for patients attending with mental health issues. The two hour target for urgent community response was being delivered sustainably, and increasing numbers of patients were being admitted to virtual wards.

Patient length of stay had been impacted by industrial action, with an increase seen in August; six patients had been inpatients in the Trust for more than 100 days, four of whom were medically fit to leave. Funding had been secured to support transfer of care hubs which would be substantively staffed.

September had seen no patients waiting for longer than 78 weeks for elective treatment, and the Trust would now focus on improving 65 week waits. It was estimated that there had been an almost 10% loss in activity as a result of industrial activity in July, with a further 11% loss seen in August. First outpatient activity continued to exceed the 108% target, and plans were in place to increase both day case and elective admitted activity. A 10% increase in suspected cancer referrals had been seen since 2022, and work was being undertaken to reduce numbers of patients on 104 day waits and on improving the faster diagnosis standard. Community waiting times were being reduced, particularly in community paediatrics, through outsourcing with a significant reduction in waiting list and patients waiting for more than 18 weeks. The Trust was working with the system to develop more sustainable solutions moving forward.

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| | Ms Williams asked what metric was of concern most from a patient perspective. Mrs O'Brien explained that her key concerns were the long waiting times for cancer and elective patients and the length of time patients spent in ED. The Trust was working hard to address all three issues, but ED was becoming more challenging due to increased activity and industrial actions.<br><br>Mrs Manson recognised the great work that had been undertaken to reduce the number of no criteria to reside patients in the Trust since the start of the year. She asked how concerning it was that the referral to treatment (RTT) waiting list had continued to increase over the last two years. Mrs O'Brien explained that revalidation work was being undertaken on waiting lists to ensure that RTT data was accurate. The Trust had focussed on treating patients who had waited for the longest, which had led to an increase in the overall waiting list; plans were in place to address the issue.<br><br>Mrs Manson asked whether the community paediatric hub which had been opened in Bexhill was running at full capacity. Mrs O'Brien explained that she was unsure, and would report back to the Board.<br><br>Mrs Churchward-Cardiff acknowledged the improvements that had been seen, particularly in diagnostic performance, but explained that she was concerned about cancer two week waits and RTT performance. She asked what big sustainable changes could be made to improve performance and Mrs O'Brien explained that that work was being undertaken to ensure that pathways were fully understood and followed best practice. In addition there was a focus on improving grip and control and on going back to basics to review long waiting patients and waiting lists to improve cancer performance.<br><br>Mr Sims noted that improved financial performance and productivity in the Trust were both predicated on reducing lengths of stay and asked about the impact that the Trust's Transfer of Care Hub (TOCH) would have. Mrs O'Brien explained that the TOCH would provide increased operational support on both sites which would increase discharge support for wards. Leaders of the TOCH would be appointed from the Trust, the ICS and the local authority and would have sight of delays across the system. Mrs Carruth reported that she had visited Worthing the previous day to undertake a discharge peer review, and had identified processes that could be used at ESHT. It was important to ensure that the TOCH was correctly resourced and that data from across the system was available in order to track patients and identify any barriers to discharge.<br><br>Mr Sims noted that the number of patients attending EDs was increasing, and asked what was being done by the Trust and the system to address this. Mrs O'Brien explained that central points of access were being developed by the system, alongside the ability for the Trust to review SECAMB data which would help patients to be redirected when they did not require ED treatment. Patients tended to attend EDs as the different pathways and services that were available to patients were not always clear.<br><br>Mrs Agbeze asked how communication with community patients could be improved to let them know about the various options for treatment. Mr Phoenix noted that the various options were well advertised, but the complex systems meant that it was understandable that patients attended EDs when they were unwell.<br><br>Mrs Manson explained that she had heard anecdotal evidence that the 111 service was not consistently directing patients to the most appropriate place for treatment. Mrs Carruth explained that she had had recent personal experience of 111, and had found that despite her best efforts she was ultimately encouraged to attend A&E. She noted that it would be very challenging for someone who did not know the NHS well to avoid coming to A&E.<br><br>*Finance*<br>Mr Reid reported that the Trust's year to date deficit in month five had been £2.2m, which would increase in September to £3.7m. The direct financial impact of strike actions was not included in the deficit figures; the Trust was unable to deliver activity beyond plan when strike actions took place. Pay costs had reduced by around £900k in the year to date with | **COB** |

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| | non-pay costs also slightly reduced. The Trust had received an allocation of transfer of care funding which would be used to maintain support for care beds until the end of the year.<br><br>Mrs Churchward-Cardiff noted that spending on temporary pay varied a lot from planned spending. Mr Reid explained that there was no plan for temporary pay spending, so this would always be reported as a large variance. There was a national limit on temporary pay spend of 4.5% for trusts and ESHT was within this target. Ms Williams noted that the matter had been discussed at September's POD meeting, with an analysis of temporary pay spending having been requested.<br><br>*The Board noted the Month 5 IPR.* | |
| **74 / 2023** | **Maternity Overview Q1**<br>Mrs Newby reported that the maternity team had seen staff joining from London and from neighbouring trusts along with a number of newly qualified midwives during the previous 12 months. The newly qualified staff would be supported for 12-18 months on a preceptorship programme. There had been an increase in the complexity of maternity service users, with challenges including the management of mental health and safeguarding issues. The service was fully compliant with the Ockenden immediate and essential actions (IEAs), and perinatal data showed normal variation with no causes for concern. The ESHT Maternity Transformation Plan and the Saving Babies Lives V2 Annual Report were presented to the Board to provide additional assurance.<br><br>Mr Phoenix praised the maternity team for the staffing improvements that had been seen, noting that this was directly related to the excellent leadership of the team which led to staff choosing to come and work at the Trust. He thanked the team for everything that they had achieved. Mrs Newby explained that a collaborative approach was taken with staff and the Maternity Voices Partnership (MVP) to ensure that the views of staff and patients were heard and considered when changes were made to the service.<br><br>Mrs Churchward-Cardiff asked whether the mix of staff in the maternity team continued to be correct given the increasing complexity of patients. Mrs Newby explained that the service had seen a number of experienced band six staff joining alongside the newly qualified staff over the last 12 months. As a result, staffing would be bottom heavy for a period while the new staff received training. Many midwives had completed an intensive care course, reflecting the continued training and development of staff. All of the maternity teams were feeling the effect of how busy the service was, but robust escalation plans were in place which were implemented when required.<br><br>Mr Sims asked whether plans were pressure tested prior to implementation to ensure that they were appropriate for the levels of demand being seen. Mrs Newby confirmed that plans were tested prior to being launched; the service had seen a threefold increase in mental health referrals since 2019/20, and mental health support was offered to perinatal patients. In addition, the service worked closely with the local authority under the Best Start in Life initiative, with two band four mental health practitioners supporting the service.<br><br>Mr Sims noted that the support needed by patients suffering from mental health conditions was very individual, and asked what was being done differently by the system in recognition of the growing mental health support that was required by the local population. Mr Phoenix reported that the challenges of providing mental health support across the system were recognised in the Sussex Shared Delivery Plan (SDP), with plans being developed to broaden the support and services that were offered. Mrs Carruth reported that one of the SDP delivery boards was focussed on mental health and autism. The gaps and challenges related to mental health provision were recognised, but the challenge was of a different scale than had been seen before. Practical training was being offered to staff to ensure that they were able to manage patients with complex mental health conditions, but changes would take some time to implement. Mrs O'Brien agreed, reporting that mental health services were subject to a significant transformation programme which was focussing on how patients could be managed in the community rather than in acute settings.<br><br>*The Board noted the Maternity Overview Q1 report.* | |

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| **75 / 2023** | **Learning From Deaths Q4**<br>Dr Merritt reported that the learning from deaths report enabled the Trust to narrow down the number of deaths reviewed in detail to the highest risk deaths. These included any deaths that had been reported to the coroner for inquest, any with the possibility of hospital acquired thrombosis, any related to a complaint, amber incident report, serious incident or root cause analysis and anyone with learning disabilities. This was between 50-70 deaths a quarter. The deaths were reviewed by a senior team and were graded on a scale of 1-6 based on any avoidability of the patients' death. During Q4 there had been two deaths graded as three (probably avoidable).<br><br>Mrs Manson noted that reviews of deaths for patients with learning disabilities had reduced to zero in some months and asked why this was. Dr Merritt explained that the Trust only reviewed these deaths once an external Learning Disability Mortality Review (LeDeR) had been completed. This could lead to significant delays, but all deaths were reviewed by the Trust.<br><br>*The Board noted the Learning From Deaths Q4 report.* | |
| **76 / 2023** | **Winter Preparedness 2023/24**<br>Mrs O'Brien explained that the Trust undertook a substantial amount of work to ensure that it was as prepared as possible winter; no additional funding was expected to be received. The ICS was required to submit a system plan for winter to NHSE, and in preparation for this a detailed ESHT plan would be submitted to the ICS before the end of the week. Bed modelling had been undertaken to account for the anticipated increase in demand; an additional ward could be created at EDGH, and measures that would support the winter period at the Conquest were being identified. Industrial action and length of stay would continue to impact on performance, and the Transfer of Care Hub would provide support for discharges. Admission avoidance would be a key factor in managing winter pressure and a finalised plan would be presented to the Board in December.<br><br>Mr Phoenix noted that the Trust was doing everything within its power to prepare for winter, and was encouraging system partners to do more where this was possible. Some additional capacity would be made available by the system, but there was risk associated with managing the winter period. The Trust would need to do everything possible to manage the winter pressures in order to look after both patients and colleagues.<br><br>Mrs Manson asked what more could be done to utilise community resources differently, and whether virtual beds would be increased. Mrs O'Brien explained that community bed modelling would be undertaken that week in order to fully understand the impact of patient flow out of acute sites. The number of virtual ward beds was constrained by the availability of workforce. Community services were closely involved in the winter planning process.<br><br>Ms Williams asked what the biggest lesson learnt from the previous winter had been, and whether plans for 2023/24 had addressed this. Mrs Carruth explained that the biggest issues the previous year had been patient length of stay and discharge ready patients. The challenges had been significant during the previous winter and had led to a reduction in compliance with the four hour clinical standard. The Trust would focus on reducing the number of discharge ready patients, but would require support from the system to achieve this. She noted that reducing the movement of staff to unfamiliar wards due to ongoing pressures would also help to support this improvement.<br><br>Mr Patel asked how the figures contained within the planning had been reached. Mrs O'Brien explained that these had been produced by the Trust, utilising planning guidance. Mr Reid explained that it would be challenging to meet the planning assumptions without any additional financial support. Discussions had taken place about funding seven day discharge support, but had not been finalised. In addition, further industrial actions would impact on the Trust's ability to manage winter pressures.<br><br>Mrs Agbeze asked whether there was a possibility of increasing the 54 virtual beds that were available. Mrs O'Brien explained that discussions with the system partners and the | **COB** |

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| | CHIC division had taken place about whether there was workforce available to support additional virtual beds.<br><br>*The Board noted the Winter Preparedness 2023/24 report.* | |
| **77 / 2023** | **Reinforced Autoclaved Aerated Concrete (RAAC) Synopsis and Timeline of Surveys**<br>Mr Aumayer reported that a number of reviews into the use of Reinforced Autoclaved Aerated Concrete (RAAC) had been mandated since 2019 and that the Trust had complied in full with the requirements for the reviews. No evidence of RAAC had been found in the Trust although a small number of areas within the Trust's estate had not been reviewed. The nature of these areas meant that the presence of RAAC was considered to be very unlikely.<br><br>*The Board noted the RAAC Synopsis and Surveys report.* | |
| **78 / 2023** | **Reports from Board Committees**<br><br>*Audit Committee*<br><br>*The Board noted the report.*<br><br>*Finance and Productivity Committee*<br><br>*The Board noted the report.*<br><br>*People and Organisational Development Committee*<br>Ms Williams reported that the summary presented to the Board had been based on the draft minutes from the meeting; she would work with the team to update the report.<br><br>*The Board noted the report.*<br><br>*Quality and Safety Committee*<br><br>*The Board noted the report.* | |
| **79 / 2023** | **Fit and Proper Person Test**<br>Mr Milner reported that the importance of Fit and Proper Person Testing (FPPT) for Trust Board's was reflected in the Letby paper discussed earlier in the meeting. The FPPT process had been enhanced and would be completed for all sitting Board members by the end of March 2024. The review process would include more detailed checks than had previously been the case, and each review would require sign off by the Chairman and submission to the regional NHSE director. FPPT tests would be aligned with Board appraisals in 2024/25 for both Executives and Non-Executives. A new competency framework for Board members was expected in October; the impact of this would be considered alongside the new FPPT processes. Mr Phoenix noted that in practical terms the process would not feel much different to the existing process for Board members.<br><br>*The Board noted the Fit and Proper Person Test update.* | |
| **80 / 2023** | **Patient Safety Incident Response Framework**<br>Mrs Carruth noted that the introduction of the Patient Safety Incident Response Framework (PSIRF) had been previously discussed with the Board, as well as by the Q&S Committee. It would represent a huge cultural shift for the Trust and she thanked Mrs Forward and her team for all the work that they had done to implement PSIRF in the Trust.<br><br>Mrs Forward explained that there had been a national drive to improve patient safety following the publication of the National Patient Strategy in 2019. The strategy had considered that learning from incidents was too focused on individual incidents. PSIRF would change the way that the Trust responded to incidents, allowing them to be undertaken more flexibly and quickly, with an increased focus on compassion and the involvement of staff, patients and families. A no blame emphasis would be placed on | |

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| | investigations, but it was important that deliberate acts were dealt with appropriately. Work had been undertaken with HR colleagues and the Deputy Director of Culture to incorporate PSIRF into how staff were supported. PSIRF would allow for quick responses to incidents, identifying what happened, what should have happened and what barriers were in place with a focus on systems and processes rather than individuals.<br><br>The plan presented to the Board set out how staff would be supported in identifying the most appropriate way to respond to an incident, with an emphasis on what could be learnt, how improvements could be implemented and shared throughout the organisation. The PSIRF Policy had been developed, based on national templates. Once the plan and the policy had been approved by the Board they would be submitted to the ICS for approval; once approved by the ICS the Trust would receive permission to launch PSIRF. The policy would be reviewed annually as PSIRF was embedded within the Trust, and would subsequently be subject to bi-annual review.<br><br>Two e-learning modules on PSIRF had been introduced for staff, alongside enhanced training for patient safety teams. Templates had been tested with clinical teams prior to the launch with positive feedback received. Reporting processes for staff would remain the same as under the current system. Every incident would continue to be discussed at the Weekly Patient Safety Summitt. The launch of Datix iCloud in November would allow data from safety incidents, complaints, inquests, claims, PALS and learning from deaths to b e triangulated. Mrs Forward anticipated that the first year of PSIRF would be challenging for the Trust as it transitioned from existing patient safety processes.<br><br>Mr Phoenix asked whether the Board leadership PSIRF module was available, and whether this was mandatory for Board members. Mrs Forward confirmed that there was a national expectation that Board members would complete the training, and that it took about 15 minutes to complete.<br><br>Mrs Agbeze noted that PSIRF represented a significant change for the Trust, explaining that the sense of excitement seen from Mrs Forward about the framework would be crucial in supporting staff through the transition. Mrs Forward reported that clinical teams were looking forward to the introduction of PSIRF having seen the impact that it would have.<br><br>Mrs Churchward-Cardiff noted that the context of incidents was a crucial factor in understanding where opportunities for errors existed and how these could be eliminated. Mrs Carruth agreed, explaining that PSIRF offered greater opportunity for identifying human factor information.<br><br>Mrs Carruth thanked Mrs Forward for her hard work on the implementation of PSIRF. She noted that she would be leaving the Trust shortly and thanked her for all she had done.<br><br>Mr Phoenix asked whether the Q&S Committee had approved the PSIRF plan and policy, and Mrs Manson confirmed that they had been discussed and approved. The Committee had recommended that the Board sign off the documents. Mr Phoenix took confidence in the recommendation from Q&S and was happy for the Board to approve the plan and policy.<br><br>Mr Phoenix noted that Q&S would oversee the Trust's transition to PSIRF, asking for an update to be presented to the Board after a year, with reporting by exception if required.<br><br>*The Board approved the Patient Safety Incident Response Framework (PSIRF) plan and policy.* | |
| **81 / 2023** | **Board Assurance Framework Quarter Two**<br>Mr Milner presented the Quarter Two Board Assurance Framework (BAF), explaining that it had been reviewed by the Audit Committee. He reported that the risk score for BAF 6 had reduced since quarter one. The scores for BAF risks 7, 8, 9 and 10 were above the anticipated year end position and work was being undertaken to address this. He noted that an update on BAF 11, which concerned equal access to services, was due to be presented to the Strategy Committee at the end of the month. | |

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| | Ms Williams asked about the benefit of including anticipated year end risk and target risk scores. Mr Milner explained that these were related to how often the risk rating was adjusted during the year and agreed to review the BAF headings for the Q3 update to improve clarity.<br><br>*The Board noted the Board Assurance Framework Quarter Two update.* | **RM** |
| **82 / 2023** | **Equality Annual Report**<br>Mr Aumayer presented the Equality Annual Report, reporting that this was the first integrated report that had been produced by the Trust. He thanked the Trust's Equality, Diversity and Inclusion lead for writing the report. He reported that the Board had discussed Equality, Diversity and Inclusion (EDI) at a recent seminar session, and that an EDI Board Sub-Committee was being set up which would start in November. Staff networks would be discussed at November's Board Seminar.<br><br>Mrs Carruth praised the helpful report and asked about the use of the term 'multicultural person'. Mr Aumayer confirmed that the term had been set nationally, as there was now movement away from using 'BAME'.<br><br>Mr Phoenix explained that oversight of the issues identified in the report would be undertaken by the EDI Committee. He praised the report, noting that it presented data that could be hard to interpret in a helpful manner.<br><br>*The Board noted the Equality Annual Report.* | |
| **83 / 2023** | **Use of Trust Seal**<br>One use of the Trust Seal was noted since the previous meeting of the Board. | |
| **84 / 2023** | **Questions from members of the public**<br>Mr Phoenix explained that a number of questions had been received from a member of the public prior to the meeting, which would be responded to by email.<br><br>Mr Hardwick noted the exceptional achievement of two members of staff in reaching 50 years of NHS service. Mr Phoenix agreed, reporting that the recognition scheme had recently been altered to recognise all NHS service and not just time spent at ESHT. Mr Aumayer explained that staff received a pin badge, a small gift, and profuse thanks in recognition for their long service.<br><br>Mr Hardwick asked what ERF, mentioned in the IPR, stood for and for an explanation about what clawback was. Mr Reid explained that ERF was the Elective Recovery Fund. The Trust had a target of achieving 108% more activity than in 2019/20, and not meeting the target meant that the Trust would receive reduced income. However, the clawback process had not been implemented due to effect of the continuing industrial actions.<br><br>Mrs Walke explained that she had been shocked by the Letby case, noting that many of Letby's colleagues had believed that she was innocent. She noted that it was often reported that parents were not listened to, and was pleased to have heard the Trust's response to the case. Mr Phoenix noted that this was not the first time that an NHS employee had abused their position, and in each case patients and staff had trusted and liked the protagonist. Mrs Carruth noted that medical teams spent considerable time together in the most challenging circumstances, forming very deep bonds making what had happened an incredible betrayal of trust. She explained that governance played a key role in providing data and evidence which could counter human instinct in reaching incorrect conclusions.<br><br>Mrs Walke noted that she was concerned about paediatric services following the Letby case and asked whether Speak Up Guardians could speak to staff in those areas to identify whether they had any concerns that they had not escalated. Mr Aumayer reported that the Speak Up Guardians were already engaging with paediatric teams, and an extended consultation period had been put in place to ensure that every member of staff had the opportunity to speak up either publicly or privately. | |

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| | Mrs Walke noted that some of the issues reported around discharging patients sat outside the Trust's control. She noted that this could lead to patients have worse experiences and outcomes, as it was not good for patients to be in hospital when they did not need to be. Mr Phoenix agreed, reporting that social care colleagues were facing challenges of their own including reduced funding and staffing challenges. Addressing the issue was a live conversation that was taking place across the system at the most senior levels, and there was a great will on the part of system partners to find a solution. | |
| **85 / 2023** | **Date of Next Trust Board Public Meeting**<br>The next meeting of the Trust Board would be taking place on Tuesday 12th December 2023 at 0930 at Horntye Park Sports Complex in Hastings. | |

# Matters Arising from the Board meeting of 10th October 2023

| Agenda Item | Action | Lead | Progress |
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| **73/2023 – Integrated Performance Report, Month 5 (August)** | Consider focus on community services data within the Trust IPR | Richard Milner | This will be picked up as part of the wider actions associated with providing greater focus at IPRs on operational performance. For the Trust IPR, the aim is for February's update to include a stronger focus on community services. |
| | Information about utilisation of the community paediatric hub to be shared with the Board | Charlotte O'Brien | The clinical workforce at the Paediatric Hub is fully utilised. A further review is underway to support increased utilisation of the available clinic space this includes a review of all clinical job plans to enable this. Review will have completed by January 2024. |
| **76/2023** | Final winter plan to be presented to the Board at December's meeting | Charlotte O'Brien | Updated winter plan included on the agenda for December's Trust Board meeting. |
| **81/2023** | Consideration to be given to changing headings for anticipated and target risks to provide clarity for the BAF Q3 update | Richard Milner | Q3 update due to be presented to Committees in January and to the Board in February 2024. |

East Sussex Healthcare NHS Trust

# Chief Executive Report

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| **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 |
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| | x | x | x | x |

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

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

**Executive Summary**

I'd like to start with a thank you to all our colleagues who continue to work so hard to make sure we deliver excellent care for our patients and our communities. I continue to be in admiration of the work I see going on across the Trust. As we approach winter, I'd like to recognise the upcoming challenges the next few months may bring; it is important to remember our Trust Values throughout this time and ensure that we are working together to maintain high quality care across our services as well as for our patients.

**Addressing financial challenges created by Industrial Action**

The NHS has been asked to undertake a rapid two week review to agree actions to improve the financial position, whilst ensuring that:

- Patient safety is protected
- Emergency care performance and capacity is prioritised
- High priority elective and cancer is prioritised
- Financial balance is achieved

The discussions are ongoing with NHS England (NHSE) and other system partners about any changes to the activity, performance and finance submissions made at the start of the year but the aim is to ensure we deliver 76% performance against the four-hour A&E waiting time target by March 2024, ensure that no patients are waiting for over 65 weeks for elective care and achieve a financial breakeven position.

As a result a number of additional internal Trust controls have been introduced and these include additional workforce controls and discretionary spend, but also rely on undertaking additional elective activity within tariff or better.

**Armed Forces Day**

I was delighted to sign the Armed Forces Covenant last week. It was incredible to be able to show our support and appreciation for Armed forces, veterans, and their families.

This pledge, made by organisations across the country, actively ensures that past and currently serving armed forces' personnel and their loved ones are not in any way disadvantaged because of their service. As an organisation that has signed the Armed

Forces Covenant, we have committed to ensuring that those who have served, as well as those who continue to serve in the armed forces reserves, are fully supported in joining and working at the trust.

To mark Remembrance Day this year, the trust chaplaincy team held Remembrance Day services on Sunday 12th of November. Trust staff gathered to remember the sacrifices of all our servicemen and women.

**NHS Staff Survey**

I'd like to say a huge thank you to those of you who have completed your NHS Staff Survey, your feedback is crucial. 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 is our current response rate, by way of comparison, last year at the same point, the Trust were at 41% substantive and 33% TWS submission rates.

- **49%** of substantive have submitted a survey which equates to **4079** colleagues.
- **35%** of TWS have submitted a survey which equates to **288** colleagues.

I am committed to making our trust a great place to work, so thank you for helping us on our journey by taking the time to complete this important, confidential survey.

**Trust Staff meet King Charles on his Birthday.**

Our NHS colleagues Felix Asibey, Pauline Abu and now retired colleague Norman Killick were invited to attend the King's 75th birthday celebrations. The afternoon tea consisted of 60 people who were also 75 and had worked within the NHS as well as teaching and volunteer services. This was followed by a reception which was attended by over 400 internationally educated nurses at Buckingham Palace.

Felix said: "I felt honoured to be invited to meet the King on such a beautiful day and will always cherish the memory of this occasion".

Pauline Abu, currently sister in charge of the Irvine Unit at Bexhill hospital and who will soon be starting as clinical lead on quality and improvement, also had the opportunity to speak to King Charles.

Pauline said: "It was really nice to meet the King, he was so friendly and so down to earth. We talked about my experiences of joining the NHS, as well as my culture and where I am from. He was so knowledgeable about it; I was really impressed. I wished him a happy birthday, and he thanked me for that. The NHS Choir were fabulous, and the ambience of the whole event was so beautiful".

**Visible Leadership**

Ensuring visible leadership is of the upmost importance. Our staff are the beating heart of the Trust and I have most enjoyed getting out and about hearing your positivity as well as your feedback.

Visits have been undertaken to teams and wards across multiple ESHT sites over the last couple of months, both by executive directors and non-executive directors. A range of different services were visited, from our Community Health visitors to our Podiatry and District Nursing Team. These visits will continue over Christmas, our Executive team are very much looking forward to spreading some festive cheer!

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| | I would like to give a special mention to our community teams: The Ivy, Infant feeding, and triage. I was incredibly proud to receive a heartwarming letter from a patient praising the professionalism and level of care provided by these teams, the dedication and ability of our staff to go above and beyond continues to blow me away.<br><br>The Chairman had the honour of presenting Novembers Hero of the month award to Neil Maskell, a waste porter at EDGH. Neil's colleagues described him as always full of smiles, polite and continuously going above and beyond to help others.<br><br>**<u>Eastbourne DGH Net Zero Carbon project on BBC South East Today</u>**<br><br>I am proud to announce that our £27m Zero Carbon project at Eastbourne DGH, which saw the installation of new energy-saving insulation, heat pumps and solar panels at the hospital over the last year, was featured on BBC Southeast last Monday.<br><br>Our director of Estates and Facilities Chris Hodgson featured on the programme explaining that this was part of a series of measures that would reduce emissions by 57% 2025 at the EDGH. This is the first solar car park in any UK hospital and will enable us to work towards our goal of zero emissions by 2050.<br><br>I'd like to thank all our colleagues who were involved in pulling this fantastic piece together with the BBC. |

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| **Next steps** | *N/A* |

East Sussex Healthcare NHS Trust

# Integrated Quality & Performance Report

**Prepared for East Sussex Healthcare NHS Trust Board**

**For the Period October 2023 (Month 7)**

# Content

East Sussex Healthcare NHS Trust

# 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

Our priorities during October have been; elective recovery including cancer; delivering safe and sustainable urgent care; reducing the number of inpatients who do not meet the criteria to reside; financial break even and the wellbeing of the workforce. Whilst we are pleased with the progress made across a number of key metrics, we continue to focus on improving performance and are committed to maintaining high standards in our quality of care. In line with guidance and to provide Board assurance information relating to the proportion of patients whose discharges are delayed and the total number of days these delays equate to has been included in the balanced scorecard.

**Key Areas of Success**

- The volume of patients on the Cancer PTL backlog (patients >62days) continues to be below trajectory and, although not quite meeting the national target backlog of 6.4%, the Trust's position of 6.7% is significantly lower the national average of 8.9%.
- 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 expecting to deliver zero >78 week waits for the remainder of 23/34.
- Staff turnover and vacancy rates reduced further in October. Turnover has reduced to 10.5%, previously peaking at 13.9% in Nov 2022.
- Our Urgent Care Response continues to be an area of success with the standard of 70% having been consistently achieved year to date. In October 87.4% of patients seen within the 2-hour response window.
- The Trust has continued to improve the diagnostic DM01 position, achieving 90.66% in October, the highest compliance rate the Trust has achieved since April 2020.
- Our Friends and Family Tests (FFT) recommendation rates for October, when compared to the most recent data released by NHS England (September), show that ESHT continues to be higher than the national average, including Emergency Departments which is the first time since March 2023 for ED.
- ERF has improved from £8,387k to £9,285k

**Key Areas of Focus**

- Whilst ED performance continues to be above the national average with the Trust ranked 43 out of 124, this position has deteriorated since September and delivering the actions from our Urgent and Emergency care improvement plan remain a key objective, with progress tracked through the Urgent and Emergency Care Oversight Group.
- The Trust is focused on reducing first outpatient appointment waiting times to a maximum of seven days for patients referred with suspected cancer, to supporting delivery of both the FDS and 62 day standards.
- 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.

# 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 | 1 | 2 | 6 | Common Cause | Inconsistent |
| Serious Incidents | 0 | 3 | 1 | 7 | Common Cause | Inconsistent |
| Never Events | 0 | 0 | 1 | 0 | Concern | Inconsistent |
| Inpatient Falls per 1,000 Bed days | | 5.48 | 5.40 | 3.86 | Common Cause | Target required |
| Pressure Ulcers, category 3 to 4 | 0 | 0 | 2 | 1 | Common Cause | Inconsistent |
| MRSA Cases | 0 | 1 | 1 | 0 | Common Cause | Inconsistent |
| Cdiff Cases | 5 | 4 | 9 | 4 | Common Cause | Inconsistent |
| MSSA Cases | 0 | 1 | 8 | 3 | Concern | Inconsistent |
| RAMI | 94 | 91.8 | 91.5 | 80.3 | Concern | Achieving |
| SHMI (NHS Digital monthly) | 100 | 100 | 99.7 | 110 | Concern | Achieving |
| Nursing Fill Rate (IP - RN, RNA and HCA) | 100% | 89.6% | 90.5% | 95.2% | Common Cause | Not Met |

| Patient Experience | Target/ Limit | Previous Month | Current Month | 19/20 Same Period | Variation | Assurance |
|---|---|---|---|---|---|---|
| Complaints received | | 28 | 38 | 54 | Common Cause | Target required |
| Complaints Response Compliance | | 28.1% | 50% | | Common Cause | Target required |
| Reopened Complaints | | 7 | 6 | 6 | Common Cause | Target required |
| A&E FFT Score | 85% | 75% | 87.9% | 90.6% | Common Cause | Inconsistent |
| A&E FFT Response Rate | | 0.508% | 0.536% | 4.98% | Common Cause | Target required |
| Inpatient FFT Score | 95% | 98.8% | 98.8% | 97.5% | Common Cause | Achieving |
| Maternity FFT Score | 95% | 100% | 98.1% | 98.8% | Common Cause | Inconsistent |
| Outpatient FFT Score | 95% | 99.2% | 97.8% | 96.7% | Common Cause | Achieving |
| Post Covid19 Assessment FFT Score | 95% | 100% | 0% | | Common Cause | Inconsistent |

| Our People | Target/ Limit | Previous Month | Current Month | 19/20 Same Period | Variation | Assurance |
|---|---|---|---|---|---|---|
| Establishment (WTE) All | | 8,163 | 8,187 | 7,184 | Improvement | Target required |
| Agency Rate | 3.6% | 1.40% | 1.49% | 1.44% | Improvement | Achieving |
| Vacancy Rate | 7.5% | 8.2% | 7.4% | 10.8% | Common Cause | Inconsistent |
| Staff Turnover | 11.6% | 10.7% | 10.5% | 10.4% | Improvement | Inconsistent |
| Retention Rate | 90% | 91.9% | 92.0% | 91.7% | Improvement | Achieving |
| Monthly Sickness - Absence % | 4.7% | 5.2% | 5.5% | 4.5% | Common Cause | Inconsistent |
| Sickness - Average Days Lost per Fte | 17 | 19.1 | 18.9 | 16.1 | Improvement | Not Met |
| Staff Appraisals | 85% | 82.4% | 82.6% | 79.6% | Improvement | Not Met |
| Statutory & Mandatory Training | 90% | 88.8% | 89.4% | 88.4% | Improvement | Not Met |

| Our Performance | Target/ Limit | Previous Month | Current Month | 19/20 Same Period | Variation | Assurance |
|---|---|---|---|---|---|---|
| 4 hour standard | 76% | 74.3% | 70.1% | 81.2% | Common Cause | Inconsistent |
| A&E > 12 hours from arrival to discharge | 0 | 430 | 705 | 218 | Common Cause | Not Met |
| A&E waits over 12 hours from DTA | 0 | 0 | 2 | | Common Cause | Inconsistent |
| Conveyance handover >60 mins | 0% | 0.711% | 1.57% | 1.22% | Improvement | Inconsistent |
| Non Elective Length of Stay | 4.48 | 4.38 | 4.46 | 3.97 | Common Cause | Inconsistent |
| Average daily NCTR | 95 | 188 | 214 | | Empty | Target required |
| 104 day Backlog | 35 | 24 | 37 | 36 | Concern | Achieving |
| Elective Activity (ELIP,DC,OPFA, OPFUP P... | 108% | 110% | 108% | | Improvement | Inconsistent |
| RTT under 18 weeks | 92% | 49.0% | 51.6% | 90.4% | Concern | Not Met |
| RTT 65 week wait | 280 | 261 | 267 | 0 | Concern | Achieving |
| RTT Total Waiting List Size | 58968 | 59903 | 57880 | 29434 | Concern | Inconsistent |
| Diagnostic <6 weeks | 1% | 12.6% | 9.34% | 0.572% | Improvement | Not Met |
| Urgent Community Response within 2 h... | 70% | 86.2% | 87.4% | | Improvement | Inconsistent |
| CHIC wait times < 13 weeks | 75% | 82.2% | 80.0% | 89.5% | Concern | Achieving |
| Intermediate Care Length of Stay | 30 | 43.8 | 34.3 | 23.3 | Common Cause | Inconsistent |
| % Discharges delayed 1+ days | | 19.5% | 22.2% | | Common Cause | Target required |
| Total delay days from monthly Discharges | | 3546 | 4117 | | Common Cause | Target required |
| Cancer 2WW | 93% | 76.1% | 85.7% | 95.4% | Common Cause | Inconsistent |
| Cancer 62 Day | 85% | 63.7% | 54.9% | 70.5% | Concern | Not Met |
| 28 Day General FDS | 75% | 74.1% | 72.7% | | Improvement | Inconsistent |

| Finance | Target/ Limit | Previous Month | Current Month | 1920 Same period | Variation | Assurance |
|---|---|---|---|---|---|---|
| Surplus/(deficit) (£'000) - in month | 30 | (1,400) | (1,317) | n/a | n/a | Not met |
| Surplus/(deficit) (£'000) - YTD | 100 | (3,605) | (4,852) | n/a | n/a | Not met |
| ERF (£'000) - in month | 8,866 | 8,387 | 9,285 | n/a | n/a | Inconsistent |
| ERF (£'000) - YTD | 57,428 | 46,548 | 56,729 | n/a | n/a | Not met |
| Efficiency (£'000) - in month | 2,967 | 2,910 | 3,132 | n/a | n/a | Inconsistent |
| Efficiency (£'000) - YTD | 15,889 | 11,800 | 14,932 | n/a | n/a | Not met |
| Capital (£'000) - YTD | 17,636 | 9,410 | 11,080 | n/a | n/a | Not met |
| Capital (£'000) - FOT | 65,730 | 63,448 | 63,386 | n/a | n/a | Not met |

# Constitutional Standards | Benchmarking

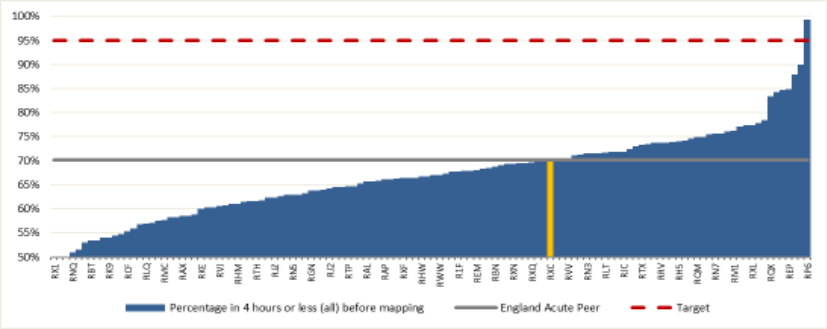
East Sussex Healthcare NHS Trust

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

## Urgent Care – A&E Performance

October 2023 Peer Review

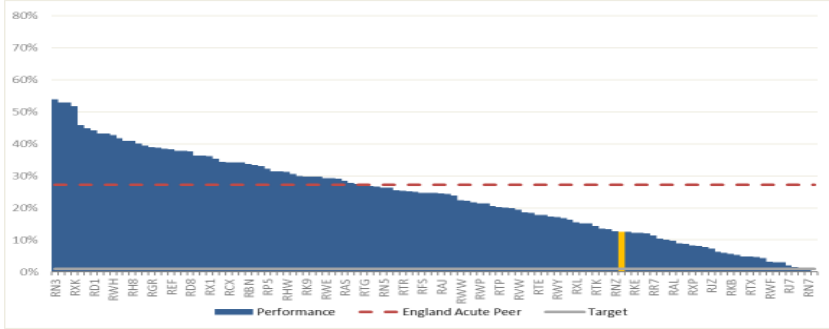
National Average: 70.2% ESHT Rank: 43/124




## Planned Care – Diagnostic Waiting Times

September 2023 Peer Review*

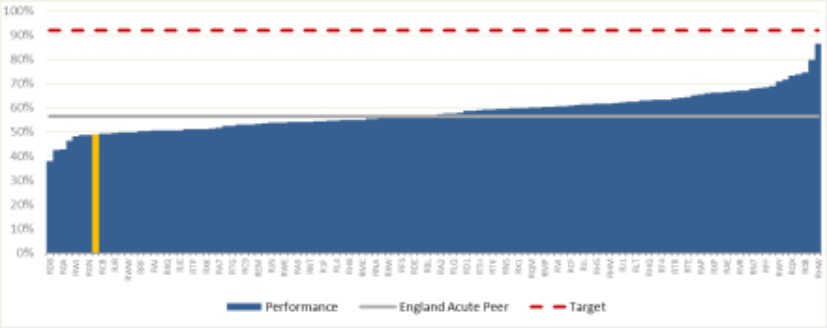
National Average: 27.3% ESHT Rank: 31/119




## Planned Care – Referral to Treatment

September 2023 Peer Review*

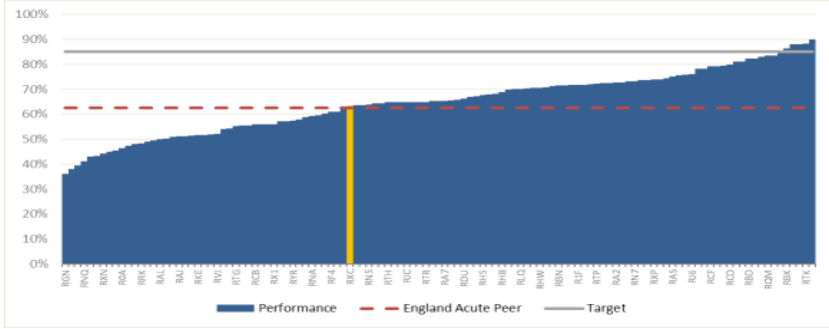
National Average: 56.4% ESHT Rank: 112/119




## Cancer Treatment – 62 Day Wait for First Treatment

September 2023 Peer Review*

National Average: 59.1% ESHT Rank: 81/119




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 remained stable during October. Outbreaks mainly involved bays but on occasions wards were closed to new admissions. IPC and clinical teams worked to maintain zero void beds due to Covid.

**Infection Control**
One MRSA bacteraemia was reported in October. It is classed as hospital onset but unavoidable as relates to a community acquired wound in a patient who was a known carrier and non concordant with treatment.
Nine cases of CDI were reported against a monthly limit of five. Four were reported as Hospital Onset Healthcare Associated and five were reported as Community Onset Healthcare Associated. All were sent for ribotyping. None of the cases were found to be due to cross infection.
Eight MSSA bacteraemia were reported in October.
Four were reported as HOHA. Of these two were unavoidable, one is not known if it was avoidable (skin/soft tissue infection) and the source of the remaining one is unknown. Of the four COHA cases, three were assessed as unavoidable (skin/soft tissue infection, septic arthritis and PICC). The PICC related infection was assessed as unavoidable as it was inserted in August under strict aseptic conditions and procedure clearly documented. The patient was receiving chemotherapy and presented with sepsis which was appropriately treated. Repeat cultures were negative. The source of the remaining case could not be established in a patient with neutropenic sepsis.

**Incidents**
There was 1 serious incident reported in September which met the Never Event criteria for a retained swab in a dental procedure under general anaesthetic. This was discussed at the Q&SC and more detail is in the CMO report to part 2 of this meeting. Of the 1,034 reported ESHT incidents, 1,000 were low or no harm (cat 1-2) with 34 at cat 3-5.

**Harms**
There were 2 incidents of Category 3 pressure damage reported in October 2023 (1 in hospital and 1 in patient's own home). There was one severity 3 inpatient fall in October. Newington Ward reported the highest number of falls with 13, noting it's patient cohort is predominantly Frailty.

**Mortality**
RAMI indices of mortality rolling 12 months remains better than peers positioned at 36 out of 122 Acute Peer Trusts. SHMI has remained stable this month at 100 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 October formal complaints represented 1.12% of all patient experience feedback received. In October the Trust received 38 new complaints. There were 10 complaints overdue at the end of October (longest being 16 working days over) with 6 complaints reopened. There were 2 contacts from the PHSO in October; these were outcomes where the PHSO closed both bereavement cases which related to care in 2020 without taking further action.

The positive FFT recommendation rates for October, when compared to the most recent data released by NHS England (September), show that ESHT continues to be higher than the national average, including Emergency Departments which is the first time since March 2023 for ED.

**Workforce**
The number of additional beds for inpatient capacity increased during October with the use of super surge beds, despite a continuing focus on discharge and our long stay patients. There are still significant numbers of patients whose primary need is psychosocial in our Emergency Departments (ED) and gateway/inpatient areas requiring specialist skills. Some patients present with extremely challenging behaviour and are resistant to care and are often aggressive and/or violent. Ward staffing in Oct remained stretched to cover the additional requirements with community teams also under continued pressure. In all areas this is likely to have had an impact on key quality KPIs, access to training 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 and roster effectiveness.

**Safeguarding**
A total of 56 Adult Safeguarding enquiries were identified in October, the predominant themes were self-neglect, neglect and domestic abuse. The safeguarding team is working with the CHIC division to undertake a learning event about self-neglect, likely to occur in the new year. Recently several safeguarding referrals have been in respect of patients with mental ill-health. There is also an increasing recognition that staff need to be cognisant of trauma informed practice regarding a person's lived experience and the Trust Safeguarding and Wellbeing teams are engaging with Changing Futures to consider work regarding this. The second cohort of domestic abuse Champions is launching and will be facilitated by the Domestic Abuse Specialist (HIDVA) and work continues with NerveCentre configuration to embed the rapid assessment screening tool.
The picture of poor mental health is also replicated within the Children's areas and at times Maternity who have required Security to ensure safety of staff and patients.

Author(s)

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

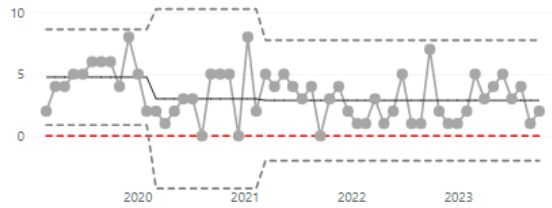
**Simon Merritt Chief Medical Officer**

# Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

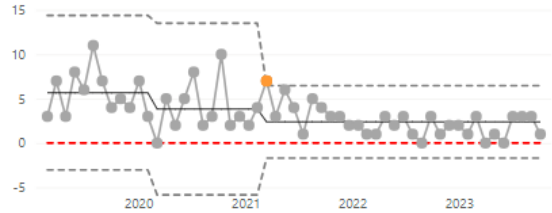
Patient Safety Incidents Causing Harm: Total, Safety

| Inconsistent | Common Cause | 2 |
|---|---|---|



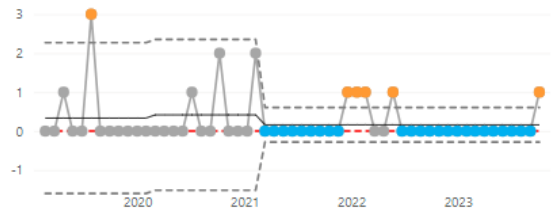

Serious Incidents: Total, Safety

| Inconsistent | Common Cause | 1 |
|---|---|---|



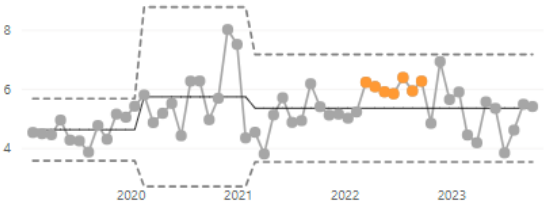

Never Events: Total, Safety

| Inconsistent | Concern | 1 |
|---|---|---|



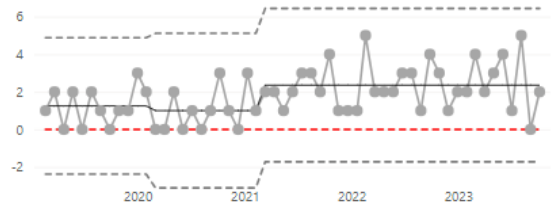

Inpatient Falls per 1,000 Bed days: Total, Safety

| Target required | Common Cause | 5.40 |
|---|---|---|



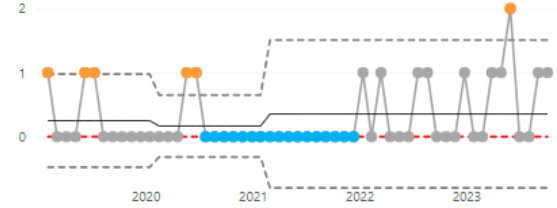

Pressure Ulcers, grade 3 to 4: Total, Safety

| Inconsistent | Common Cause | 2 |
|---|---|---|



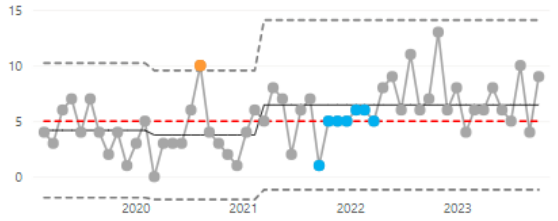

MRSA Cases: Total, Safety

| Inconsistent | Common Cause | 1 |
|---|---|---|



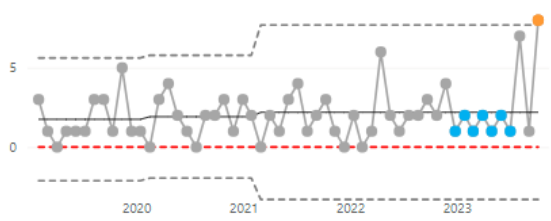

Cdiff Cases: Total, Safety

| Inconsistent | Common Cause | 9 |
|---|---|---|



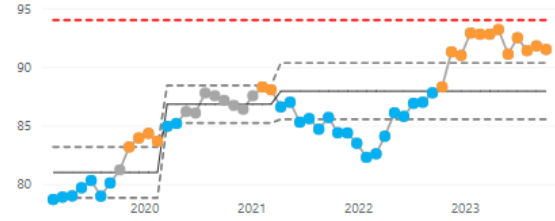

MSSA Cases: Total, Safety

| Inconsistent | Concern | 8 |
|---|---|---|




RAMI: Total, Safety

| Achieving | Concern | 91.5 |
|---|---|---|

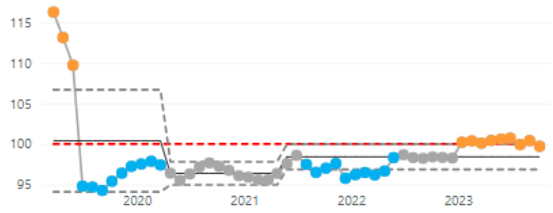


# Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

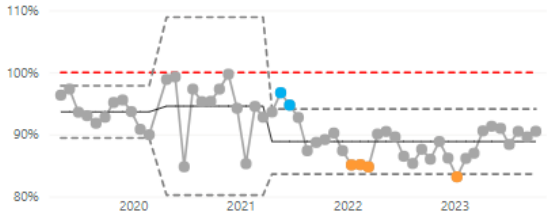
SHMI (NHS Digital monthly): Total, Safety

| Achieving | Concern | 99.7 |
|---|---|---|



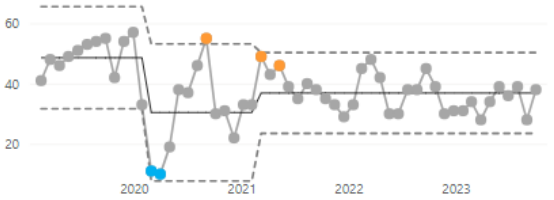

Nursing Fill Rate (IP - RN, RNA and HCA): Total, Safety

| Not Met | Common Cause | 90.5% |
|---|---|---|



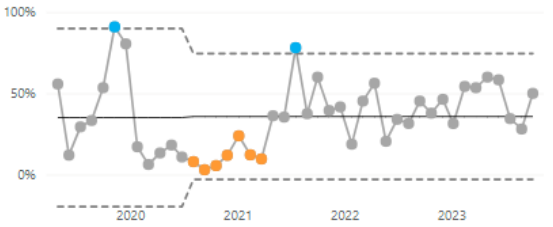

Complaints received: Total, Patient Experience

| Target required | Common Cause | 38 |
|---|---|---|



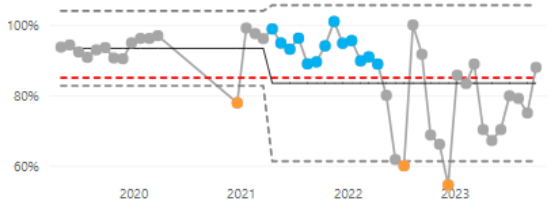

Complaints Response Compliance: Total, Patient Experience

| Target required | Common Cause | 50% |
|---|---|---|



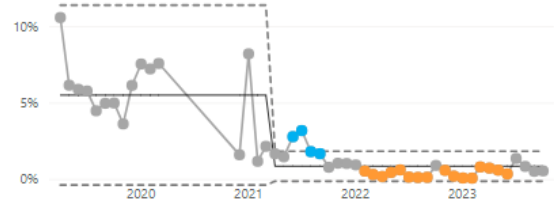

A&E FFT Score: Total, Patient Experience

| Inconsistent | Common Cause | 87.9% |
|---|---|---|



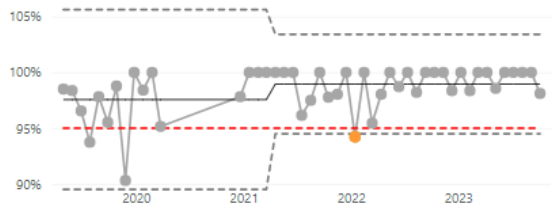

A&E FFT Response Rate: Total, Patient Experience

| Target required | Common Cause | 0.536% |
|---|---|---|



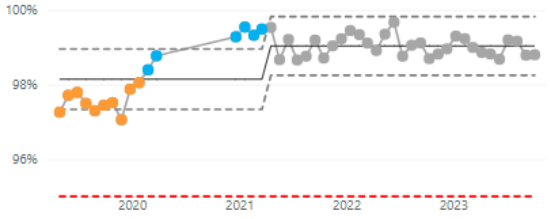

Maternity FFT Score: Total, Patient Experience

| Inconsistent | Common Cause | 98.1% |
|---|---|---|



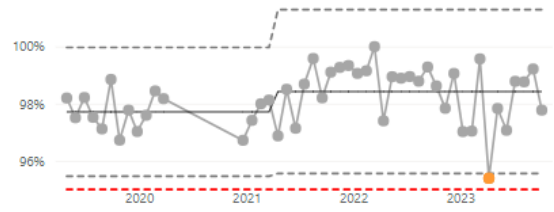

Inpatient FFT Score: Total, Patient Experience

| Achieving | Common Cause | 98.8% |
|---|---|---|




Outpatient FFT Score: Total, Patient Experience

| Achieving | Common Cause | 97.8% |
|---|---|---|



# Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

Quality and Safety

| Title | Summary | Actions |
|---|---|---|
| **Patient Safety Incident Response Framework (PSIRF)** | • The Patient Safety Incident Response Plan (PSIRP) and Policy have been approved by the Trust Board and approved by the ICB. The go live date of 20/11/23 was achieved. 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.<br>• From 20/11/23 all severity 3+ incidents (known as events in future) now have a PSIRF compliant response template completed to identify learning.<br>• Completion of a communication strategy to support the ongoing implementation of PSIRF. |
| **Nursing & Midwifery Workforce** | • Additional super surge beds and significant numbers of patients requiring enhanced observation for cognitive impairment, high risk of falls or patients with challenging/violent behaviour during Oct resulted in ongoing additional staffing requirements via TWS. Ward nursing CHPPD overall was 8.7 for Oct (noting distortion by specialist areas) with 16 areas less than 8. Nursing fill rates for day shifts RN 89% and HCSW 85% and night shifts 99% for RN and 91% for HCSW so remains similar to last month. | • The Nursing Establishment Review for wards has completed and community nursing establishment review commenced in November with the Theatres workforce gap analysis and review to be completed<br>• Plans in place to review and revise reporting to ensure more inclusivity in terms of services and roles<br>• Nursing/Midwifery Roster compliance sessions continue with evidence of good controls<br>• Work on improving the education and career progression framework continues including supervision and role of practice educators. |
| **Inpatient Falls** | • Rates remain within 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. |
| **Patient Experience** | Reviewing the monthly risk rating of all complaints, most were moderate in common with the general pattern;<br>• 2 high risk where the action/omission by the Trust has placed a patient at risk of or suffered significant harm<br>• 19 moderate risk where aspects of clinical care appear suboptimal<br>• 16 low risk where clinical quality does not form part of the complaint.<br><br>Of the 38 complaints in October, 78% covered three categories:<br>Clinical Treatment =15, Patient Care =9, Communication =5 | • The Patient Experience Team continue to work with divisions to help identify learning and actions from complaint and also trends and themes from all experience feedback received. |
| **Pressure Damage** | • Two Category 3 PUs were reported in October ( 1 in hospital and 1 in the community in patient's own home)<br>• New national guidance related to pressure ulcers including their categorisation has now published and is being reviewed by the PUSG. | • The Pressure Ulcer Steering Group (PUSG) are working with the Trust Patient Safety Lead, to implement PSIRF going forward.<br>• An action plan is underway to improve compliance to meet CQUIN 12 – Pressure Ulcer Prevention in line with NICE Guidance |

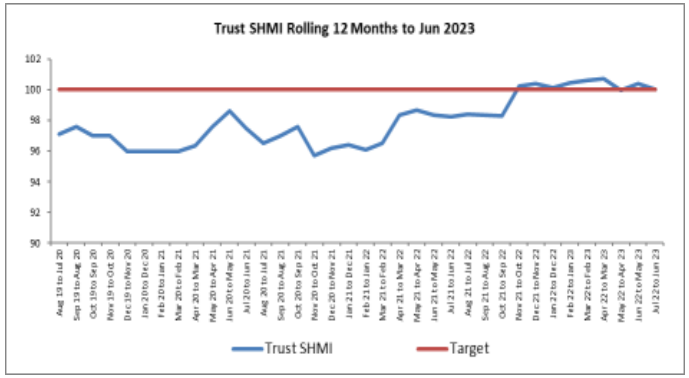
# Effective Care - Mortality

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.

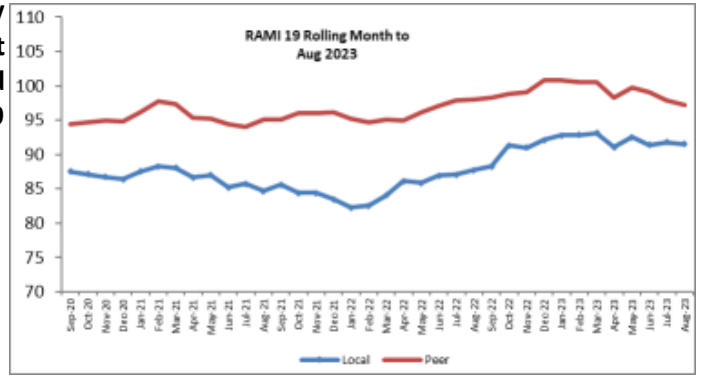
**Summary Hospital Mortality Indicator (SHMI)**

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

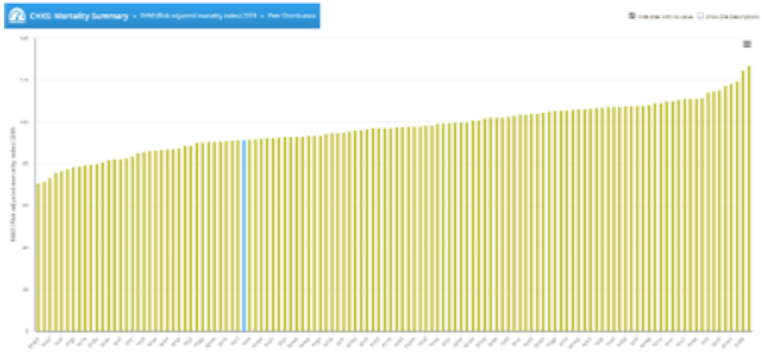



- SHMI – Jul 2022 to Jun 2023 is showing an index of 100 and is within the expected range. EDGH is showing 99 and Conquest is 101.
- RAMI 19 – Sep 2022 to Aug 2023 (rolling 12 months) is 92 compared to 88 for the same period last year. Aug 2022 to Jul 2023 was also 92.
- RAMI 19 was 83 for the month of August and 88 for July. Peer value was 91 for August.
- Crude mortality without confirmed or suspected covid-19 shows Sep 2022 to Aug 2023 at 1.62% compared to 1.59% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 45% for August 2023 deaths compared to 53% for July 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 36/122

# Effective Care – Mortality (continued)

East Sussex Healthcare NHS Trust

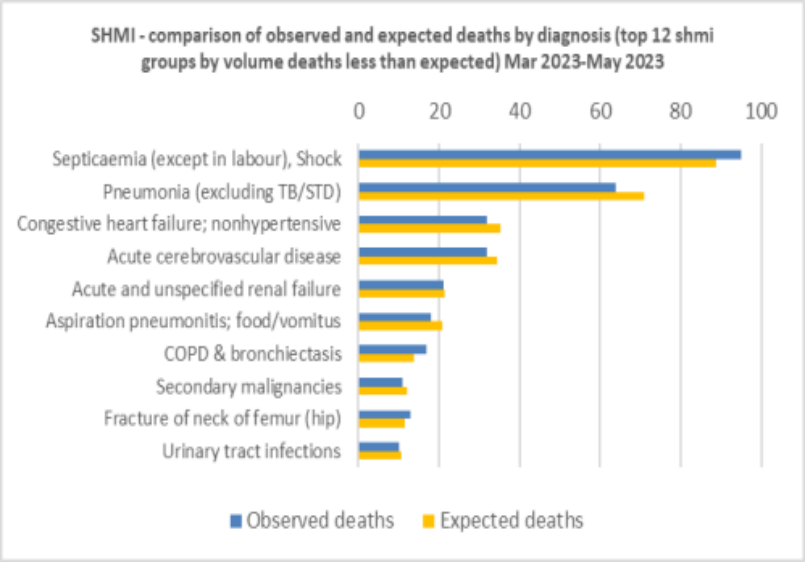
## October 2023 Main Cause of In-Hospital Death Groups (ESHT)

| Description | Deaths |
|---|---|
| Cancer | 20 |
| Sepsis/Septicaemia | 16 |
| Pneumonia | 14 |
| Heart Failure | 11 |
| Community-acquired Pneumonia | 8 |
| Aspiration Pneumonia | 6 |
| Chronic Obstructive Pulmonary Disease (COPD) | 4 |
| Frailty of old age | 4 |
| Stroke | 4 |
| Atrial Fibrillation (AF) | 3 |
| Dementia | 3 |
| Hospital-acquired Pneumonia | 3 |
| Urosepsis | 3 |
| Bowel Obstruction | 2 |
| COVID-19 | 2 |
| Liver Disease | 2 |
| Myocardial Infarction (MI) | 2 |
| Acute Kidney Injury (AKI) | 1 |

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

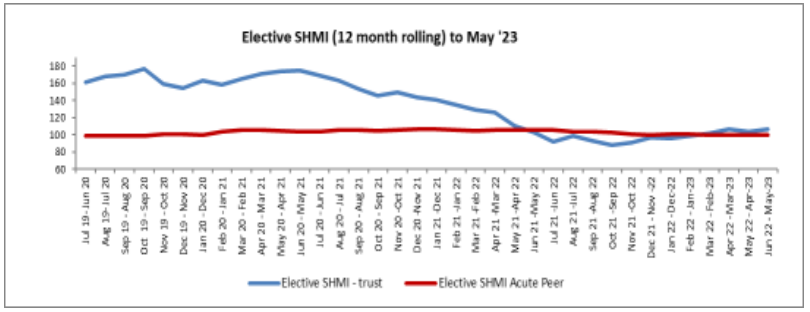
12 cases for which no CoD has been entered on the database and therefore no main cause of death group selected.

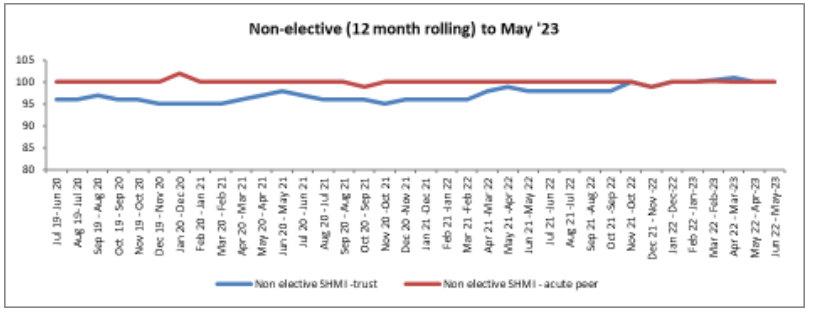
## SHMI Diagnosis Main Groups




## 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 0.2% to 10.5%,** which equates to 729.0 fte leavers in the last 12 months<br>**Vacancy rate reduced by 0.8% to 7.4%.** Current vacancies are showing as 596.2 ftes<br>**Mandatory Training rate increased by 0.6% to 89.4%**<br>**Appraisal compliance increased by 0.2% to 82.6%.** | **Monthly sickness increased by 0.3% to 5.5%,** whilst<br>**Annual sickness was unchanged at 5.2%** |  <br>**Steve Aumayer**<br>Chief People Officer |

**Overview:**

Turnover continues to fall, by 0.2% to 10.5%, the 8th consecutive monthly fall. The main reductions were for Admin& Clerical staff, down by 0.9% to 11.9% (173.1 fte leavers), Scientific & Tech staff (Pharmacists & Pharmacy Technicians, Optometrists, Resus & Chaplaincy staff) down by 0.3% to 10.3% (10.9 fte leavers). Registered Nursing & Midwifery turnover reduced by 0.2% to 9.5% (201.7 fte leavers). Medical & Dental turnover, however, continues to buck the trend increasing by 1.6% to 13.0% (40.8 fte leavers), whilst Estates & Ancillary turnover also increased this month by 0.4% to 8.4% (53.8 fte leavers).

The Trust vacancy rate reduced again by 0.8% to 7.4% (596.2 fte vacancies), despite a small increase in substantive budget this month (+11 ftes). This is due to successful recruitment. Vacancies fell for Registered Nursing & Midwifery (down by 13.3 ftes to 159.4), AHPs (down by 6.4 ftes to 66.9), Additional Clinical Services (unregistered clinical staff) (down by 24.5 ftes to 255.5) and Admin & Clerical staff (down by 11.0 ftes to 118.9), Medical & Dental vacancies increased by 8.8 ftes to 157.3.

The monthly sickness rate increased by 0.3% to 5.5%. This mirrors the seasonal increases from previous years and, as a result, the annual sickness rate is unchanged at 5.2%. In fact, the average sickness days per fte has fallen slightly by 0.2 to 18.9 as trends are slightly lower. The highest increase is for Cold, Cough, Flu up by 507 fte days lost to 1,115. The increase for Chest & Respiratory illnesses is more modest at 234 fte days lost to 2,074 and the number of staff off sick with Covid averaged 35 in Oct, despite reaching a high of 52 on 27 Oct (since when it has reduced to 33 on 10th Nov). All the main reasons for sickness increased, with the exception of Gastrointestinal illnesses which fell by 77 to 672 fte days lost. Other MSK increased by 268 to 1,653 fte days lost, which is the highest it has been in the last four years.

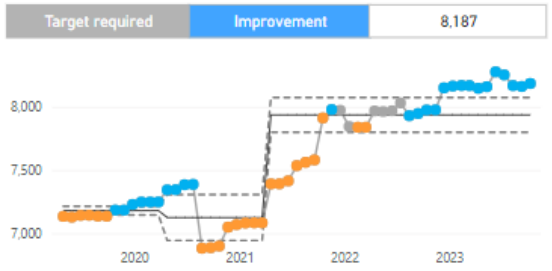
The monthly training rate increased by 0.6% to 89.4%. There were improvements in compliance for Fire Safety, up by 1.0% to 86.9%, Infection Control up by 0.8% to 88.0%, Info Governance also up by 0.8% to 85.4%, MCA and DoLs training up by 0.6% to 87.0% and Moving & Handling up by 0.5% to 94.8%. Safeguarding compliance, however, reduced by 0.8% to 87.0%. Medical & Dental compliance has improved by 4.3% but is still the lowest amongst staff groups at 73.7% (+1.3% from last month). Their compliance has improved by 5.6% since Jr Dr mandatory training has been directly managed by Education

The appraisal rate showed a slight increase of 0.2% to 82.6%, matching the previous high of Aug 23. For staff groups, the trend varies. AHPs compliance increased by 3.0% to 82.9%, Estates & Ancillary staff compliance increased by 1.6% to 87.8% and Additional Clinical Services increased by 0.7% to 82.7%. Registered Nursing & Midwifery increased slightly by 0.1% to 81.7% but Medical & Dental compliance reduced by 0.3% to 90.5% and Admin & Clerical reduced by 0.8% to 81.1%.

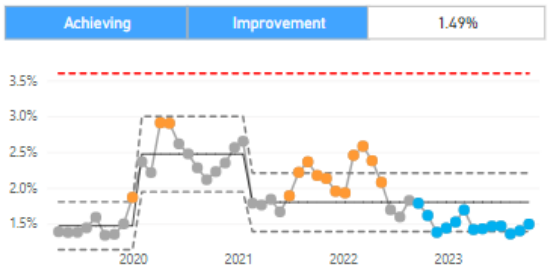
# Our People Core Metrics

East Sussex Healthcare NHS Trust

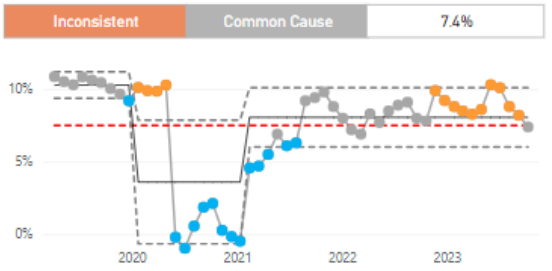
Establishment (WTE) All: Total, Our People



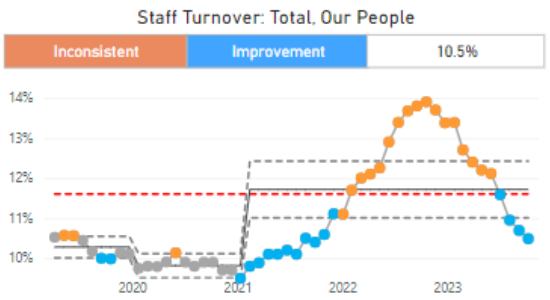

Agency Rate: Total, Our People



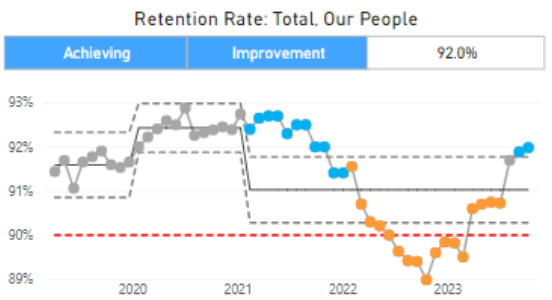

Vacancy Rate: Total, Our People



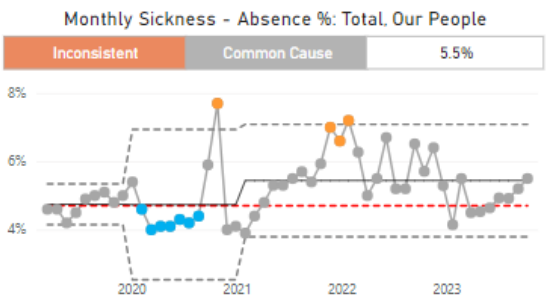

Staff Turnover: Total, Our People



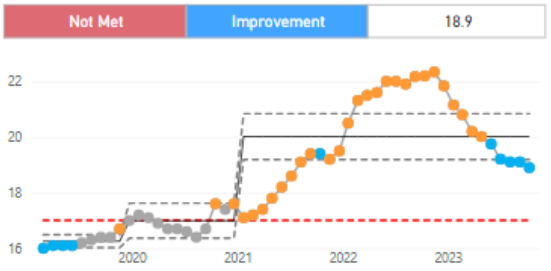

Retention Rate: Total, Our People



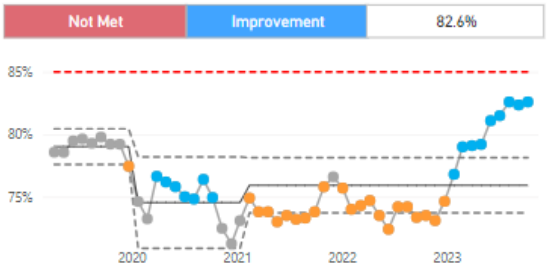

Monthly Sickness - Absence %: Total, Our People



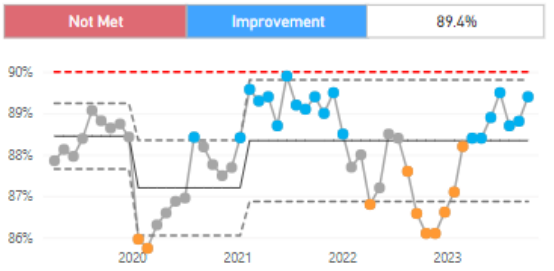

Sickness - Average Days Lost per Fte: Total, Our People




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** | **Continued reduction, with a further reduction of 0.2% to 10.5**% represents downward trend from high of 13.9% in Nov 22. ICB target of 11.6% exceeded.<br><br>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 (i.e. 10 – 10.5%). | Phase 1 of the exit process changes have been agreed: a new Exit survey and Staying with the Trust survey, (for staff taking up a new role in the Trust). Phase 2 is in progress: review of the Exit Interview template & process and Thrive and Grow conversations.<br><br>The Thrive and Grow conversations offer an opportunity for colleagues to have a discussion with their line manager about areas for development or ways in which they can flourish within their current role. This approach is being piloted within CHIC, Frailty and Occupational Health. Thrive and Grow conversations would be offered at any point during a colleague's employment, not purely when they are thinking of leaving.<br><br>The first cohort of Restorative Supervisors have completed their training and are now consolidating skills prior to rolling this offer out to pilot areas from the New Year.<br><br>In response to feedback from Internationally Recruited (IR) colleagues around retention, face to face inductions have been restarted and improvements made to the welcome pack offered to all IR colleagues. This includes resources for local services and community groups in addition to Trust services. |
| **Vacancy Rate** | **Vacancy rate reduced by 0.8% to 7.4%** (596.2 fte vacancies). This is below target for the first time since Apr 22.<br><br>This is due to successful recruitment. | Some success with difficult to recruit medical posts e.g.2 Respiratory Consultants recruited, Locum Consultants in Cardiology, Microbiology & Urology.<br><br>Collaborative working with local DWP to promote posts, as well as the ICS re International Nurses and a Virtual Recruitment site.<br><br>Planned cohorts of International nurses arriving Nov, Dec and early Jan. as agreed with NHS England. New to Care pipeline in place starting post Xmas<br><br>Activity to increase volunteer numbers across the Trust and working with Education colleagues re Recruitment events for the next 12 months |

# Our People | Areas of Focus

East Sussex Healthcare NHS Trust

| Title | Summary | Actions |
|---|---|---|
| **Sickness** | **Monthly sickness increased by 0.3% to 5.5%, whilst annual sickness was unchanged at 5.2%.**<br><br>The annual rate remains lower than its peak of 6.1% in Dec 22 as we recover from the effects of the pandemic. As a result, **average sickness days per fte continue to fall, down 0.2 this month to 18.9 from a high of 22.3 in Dec 22**. This is the lowest level since Sep 21<br><br>**Cold, Cough & Flu illnesses rose by 507 fte days** in Oct. Absences due to **Other MSK increased by 268 fte days lost** to 1,653 fte days lost in month, the highest it has been in the last four years | Whilst there was a temporary increase in COVID absence this is by no means reflective of the previous highs and with frontline colleagues taking up the offer of vaccinations it is anticipated this will support a levelling out of absence.<br><br>HR continue to encourage managers to review short term absence and ensure they are capturing relevant triggers to allow for the appropriate monitoring of sickness cases. This is both as a supportive measure for colleagues where work activity or practice may be impacting on health and that we are able to continue with an effective service delivery. The Wellbeing Leads are met with regularly to share any concerns where areas are showing as a hotspot and needing additional support. |
| **Statutory & Mandatory Training** | **Trust compliance has slightly increased by 0.6% to 89.4**%, just shy of the 90% target. | 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 issue continues to be completed appraisals not being uploaded onto ESR. There has been some slight improvement in Medicine sub specialities, however junior doctor compliance in Medicine and DAS will be main focus over next 4 weeks working with the Divisions. |
| **Appraisal** | **Compliance increased by 0.2% to 82.6%,** equalling the high point reached in Aug 23**.** A year ago the rate was 73.4%. | Education continue to monitor appraisal rates and offer support to areas of low compliance. Focus for this month will remain on those areas with < 50% compliance. |

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

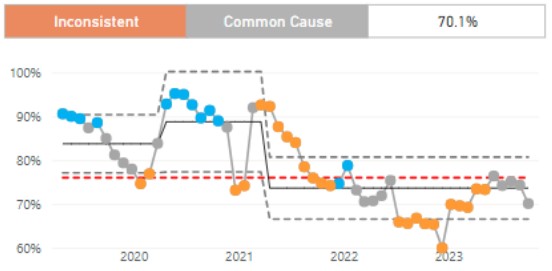
East Sussex Healthcare NHS Trust

| | Positives | Challenges & Risks | Author |
|---|---|---|---|
| **Responsive** | **Urgent Community Response (UCR)**<br>The UCR standard of 70% has been consistently achieved year to date, with >87% of patients seen within the 2-hour response window in October.<br><br>**Cancer**<br>The volume of patients on the Cancer PTL backlog (patients >62days) continues to be below trajectory and, although not quite meeting the national target backlog of 6.4%, with 6.7% of the total PTL for ESHT, this position is significantly lower the national average of 8.9%.<br><br>**Elective waiting list:**<br>Validation and increasing activity levels has supported a decrease in the overall PTL size, despite increasing referral numbers.<br><br>**DM01:**<br>October performance rose to 90.66%, the highest compliance rate the Trust has achieved since April 2020. | **4 Hour Emergency Access Clinical Standard**<br>Performance against the Emergency Access Clinical standard deteriorated in October with only 70.1% of people attending A&E seen within 4 hours. The Trust continues to focus on the comprehensive improvement plan that has been developed to support sustainably delivering 76% (national standard).<br><br>**Bed Occupancy and LoS:**<br>Bed Occupancy across ESHT is not meeting plan (plan of 92.7%). Five-month SPC analysis of performance at ESHT shows a steady increase in occupancy and it is recognised that further work is needed to support a reduction in both LoS and occupancy rates,<br><br>**Elective waiting list:**<br>Reducing the number of patients waiting more than 65 weeks for elective treatment continues to be an area of focus. Although comfortably below trajectory (delivering 267 against a trajectory of 280) for the number of patients waiting >65 weeks the trusts ambition is to eliminate 65 weeks at the end of March 2024.<br><br>**Cancer**<br>The Trust has met its 62 day and 104 day cancer trajectories. However, is not meeting the 28 day faster diagnosis standard, nor the 62 day standard. There are actions to address this as this remains a key focus for the Trust | **Charlotte O'Brien**<br>Chief Operating Officer |
| **Actions:** | • Delivering on the agreed actions from the Urgent Care Improvement Plan to support sustainable delivery of the 76% Emergency Access Clinical Standard.<br>• Winter planning commenced.<br>• Embedding actions from the Elective Deep Dive assurance pack to support achieving zero 65 week waits by March 2024.<br>• Focus on 28 day FDS achievement across all departments, reducing the 62 day backlog and eliminating 104 day waits. | | |

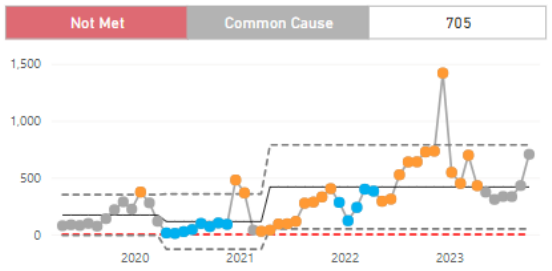
# Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

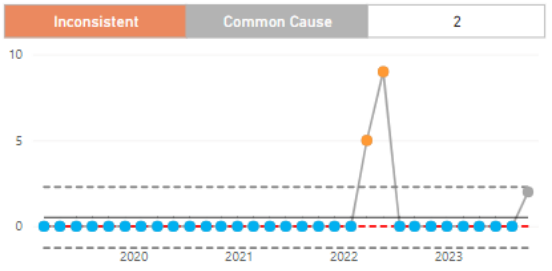
4 hour standard: Total, Our Performance



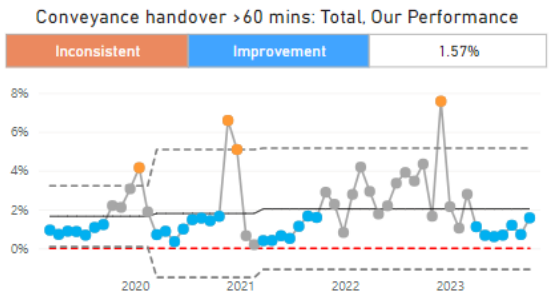

A&E > 12 hours from arrival to discharge: Total, Our Perfor...



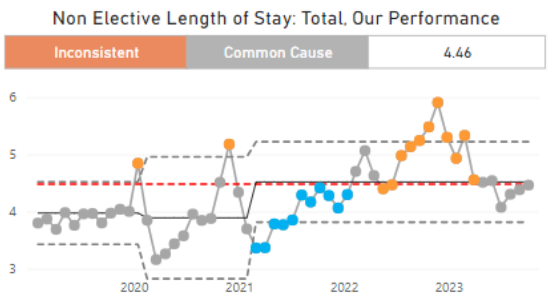

A&E waits over 12 hours from DTA: Total, Our Performance



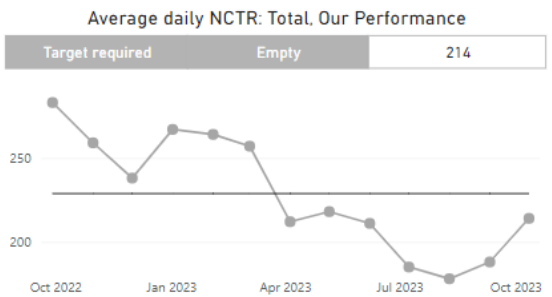

Conveyance handover >60 mins: Total, Our Performance



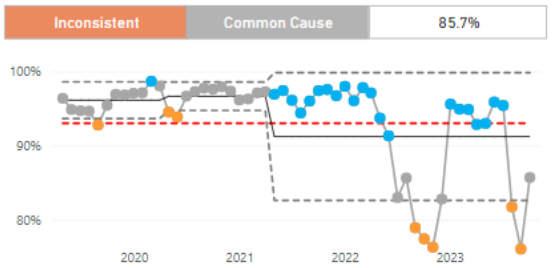

Non Elective Length of Stay: Total, Our Performance



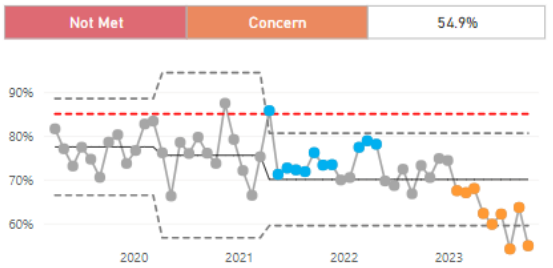

Average daily NCTR: Total, Our Performance



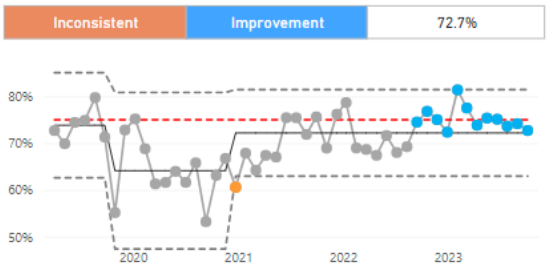

Cancer 2WW: Total, Our Performance




Cancer 62 Day: Total, Our Performance




28 Day General FDS: Total, Our Performance

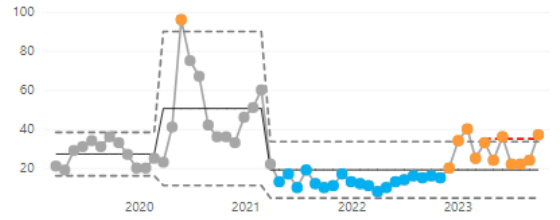


# Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

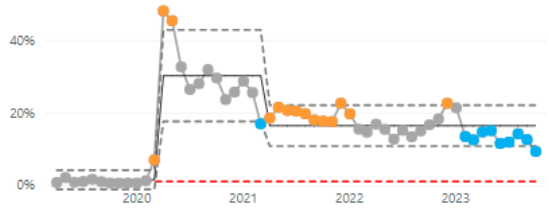
104 day Backlog: Total, Our Performance

| Achieving | Concern | 37 |
|---|---|---|



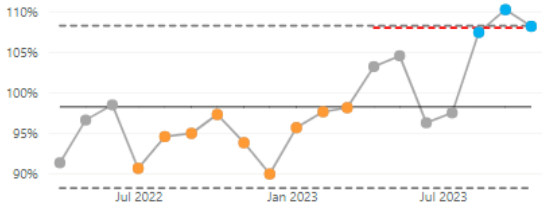

Diagnostic <6 weeks: Total, Our Performance

| Not Met | Improvement | 9.34% |
|---|---|---|



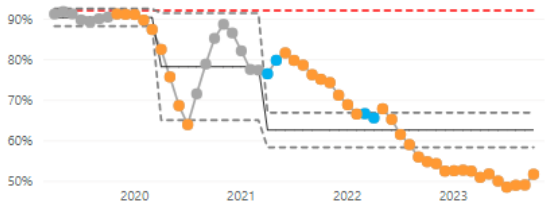

Elective Activity (ELIP,DC,OPFA, OPFUP Proc): Total, Our Perf...

| Inconsistent | Improvement | 108% |
|---|---|---|



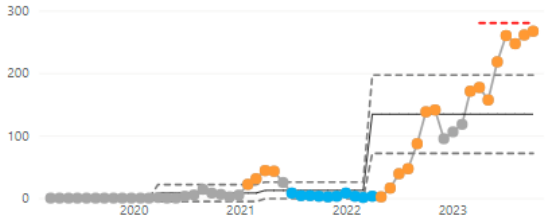

RTT under 18 weeks: Total, Our Performance

| Not Met | Concern | 51.6% |
|---|---|---|



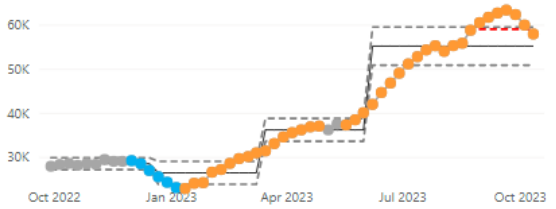

RTT 65 week wait: Total, Our Performance

| Achieving | Concern | 267 |
|---|---|---|



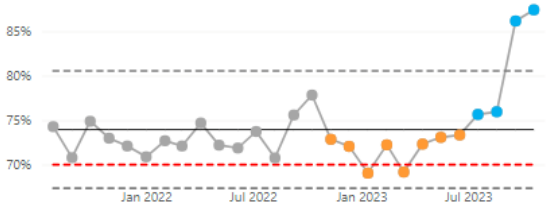

RTT Total Waiting List Size: Total, Our Performance

| Inconsistent | Concern | 57880 |
|---|---|---|



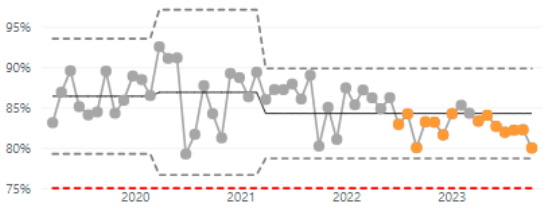

Urgent Community Response within 2 hours: Total, Our Perf...

| Inconsistent | Improvement | 87.4% |
|---|---|---|



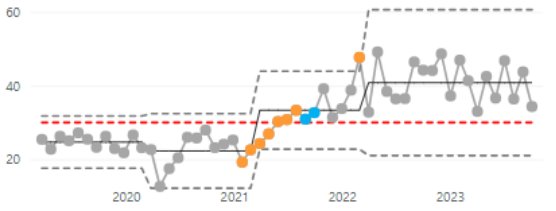

CHIC wait times < 13 weeks: Total, Our Performance

| Achieving | Concern | 80.0% |
|---|---|---|




Intermediate Care Length of Stay: Total, Our Performance

| Inconsistent | Common Cause | 34.3 |
|---|---|---|



# Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

| Title | Summary | Actions |
|---|---|---|
| **Emergency Access Clinical Standard** | 76% patients should be seen and discharged, treated or admitted within 4 hours, the Trust achieved 70.1% against the standard in October 2023. | • Reducing time to initial assessment – Triage<br>• Ongoing focus to support a reduction in non-admitted breaches.<br>• Protecting CDU, increasing streaming to Medical, Surgical and Women and Children SDEC areas – Admission policy re-launch and cross divisional escalation plans.<br>• Clinical leadership training to support overnight performance |
| **Patients in department over 12 hours from arrival to discharge** | There was an increase in September for the number of patients waiting over 12 hours from arrival to discharge from 430 in September to 705 in October, this included 2 Decisions to Admit over 12 hours. | • Continued work with system partners around timely support for patients awaiting mental health review / assessment and or mental health bed<br>• Ongoing focus on maintaining reductions in LOS and the number of NCTR patients in both the acute and community bed base<br>• Early escalation and actions to reduce risk |
| **Conveyance Handover >60 mins** | The percentage of conveyed patients handed over >60 mins was 1.57% in October. | • Continue to work on key actions that will improve the efficiency of the handover process and will including optimising the Rapid Assessment and Triage model. |
| **Non elective Length of Stay** | October has seen the Trusts non-elective Length of Stay (LoS) increase to 4.46 days, 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 September.<br><br>To note, new discharge ready metrics have been added to the balanced scorecard. Work is underway to improve the number of patients discharged on the day they are discharge ready and to reduce the overall number of delay days for those who do experience a delay. | • Divisional teams undertaking long length of stay reviews for patients over 7, 14 and 21 days, escalation into the weekly system escalation meeting (Thursday) from this to by fortnightly F2F System Exec meeting.<br>• Weekly CNO meetings with the Head of Discharge around complex cases and will link in with CMO as required.<br>• The development of the Transfer of Care Hub in progress with recruitment to ToCH lead and on-going recruitment to CSM, Discharge Sister & OSO. The development of Rhythm of the Day and Week to include ToCH core requirements and processes.<br>• In progress, data validation for P0's & P1 daily reviews, with scrutiny over the complex cases and escalation to CNO.<br>• Over 21 days LOS – This has increased to 154 (21/11/23). Of the 154 patients there are 10 over 100 days. 3 of the 10 patients meet the Criteria to Reside. |

# Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

| Title | Summary | Actions |
|---|---|---|
| **Elective Activity** | The Trust delivered 108% of Elective Activity in October, a slight decrease in the previous month. First Outpatient Appointment activity continues to exceed 108%, but further focus is needed to progress plans to increase admitted activity (both day case and Elective inpatients). | • Outpatient productivity programme underway<br>• Theatre productivity programme in place.<br>• Review of pre-assessment procedures to support theatre utilisation.<br>• Continued and improved utilisation of the Care Coordination Service to support more efficient waiting list management and improve utilisation.<br>• 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 165 patients (versus a trajectory of 175) as at the end of October. This equates to 6.7% of the total PTL for ESHT, the Sussex average is currently at 10.1% and national average at 8.9%.<br><br>The Trust reported 50 >104 waits at the end of October against a trajectory of 30. Long waiting patient delays relate to a number of reasons, for example, complex pathways, diagnostic delays and tertiary centre delays.<br><br>The Cancer Waiting Time Standards remained challenged in September (2ww 85.7%, FDS 72.7% and 62 Day 54.9%.).<br><br>The Trust continues to receive high number of suspected cancer referrals with 2670 received in October 2023, an overall 20% increase compared to October 2022. | • Twice weekly PTLs in place to focus on reducing the number of patients in the >62 day backlog and to expedite patient pathways.<br>• PTLs include 28 day FDS reviews to ensure timely patient communication.<br>• Supporting plans including working with other providers to support the treatment of patients who have been waiting >104 days.<br>• Weekly focus on patients waiting >104 days and patients approaching >104 days.<br>• Standard Operating Procedure developed and introduced to reduce first seen/contact to 7 days to support improvement and achievement of 28 FDS. This currently is challenging in most specialties.<br>• Plans to review capacity and demand for first seen/contact and BBN in Divisions.<br>• Successful bid to the Surrey and Sussex Cancer Alliance for a Breast Triage Pathway Matron to support triage, provide cover for FDS and develop to support breast clinics all supporting an improvement in performance. |
| **Diagnostic DMO1** | October performance rose to 90.66% compliance with improvements seen in MRI and CT. ESHT target remains 95% by the end of March 24.<br><br>Overall waiting list fell to 7,592 a drop of 203 on the September figure.<br><br>Overdue Echo Surveillance patients (c1,100) will be added to DM01 position from January 24 which will reduce overall DM01 performance by 11% | • Endoscopy continue to show an improving position. Remaining breaches are in enhanced sedation colonoscopy patients which will remain a focus for the department to date.<br>• Improvement across Radiology modalities helped overall position to improve, and work will continue to stay on top of increasing demand for CT and MRI.<br>• Ongoing work around recording of Sleep Studies nearly complete. Likely to start recording from January 24.<br>• Cardiac Echo to start reducing overdue Surveillance backlog by 100 per month starting immediately. Insourcing to continue until end of March 24. |

# Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

| Title | Summary | Actions |
|---|---|---|
| **RTT Total Waiting List Size** | Whilst the volume of patients on a referral-to-treatment (RTT) pathway remains significantly higher than 19/20, the impact of the targeted technical validation can be observed, with a reduction of 2023 patients in the overall PTL size.<br><br>The Trust continues to focus on validation of waiting lists, with specific focus on the 65 week risk cohort for 23/24, as well as the non RTT Follow-up waitlist. | • Review of insourcing in a range of specialities to support a reduction in waiting times for patients on a RTT pathway.<br>• Continued focus on validation and pathway management to ensure a more accurate PTL, and support the development of modernised pathways, training and better use of digital technology. |
| **RTT long wait position (78 and 65 weeks)** | 65 week trajectories have been revised to provide greater understanding of the long wait position. The Trust has delivered against trajectory for October with 267 pathways over 65 weeks, against a trajectory of 280.<br><br>The Trust reported one 78 week breach in October, a late transfer over from another provider, who has since been discharged. The Trust is confident that there will be zero patients waiting >78 weeks in November. | • Weekly DCOO led review of all >78 week risks<br>• Daily monitoring of the longest waiting patients to ensure pathways are progressing.<br>• Utilisation of SPH where possible to support long wait position.<br>• Exploring mutual aid, both via the ICS and the Digital Mutual Aid System, including PIDMAS.<br>• Targeted validation.<br>• Increasing FOPA attendances. |
| **Community Waiting Times** | The Trust's most challenged community service in terms of waiting times continues to be Paediatrics, with demand continually outstripping capacity.<br><br>Outsourcing to Psicon continues and this has supported a decrease in the waiting list for New appointments over the last 12 months (from 2814 to 2175). The number of children waiting over 3 years has also decreased from 209 in Nov 22 to 9 in Sep 23. The number of children waiting over 18m has reduced from 823 in Nov 22 to 162 in Sept 23. | • Outsourcing to Psicon ongoing<br>• Ongoing recruitment initiatives to support the service.<br>• Pathway redesign work continues for Sleep/melatonin, supported by the ICB.<br>• Ongoing validation of the community waiting list for NEW and FU patients.<br>• 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 improved marginally from £1,400k to £1,317k<br>• ERF improved from £8,387k to £9,285k<br>• Efficiency improved from £2,910k to £2,967k<br>• Capital spend is £6,556k behind plan | Risk analysis shows a potential range from £19.7m deficit position (worsened) for the downside to a £11.9m deficit position (worsened) against the base case (note this is prior to announcements of new funding and rule changes made in mid November). This is however predicated on a number of assumptions – particularly the improved run rate for CIP delivery and recovery of the elective position.<br>Main risks are: delivery of efficiency plan, elective activity, non-pay inflation and pay award funding. |  <br>**Damian Reid**<br>Chief Financial Officer |

**Overview:**

**I&E**: For M7 the Trust reported a £1.4m adverse position against a breakeven plan, YTD this is £5.0m adverse. This is driven by industrial action costs, non-pay inflation above funding, unfunded pay award and increased costs in the services as a result of mental health patients waiting for onwards placement into mental health beds.

**Run rate:** The underlying run rate remained consistent with the prior month at £1.4m deficit in month. To Breakeven run rate needs to reduce by £2.0m per month, a straight-line forecast would therefore suggest a forecast deficit of £12.4m.

**Efficiency**: Divisions have delivered £14.9m efficiency YTD against the plan of £15.9m resulting in £1.0m adverse position. This is largely associated with the ERF delivery and LoS offset by vacancy slippage and CNST maternity rebate. The RAG is amber due to 47% of the YTD actual being non-recurrent and there is slippage in ERF delivery of £2.4m, which is being offset by vacancy slippage..

**Capital:** Total plan for 2023/24 is £65.7m. Capital spend is behind plan at M7 by £6.6m. Forecast before mitigations is a slippage of £2-3m however we expect to be able to mitigate this through new schemes.

# Exec summary

East Sussex Healthcare NHS Trust

| £m | RAG | YTD Plan | YTD actual | Var F/(A) | Commentary |
|---|---|---|---|---|---|
| Surplus/ deficit | R | 0.0 | (5.0) | (5.0) | • For M7 the Trust reported a £1.4m adverse position against a breakeven plan, YTD this is £5.0m adverse. This reflects a lower-than-expected performance against elective activity targets of (£0.7m) across M1-7 alongside pay pressures for temp staffing in Med/UC/Theatres and Industrial Action (£1.4m YTD). Pay Award Gap of (£1.4m) ytd against income. Non pay pressures caused by system wide inflation of (£3m) and Drugs (£1.5m), offset by LA funding support ytd of £2.5m. |
| Income | A | 379.1 | 377.2 | (1.9) | • Income is £1.9m adverse to plan YTD driven by underperformance against elective activity targets of £0.7m and Pay award shortfall of £1.4m. Slightly offset by cost and volume Drugs. |
| ERF activity | R | 57.4 | 56.7 | (0.7) | • The under-performed against its plan by £0.2m in month and £2.5m YTD based on initial data prior to the 2% baseline adjustment, this reduced the gap to £0.7m. Catch up from prior months<br>• We have noted material movements in the data for Freeze so the underlying position may improve (but this will not affect the bottom line due to clawback mechanism) |
| Pay | A | (255.3) | (255.4) | (0.1) | • Pay cost is (£0.1) overspent ytd driven by Industrial Action cover costs at £1.4m ytd alongside premium costs in Urgent Care/Med/DAS, offset by vacancies ytd and reserves released of £1.0m.<br>• The Trust is using 3% more contracted staff than in 22/23 month 7. |
| Non-pay | A | (123.7) | (126.7) | (3.0) | • Non-pay costs adverse to plan ytd, with LA supported funding partly offsetting high non pay spend across most Divisions in month. Overall LA funding support ytd of £2.5m offsetting pressures in Med/UC/Theatres alongside inflationary pressures Trust Wide of £3m and Drugs £1.5m. |
| Efficiency | A | 15.9 | 14.9 | (1.0) | • The Divisions have delivered £14.9m efficiency YTD against the plan of £15.9m resulting in £1m adverse position. This is largely associated with the ERF delivery and LoS this is offset by vacancy slippage and the CNST maternity rebate. The RAG is amber due to 47% of the YTD actual being non-recurrent and there is slippage in ERF delivery of £2.5m, which is being offset by vacancy slippage. |
| Capital | A | 17.6 | 11.0 | 6.6 | • Total plan for 2023/24 is £65.7m. The capital plan is backloaded and expenditure is behind plan at M7 by £6.6m. |
| Risk | A | n/a | n/a | n/a | • Risk analysis shows a potential range from £19.7m deficit position for the downside to a £11.9m deficit position against the base case, worse than M6 due to higher non pay activity in Month 7. This is however predicated on a number of assumptions – particularly the improved run rate for CIP delivery and recovery of the elective position.<br>• ICB considering amending the forecast formally for M9 although we are still waiting on a proper understanding of revised rules around ERF – in particular how future strikes beyond April-Oct will be accounted for. |

# Income and Expenditure

East Sussex Healthcare NHS Trust

## Trust I&E position

| | Month (£'000) | | | YTD (£'000) | | |
|---|---|---|---|---|---|---|
| | Plan | Act | Var | Plan | Act | Var |
| **Income** | | | | | | |
| Contract income | 45,947 | 46,041 | *94* | 327,265 | 327,878 | *612* |
| Divisional | 7,482 | 7,301 | *(181)* | 47,627 | 45,798 | *(1,829)* |
| ERF | 946 | 1,365 | *418* | 4,021 | 3,322 | *(699)* |
| Covid - variable | 20 | 9 | *(11)* | 138 | 132 | *(6)* |
| **Total Income** | **54,395** | **54,715** | ***320*** | **379,052** | **377,130** | ***(1,921)*** |
| **Operating Expense** | | | | | | |
| **Pay** | | | | | | |
| Permanent | (35,949) | (32,394) | *3,554* | (251,045) | (223,273) | *27,772* |
| Temporary | (804) | (4,433) | *(3,629)* | (4,135) | (32,006) | *(27,872)* |
| **Total pay** | **(36,752)** | **(36,827)** | ***(75)*** | **(255,180)** | **(255,280)** | ***(100)*** |
| **Non-pay** | | | | | | |
| Drugs | (1,129) | (1,463) | *(334)* | (7,826) | (9,534) | *(1,708)* |
| TEDD | (3,521) | (3,916) | *(395)* | (24,361) | (26,646) | *(2,285)* |
| Clinical supplies | (4,431) | (4,607) | *(176)* | (30,021) | (29,872) | *148* |
| Purchased services | (1,220) | (1,274) | *(54)* | (7,920) | (8,833) | *(912)* |
| Finance costs | (2,498) | (2,494) | *4* | (17,486) | (17,451) | *36* |
| Other | (4,798) | (5,424) | *(627)* | (36,042) | (34,147) | *1,895* |
| **Total non-pay** | **(17,596)** | **(19,178)** | ***(1,581)*** | **(123,656)** | **(126,483)** | ***(2,827)*** |
| Covid exp - block | - | (23) | *(23)* | - | (104) | *(104)* |
| Covid exp - variable | (17) | (4) | *12* | (116) | (116) | *(0)* |
| **Total Expense** | **(54,365)** | **(56,033)** | ***(1,668)*** | **(378,952)** | **(381,983)** | ***(3,031)*** |
| **Surplus/(Deficit)** | **30** | **(1,317)** | ***(1,347)*** | **100** | **(4,852)** | ***(4,952)*** |

## I&E position

- In Month 7 the Trust is reporting an adverse position of (£1.4m) against a breakeven plan. YTD the Trust is (£5.0m) 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 (£1.4m YTD) offset by reserves release, with pressures on non pay in CORE/Med/Theatres caused by inflation being supported by LA funding.

## Income

- The position is adverse by (£1.9m) ytd, the main drivers being;
  - Lower than planned elective activity against target by £0.7m (partially offset by lower associated costs), this is after the 2% baseline adjustment, underlying position is £2.5m shortfall.
  - Note that the Doctors' strike days would have contributed in part to this in April (15% of working days impacted) ,June (16%), July (16% Junior plus Consultant days) Aug (16%) and Sept (15%).
  - Pay Award income shortfall (offsetting pay variance) of £1.4m for M1-7.

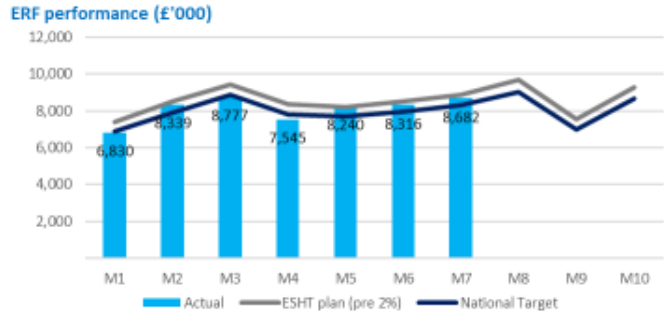
## Expense

- The Trust has a breakeven pay position YTD. Temporary and premium staffing costs in Urgent Care and DAS plus Industrial Action cover costs of £1.4m ytd. Offset by CDC and VW vacancies alongside reserves release of £1.0m.
- M7 Pay overspent by (£0.1m) due to slight extra pressure in DAS, vacancies in CDC/VW offsetting IA pressures in month.
- All pay awards now processed for 23-24. An overall shortfall of commissioner income of £2.3m FYE, but currently offset by vacancy level in the Trust as at M7.
- Use of temporary staff at higher unit cost partially offset by WTE usage below budget but still overspent.
- Month 7 Non pay was £1.4m overspent of which continuing pressures against Theatres, CORE and Medicine plus other pressures, so two months of higher spend. Overall overspend M1-7 of £3.0m is supported by LA support of £2.5m, so net non-pay is actually pressured ytd due to inflationary pressures and Drugs activity.

# ERF - Trust

## ERF performance

- The under-performed against its plan by £0.2m in month and £0.7m YTD based on initial data. The includes the 2% national reduction to the ERF target
- It should be noted that there is a two-month lag on freeze data and we have seen a small improvement in the M5-6 position now in M7
- Also YTD prices have increased by 2.1%, due to tariff changing to reflect pay awards
- T&O represents the majority of the underperformance, with Cardiology also exhibiting a material adverse variance.




| | In Month | | | | YTD | | | |
|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Var | | Plan | Actual | Var | |
| | £'000 | £'000 | £'000 | % | £'000 | £'000 | £'000 | % |
| Daycase | 3,122 | 3,042 | (80) | (2.6%) | 20,911 | 20,006 | (905) | (4.3%) |
| Elective | 2,211 | 1,749 | (461) | (20.9%) | 15,001 | 12,084 | (2,917) | (19.4%) |
| New OP | 1,725 | 1,812 | 88 | 5.1% | 11,209 | 11,034 | (175) | (1.6%) |
| OP Procedures | 1,737 | 1,849 | 112 | 6.4% | 11,637 | 11,956 | 320 | 2.7% |
| Ward Attenders | 71 | 149 | 78 | 109.0% | 492 | 1,091 | 598 | 121.5% |
| ERS | - | 80 | 80 | | - | 557 | 557 | |
| **Internal plan** | **8,866** | **8,682** | **(184)** | **(2.1%)** | **59,250** | **56,729** | **(2,521)** | **(4.3%)** |
| Baseline Adj | - | - | - | | (1,822) | - | 1,822 | |
| Prior period catch-up | - | 603 | 603 | | - | - | - | |
| **I&E impact** | **8,866** | **9,285** | **419** | **4.7%** | **57,428** | **56,729** | **(699)** | **(1.2%)** |

| | In Month | | | YTD | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Var | Plan | Actual | Var |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Trauma and Orthopaedic Service | 1,706 | 1,406 | (300) | 11,395 | 9,099 | (2,295) |
| Cardiology Service | 752 | 617 | (136) | 4,793 | 3,845 | (948) |
| Respiratory Medicine Service | 203 | 127 | (76) | 1,284 | 909 | (375) |
| Clinical Oncology Service | 184 | 112 | (72) | 1,219 | 813 | (406) |
| Interventional Radiology Service | 53 | 2 | (51) | 457 | 200 | (257) |
| Orthodontic Service | 65 | 32 | (32) | 363 | 191 | (171) |
| Maxillofacial Surgery Service | 150 | 124 | (26) | 1,103 | 934 | (169) |
| Vascular Surgery Service | 52 | 33 | (19) | 388 | 265 | (123) |
| Respiratory Physiology Service | 63 | 46 | (17) | 355 | 248 | (108) |
| Ear Nose and Throat Service | 366 | 351 | (15) | 2,670 | 2,207 | (463) |
| Gastroenterology Service | 516 | 505 | (11) | 3,618 | 3,327 | (291) |
| Rheumatology Service | 241 | 231 | (11) | 1,546 | 1,519 | (27) |
| Breast Surgery Service | 213 | 203 | (10) | 1,430 | 1,375 | (55) |
| Endocrinology Service | 63 | 53 | (10) | 338 | 370 | 32 |
| Transient Ischaemic Attack Service | 48 | 38 | (10) | 312 | 264 | (48) |
| Trust | 7 | - | (7) | 49 | 225 | 175 |
| Chemical Pathology Service | 17 | 12 | (5) | 102 | 83 | (19) |
| Stroke Medicine Service | 8 | 6 | (3) | 48 | 27 | (21) |
| Neurology Service | 134 | 132 | (2) | 813 | 812 | (1) |
| Anaesthetic Service | 9 | 8 | (1) | 72 | 66 | (6) |
| Paediatric Epilepsy Service | 6 | 5 | (0) | 15 | 31 | 16 |
| Palliative Medicine Service | 0 | 2 | 1 | 2 | 4 | 2 |
| Hepatology Service | - | 1 | 1 | - | 4 | 4 |
| BCSP | 25 | 29 | 4 | 137 | 213 | 75 |
| Elderly Medicine Service | 33 | 38 | 5 | 200 | 174 | (26) |
| Paediatric Dermatology Service | - | 5 | 5 | - | 37 | 37 |
| Paediatric Trauma and Orthopaedi | - | 5 | 5 | - | 37 | 37 |
| Diabetes Service | 7 | 18 | 11 | 55 | 92 | 37 |
| Paediatric Service | 142 | 154 | 12 | 980 | 1,126 | 146 |
| General Internal Medicine Service | 19 | 53 | 34 | 135 | 169 | 34 |
| Clinical Haematology Service | 210 | 245 | 35 | 1,703 | 1,609 | (94) |
| Acute Internal Medicine Service | - | 40 | 40 | - | 359 | 359 |
| Dermatology Service | 192 | 235 | 42 | 1,385 | 1,623 | 238 |
| Gynaecology Service | 536 | 582 | 45 | 3,761 | 3,826 | 65 |
| Urology Service | 866 | 912 | 46 | 5,369 | 5,769 | 400 |
| General Surgery Service | 913 | 1,027 | 114 | 6,200 | 6,295 | 95 |
| Ophthalmology Service | 1,059 | 1,286 | 227 | 6,888 | 8,524 | 1,636 |
| **Sub total** | **8,866** | **8,682** | **(184)** | **59,250** | **56,729** | **(2,521)** |
| 2% adjustment | | | | (1,822) | | 1,822 |
| **Total** | | | | **57,428** | **56,729** | **(699)** |

# Pay costs

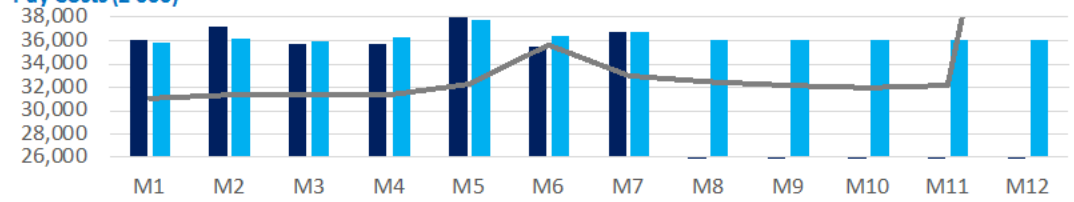
East Sussex Healthcare NHS Trust

## Pay analysis

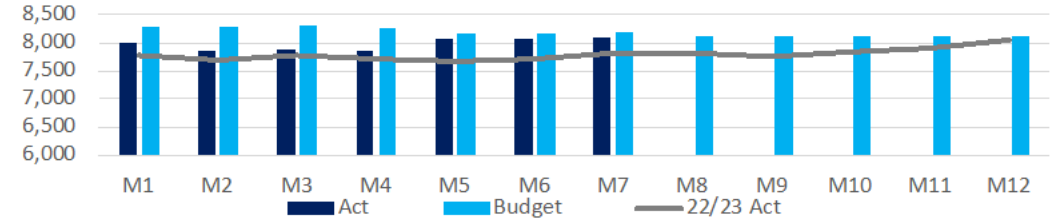
| All staff | Pay costs (£'000) - In Month | | | | | WTE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Act | Var | PY | YTD var | YTD ave | Act | Var | PY | YTD var | YTD Ave |
| Medical | (8,696) | (445) | (8,466) | (2,813) | (8,493) | 892 | 18 | 853 | 0 | 864 |
| Nursing | (14,337) | 613 | (14,019) | 818 | (14,581) | 3,770 | (91) | 3,667 | (124) | 3,711 |
| AHP | (4,973) | 909 | (4,453) | 3,518 | (4,847) | 1,240 | (96) | 1,117 | (126) | 1,204 |
| Admin | (4,286) | 122 | (3,874) | 1,751 | (4,165) | 1,362 | (85) | 1,312 | (88) | 1,355 |
| Other | (4,536) | (1,292) | (2,976) | (3,392) | (4,382) | 848 | 182 | 812 | 70 | 843 |
| **Total** | **(36,827)** | **(94)** | **(33,787)** | **(119)** | **(36,469)** | **8,112** | **(72)** | **7,760** | **(268)** | **7,977** |

| Temporary | Pay costs (£'000) | | | | | WTE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Aug | Sep | Oct | PY | YTD | Aug | Sep | Oct | PY | YTD Ave |
| **Bank** | **(2,162)** | **(2,030)** | **(1,731)** | **(1,634)** | **(13,445)** | **522** | **538** | **537** | **476** | **489** |
| Medical | (357) | (281) | (328) | (460) | (2,237) | 26 | 22 | 22 | 35 | 24 |
| Nursing | (341) | (365) | (312) | (437) | (2,663) | 49 | 59 | 69 | 85 | 60 |
| AHP | (203) | (170) | (156) | (78) | (1,175) | 28 | 26 | 22 | 16 | 24 |
| Admin | (141) | (95) | (102) | (1) | (738) | 6 | 6 | 8 | 1 | 6 |
| Other | - | - | - | - | - | - | - | - | - | - |
| **Agency** | **(1,042)** | **(910)** | **(898)** | **(976)** | **(6,813)** | **109** | **113** | **121** | **137** | **114** |
| **Locum** | **(1,593)** | **(1,454)** | **(1,370)** | **(1,922)** | **(9,453)** | **124** | **129** | **107** | **87** | **106** |
| **WLI** | **(342)** | **(22)** | **(429)** | **(278)** | **(2,272)** | **34** | **36** | **43** | **20** | **39** |
| **Total Temp** | **(5,139)** | **(4,416)** | **(4,428)** | **(4,810)** | **(31,983)** | **790** | **815** | **809** | **720** | **748** |

Pay Costs (£'000)




WTEs




### Pay analysis

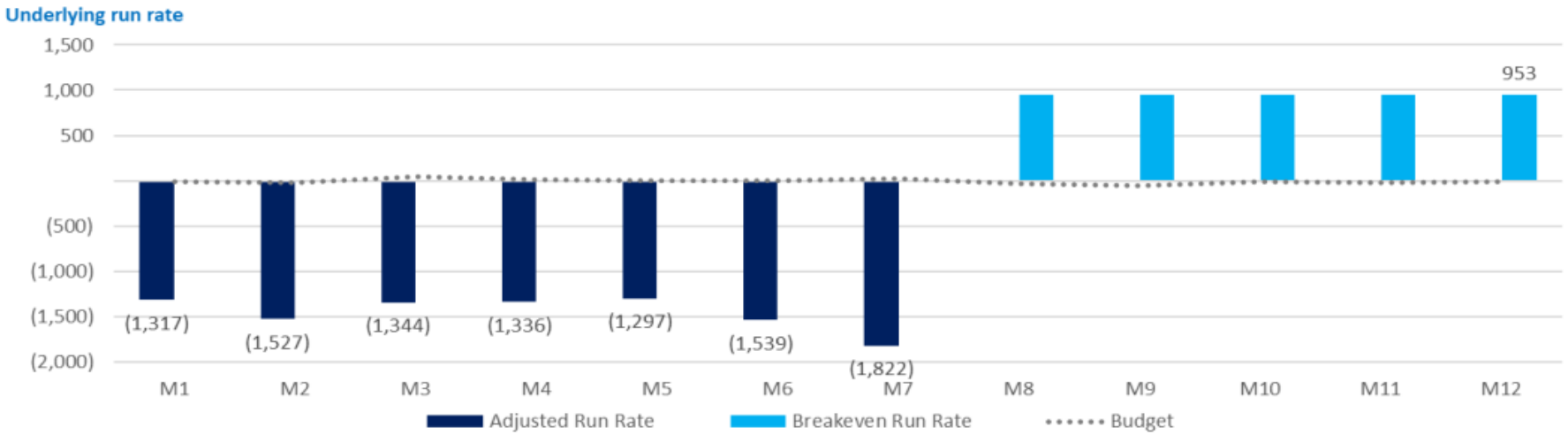
- M7 pay costs are higher than budget, due to released reserves, vacancies within CDC and VW (income funded schemes). IA £0.3m in month.
- Overall the in month spend of £36.8m is £3.1m higher than 22-23 comparator due to investment in Urgent Care, CDC and Virtual Ward, aligned with material central changes being smoothed over the 23-24 year.
- AFC Pay Award for 23-24 was processed in month 3. Overall increase in budget of £17.2m. Potential income shortfall of approx. £2m fye.
- M&D Pay Award processed M7, increase to budget of £6m. Income shortfall approx. £0.3m fye.
- Nursing & Medical staffing groups are over spending, mainly linked to Medicine/UC/DAS.
- Nursing spending is impacted by the continuation of escalation wards (extra beds above funded) and supernumerary double running costs.
- Whilst WTEs are below budget, cost are above. This is driven by use of temporary workforce which is more expensive, especially in Urgent Care for Senior Medical posts.
- YTD Industrial action cover costs of £1.4m in spend.

### PY comparison

- Pay (£) is overall is above the 22/23 comparator as described above.
- Pay WTE is higher than the prior year comparator aligned to the investments above.
- Pay WTE is 352 fte higher.

# 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 (£1.8m). The analysis has removed net £5.4m of one-off items which whilst don't impact the run rate will still impact the in year financial position. Driven by:
  - £1.8m 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.
- M7 underlying run rate is a (£1.8m deficit), this is in £0.3m higher than the previous month (£1.4m deficit). Taking the current average months run rate and extrapolating gives an overall deficit of £12.0m. Increase in month due to higher non pay costs for second month in a row. These are being reviewed for trends.
- 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 **£2.4m** reduction per month compared to M7.

# Divisional Summary

East Sussex Healthcare NHS Trust

## Divisional position

| Division | Variance to budget - M7 | | | | | | | YTD overall Variance | Underlying Run Rate | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Contract Income | Divisional income | Pay | Non pay | Overall Variance | Over all Variance | WTE | | Aug | Sep | Oct | |
| | £'000 | £'000 | £'000 | £'000 | £'000 | M6 | WTE | £'000 | £'000 | £'000 | £'000 | |
| CHIC | - | (113) | 180 | (54) | 13 | (37) | (13) | (330) | (4,109) | (4,138) | (4,169) | q |
| Core Services | (44) | 25 | 459 | (523) | (83) | 228 | (51) | (317) | (6,487) | (6,412) | (6,636) | q |
| Estates & Facilities | - | 47 | 5 | 187 | 239 | 192 | (2) | 648 | (3,118) | (3,167) | (3,026) | p |
| Medicine | 16 | (183) | 104 | (232) | (296) | (539) | +29 | (3,171) | (4,095) | (4,971) | (3,818) | p |
| DAS | (199) | 2 | (459) | (328) | (984) | (187) | +54 | (3,871) | (3,274) | (4,100) | (3,020) | p |
| Urgent Care | 50 | (21) | (231) | (166) | (367) | (377) | +58 | (2,108) | (4,998) | (5,532) | (4,993) | p |
| WCSH | 179 | 83 | 255 | (238) | 280 | (108) | (57) | 304 | (2,561) | (3,030) | (2,323) | p |
| Corporate Services | - | 22 | (346) | (79) | (403) | 191 | (37) | 1,479 | (5,496) | (5,661) | (5,301) | p |
| SPH | - | 140 | 68 | (79) | 129 | (121) | (13) | (109) | (64) | (22) | 258 | p |
| Central/Trust wide | 510 | (194) | (110) | (80) | 125 | (641) | (248) | 2,524 | 33,154 | 35,262 | 31,864 | q |
| **ESHT** | **512** | **(192)** | **(75)** | **(1,592)** | **(1,347)** | **(1,400)** | (280) | **(4,952)** | **(1,047)** | **(1,772)** | **(1,165)** | p |

- **CHIC** – headroom has gradually been reducing as recruitment is catching up to investments and we have now seen in M1-7 overspends in the division for the first time in a number of years, however lowering in M5-7. Pay pressures due to Minerva contract supporting Urgent Community response now above budgeted levels but contract has now ended. 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 M6-M7 attributed to catch up and activity aligned to outsourcing in Radiology.
- **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 M6-7 due to actual consumption/tariff lower than forecast for 23-24. Tariff element £0.4m underspent ytd.
- **Medicine** – Overspend driven Escalation beds above funded ytd, this is exacerbated by significant service overspends in Gastro, haematology and Cardiology. IA costs £0.5m ytd. Supernumerary staffing and premium staffing continues to be a driver of these variances.
- **DAS** – Electivity activity lower than plan ytd with under performance of £0.9m 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). IA costs approx. £0.4m ytd. Excluding CIP target the division is overall below establishment (also true for Urgent Care). DAS overall is the worst performing division with Medicine and Urgent second and third on the list respectively.
- **UC** – Premium costs for Medical staffing continuing to cause pressures alongside supernumerary staffing. IA costs £0.4m ytd.
- **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 M1-7 resulting in lower performance than forecast ytd. Compucare system now being utilised.

# Efficiency

East Sussex Healthcare NHS Trust

| Division | In Month | | | Ytd – M7 | | | 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 | 911 | 986 | 76 | 4,373 | 2,776 | (1,597) | 4,204 | 641 | 4,845 | 9,247 | (4,403) |
| Urgent Care | 194 | 126 | (68) | 681 | 767 | 86 | 1,154 | 159 | 1,313 | 1,919 | (606) |
| DAS | 823 | 320 | (503) | 4,906 | 3,099 | (1,806) | 4,180 | 964 | 5,144 | 9,235 | (4,091) |
| Core Services | 311 | 708 | 397 | 1,399 | 1,893 | 494 | 1,423 | 1,777 | 3,201 | 3,504 | (304) |
| CHIC | 63 | 179 | 116 | 485 | 1,222 | 737 | 496 | 1,659 | 2,155 | 844 | 1,311 |
| WCSH | 102 | 244 | 142 | 877 | 1,773 | 896 | 963 | 1,339 | 2,301 | 1,980 | 321 |
| Estates & Facilities | 162 | 165 | 4 | 1,071 | 894 | (177) | (47) | 1,287 | 1,240 | 1,697 | (456) |
| Corporate | 314 | 406 | 91 | 1,998 | 2,519 | 521 | 2,394 | 1,838 | 4,232 | 3,538 | 694 |
| Sussex Premier Health | 87 | (1) | (88) | 99 | (10) | (109) | (19) | - | (19) | 543 | (562) |
| **Total** | **2,967** | **3,133** | **166** | **15,889** | **14,932** | **(956)** | **14,747** | **9,664** | **24,411** | **32,507** | **(8,096)** |

**Overview**

- The divisions have delivered £3.1m of efficiencies in the month, this is £0.1m more than the £3.0m plan.
- The in-month variance is largely due to additional vacancy slippage, the impact of this is partially offset by LoS, Theatres and Demand Management not delivering to plan.
- 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 £1.0m YTD, this is largely driven by £2.5m under-delivery on ERF and LoS not delivering to plan, this is partially offset by vacancy slippage and the CNST rebate (received earlier than planned).
- The current forecast has a £8.1m gap, however the risk adjusted forecast is £22.3m, so the gap is higher at £10.2m, this is higher than last month, but is as a result of a detailed review of the forecasts and the forecast position is now more closely aligned to the risk adjusted.
- Currently 40% of the £24.4m is non-recurrent, of this £8.2m is vacancy slippage, however the proportion of non-recurrent is 47% 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

| Trust Lead | Capital Scheme | In Month | | | YTD | | | Full Year | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Plan £'000 | Actual £'000 | Variance £'000 | Plan £'000 | Actual £'000 | Variance £'000 | Plan £'000 | Fcast £'000 | Variance £'000 |
| | **Original** | | | | | | | | | |
| DIG | Digital Programmes | 288 | 554 | 266 | 1,166 | 1,804 | 638 | 3,500 | 3,247 | (253) |
| DIG | Our Care Connected | - | - | - | - | - | - | 900 | 900 | - |
| | **Total Digital** | **288** | **554** | **266** | **1,166** | **1,804** | **638** | **4,400** | **4,147** | **(253)** |
| EME | Diagnostic Equipment | 263 | 63 | (199) | 788 | 258 | (530) | 1,750 | 1,750 | - |
| EME | Medical Equipment | 338 | 227 | (110) | 1,013 | 508 | (505) | 2,250 | 1,938 | (312) |
| | **Total Medical Equipment** | **600** | **290** | **(310)** | **1,800** | **766** | **(1,034)** | **4,000** | **3,688** | **(312)** |
| EST | Fire | 80 | 67 | (13) | 288 | 674 | 386 | 1,600 | 1,600 | - |
| EST | Backlog | 529 | 250 | (279) | 1,624 | 2,042 | 418 | 10,575 | 8,100 | (2,475) |
| EST | Cath Lab Replacement | - | 34 | 34 | 1,650 | 1,573 | (77) | 1,650 | 1,650 | - |
| EST | Cardiology Business Case | 400 | 212 | (188) | 1,600 | 239 | (1,361) | 2,000 | 2,000 | - |
| EST | Clinical - Prior Year | - | (2) | (2) | - | 74 | 74 | - | 90 | 90 |
| EST | Decant Ward | 25 | 31 | 6 | 75 | 527 | 452 | 500 | 600 | 100 |
| EST | Discharge Lounge | 100 | 8 | (92) | 500 | 453 | (47) | 500 | 500 | - |
| EST | Elective Hub | 596 | 13 | (584) | 1,490 | 163 | (1,327) | 7,451 | 7,451 | - |
| EST | Friston Paeds | - | (2) | (2) | 375 | 152 | (223) | 375 | 375 | - |
| EST | ICU adaptations Conq | 10 | 2 | (8) | 50 | 3 | (47) | 50 | 135 | 85 |
| EST | Ophthalmology Business Case | 400 | (10) | (410) | 1,600 | 579 | (1,021) | 2,000 | 2,000 | - |
| EST | Ward Refurbishment | 100 | 23 | (77) | 375 | 425 | 50 | 1,250 | 1,250 | - |
| | **Total Estates** | **2,240** | **624** | **(1,616)** | **9,627** | **6,905** | **(2,722)** | **27,951** | **25,751** | **(2,200)** |
| FIN | Business Case Development | - | - | - | - | 26 | 26 | - | - | - |
| FIN | Divisional Small Works | 40 | 37 | (3) | 280 | 75 | (205) | 500 | 500 | - |
| FIN | Minor Capital | 72 | - | (72) | 504 | 336 | (168) | 900 | 900 | - |
| FIN | Planned slippage/prioritisation | (37) | - | 37 | (167) | - | 167 | (521) | - | 521 |
| | **Total Finance** | **75** | **37** | **(38)** | **617** | **437** | **(180)** | **879** | **1,400** | **521** |
| | **System Capital** | **3,203** | **1,505** | **(1,698)** | **13,209** | **9,911** | **(3,298)** | **37,230** | **34,986** | **(2,244)** |
| | **New** | | | | | | | | | |
| EST | Building For Our Future | 92 | 103 | 11 | 641 | 423 | (219) | 1,145 | 1,145 | - |
| EST/EME | Community Diagnostic Centre | - | 7 | 7 | 1,000 | 291 | (709) | 1,000 | 900 | (100) |
| EST | Elective Hub EDGH | 716 | 19 | (697) | 1,791 | 121 | (1,670) | 8,956 | 8,956 | - |
| DIG | Diagnostics Digital Capability (LIMS) | - | - | - | - | 283 | 283 | 914 | 914 | - |
| DIG | Diagnostics Digital Capability (OCS) | - | - | - | - | - | - | 451 | 451 | - |
| DIG | Diagnostics Digital Capability (Image Sharing) | - | - | - | - | - | - | 1,000 | 1,000 | - |
| DIG | Frontline Digitalisation (EPR) | - | - | - | - | - | - | 5,300 | 5,300 | - |
| EST | NHP Enabling Fees | 805 | - | (805) | 994 | - | (994) | 4,734 | 4,734 | - |
| EST | Endoscopy | - | - | - | - | - | - | 5,000 | 5,000 | - |
| | **Total Additional Capital** | **1,613** | **129** | **(1,483)** | **4,426** | **1,118** | **(3,308)** | **28,500** | **28,400** | **(100)** |
| | **Total Capital** | **4,816** | **1,635** | **(3,181)** | **17,636** | **11,030** | **(6,606)** | **65,730** | **63,386** | **(2,344)** |
| EST | PSDS3 | - | - | - | - | 2,454 | 2,454 | 165 | 165 | - |
| EST | PSDS3 Income | - | - | - | - | (2,454) | (2,454) | (165) | (165) | - |
| | **Total Grant Capital** | **-** | **-** | **-** | **-** | **0** | **0** | **-** | **-** | **-** |
| FIN | Donated Expenditure | 120 | 94 | (26) | 840 | 161 | (679) | 1,500 | 1,500 | - |
| FIN | Donated Income | (120) | (132) | (12) | (840) | (161) | 679 | (1,500) | (1,500) | - |
| | **Total Donated Capital** | **-** | **(38)** | **(38)** | **-** | **-** | **-** | **-** | **-** | **-** |
| | **Total Capital** | **4,816** | **1,597** | **(3,219)** | **17,636** | **11,030** | **(6,606)** | **65,730** | **63,386** | **(2,344)** |

East Sussex Healthcare NHS Trust

## Capital

- The planned capital allocation for 2023/24 is £65.7m and is made up of the core ICS allocation of £37.2m plus national programmes expected in year of £28.5m.
- The capital expenditure incurred totals £11.0m compared to a plan of £17.6m. The current position is therefore behind plan by £6.6m. The plan is back loaded in-line with trends from previous years and the major national schemes that are scheduled to deliver in Q4.
- Capital expenditure was largely driven by the following schemes:
  - Estates works of £6.9m, the main schemes being fire compartmentalisation (£674k), backlog maintenance (£2,042k), cath lab replacement (£1,573k), decant ward (£527k), discharge lounge (£453k), ophthalmology business case (£579k), and ward refurbishments (£425k).
  - Community Diagnostics Centre £291k which combines costs for both equipment and works.
  - Diagnostics Digital Capability £283k.
  - Building for Our Future £423k.
- The Elective Care Hub is split funded partly from system funding (£7.5m) and national PDC schemes (£9m). The scheme is behind plan with expenditure of £284k ytd.
- Following the revised plan being agreed, a revised forecast has been worked through and indicates a projected underspend of £2.3m at year-end. However, the Trust is working through a range of options and monitoring the situation closely to try and mitigate the risk of under delivery.

# Assets and Liabilities

East Sussex Healthcare NHS Trust

Finance

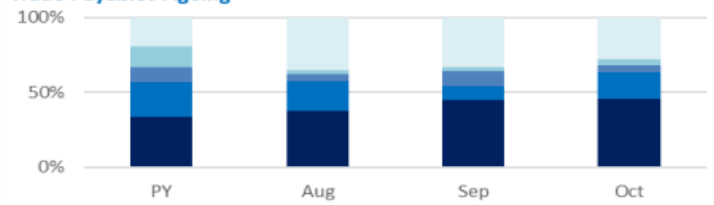
**Trust Assets and Liabilities**

| | Aug | Sep | Oct | Change |
|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 |
| **Non-current assets** | **349,018** | **348,516** | **348,453** | **(63)** |
| Inventories | 8,254 | 8,482 | 9,006 | 525 |
| Trade and other receivables | 37,523 | 43,011 | 37,246 | (5,765) |
| Cash and Cash equivalents | 50,783 | 43,701 | 43,756 | 55 |
| **Current Assets** | **96,560** | **95,193** | **90,008** | **(5,185)** |
| Trade and other payables | (59,647) | (56,161) | (56,210) | (49) |
| Other liabilities | (15,376) | (18,479) | (14,590) | 3,889 |
| **Current Liabilities** | **(75,024)** | **(74,639)** | **(70,800)** | **3,839** |
| **Non-current liabilities** | **(11,371)** | **(11,371)** | **(11,371)** | **-** |
| **Total assets employed** | **359,184** | **357,699** | **356,291** | **(1,409)** |

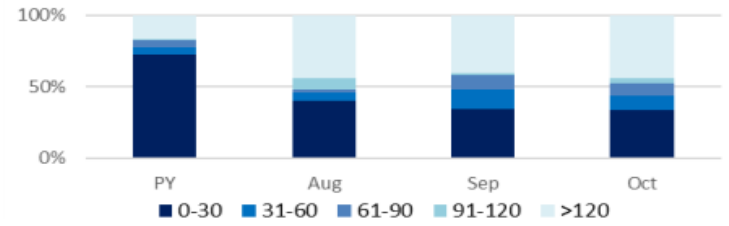
**BPPC (Based on invoice count)**

| | | | | |
|---|---|---|---|---|
| Trade | 80.4% | 81.5% | 83.5% | 2.0% |
| NHS | 95.9% | 96.3% | 96.6% | 0.3% |

**Trade Payables Ageing**




**Trade receivables Ageing**




## Balance sheet

- There has been a slight decrease in non-current assets in month 7.
- Current assets has decreased in month by £5.2m, this is due to a decrease in Trade and Other Receivables of £5.8m relating to income accruals, offset by an increase in inventories of £0.5m.
- There were 4 weekly payment runs in October. The average payment run value was £4.3m.
- Current liabilities has decreased in month by 3.8m due to a reduction in the level of deferred income.
- The Trust continues to hold significant cash balances at £43.8m and as such despite the deficit position does not need revenue PDC support from NHSE at this point.

## Better Payment Practice Code (BPPC)

- An increase in BPPC for Trade and for NHS in month. Where possible, the Financial Services team continue to prioritise performance, with non-NHS payables a particular focus. Poor performance is largely due to issues with no purchase orders quoted on invoices or raised, or delays to receipting of goods and services.

## Trade and Other Payables

- A decrease in month of £1.7m on the creditor position decreasing the purchase ledger total to £10.6m. The number of invoices registered on the system is 4,405, a decrease of 1,736 in month.
- 76% of the outstanding invoices are payable to trade (Non-NHS) suppliers and the balance to NHS providers. The Trust processes weekly payment runs.
- Most aged invoices are stuck in the system due to issues relating to the 'No PO, No Pay' policy.

## Trade and Other Receivables

- The sales ledger balance decreased by £1.3m in month to a total of £4.9m.
- The invoice count on the sales ledger is 2,132, a decrease of 95 in month.
- The ageing profile of debt due has decreased by £0.7m in month and now totals £3.3m.

# Risk adjusted forecast outturn

East Sussex Healthcare NHS Trust

- The base case already includes a high degree of stretch, the upside scenario therefore represents a "what it would take" scenario.
- Risk analysis shows a potential range from £19.7m deficit position for the downside to a £11.9m deficit position against the base case, worse than M6 due to higher non pay activity in Month 7. This is however predicated on a number of assumptions – particularly the improved run rate for CIP delivery and recovery of the elective position.
- ICB considering amending the forecast formally for M9 although we are still waiting on a proper understanding of revised rules around ERF – in particular how future strikes beyond April-Oct will be accounted for.

| | Downside £'000 | Base £'000 | Upside £'000 | Commentary |
|---|---|---|---|---|
| **M7 YTD** | **(4,952)** | **(4,952)** | **(4,952)** | |
| **Risks** | | | | |
| Elective Activity Target | (2,701) | (1,801) | - | *Underachieved by £2.5m across Month 1-7, discounting clawback*<br>**Base:** assumption in line with current performance, however see mitigations and elective recovery offsetting this. **Downside** adds in 50% allowance against current underperformance for further strikes.**Upside** shows full delivery against plan. |
| Efficiency | (8,900) | (7,500) | (7,500) | *Overall target of £32.5m in 23.24.*<br>Base/**Upside** assumption is £7.5m stretch included in final 23-24 breakeven plan, which has been updated based on latest forecasts of run rate impact. **Downside**: the risk assessed forecast is £23.6m, so the gap is higher at £8.9m. |
| Run rate | - | (129) | (129) | **Base/Upside**: Extrapolation of Month 7 run rate adjusting for ERF and efficiency (shown in lines above) shows net pressures once risk accounted for elsewhere. **Downside** assumptions reflected in other lines so no benefit. |
| Non Pay Inflation | (1,458) | (700) | - | *Non pay Inflation assigned to known contract price changes such as Utilities. Generic price increases not funded in baseline ,*<br>**Downside:** assumes 2% increase on remaining non pay budget for 23-24 across the remainder of the year.<br>**Base:** assumes some additional costs materialising, currently set at £0.7m.<br>**Upside**: no additional non-pay inflation costs |
| Winter/Covid pressures | (1,500) | - | - | *Increasing expenditure based on additional operational demand over winter*<br>**Base/Upside:** Additional funding from ICB for Winter pressures, therefore set at zero for base case.<br>**Downside**: £1.5m included for potential risk against funding such as increased Escalation beds or Covid. |
| Pay award | (1,370) | (970) | (970) | *There is a risk that the full cost is not fully funded.*<br>**Base/Upside Case**: Assumes pay award absorbed via vacancy factor M1-7 so full potential cost not realised in year.<br>**Downside**: based on the gap identified in the pay workings of £2.3m based upon Budgeted establishment for 23-24, adjusted ytd but risk added. |
| **Mitigations** | | | | |
| Planned Efficiences | - | 2,057 | 6,957 | Assumed additional efficiences found in line with current forecast projections accounting for risk figure above with adjustment (i.e. Plan of £32.5m, pre-risk adjusted £24.4m, so adjusted to £6m shortfall). Upside cases assumes almost full delivery of CIP |
| Elective Recovery | - | 900 | - | **Downside: no recovery**<br>**Base:** assumes half the current run rate is mitigated through lower strikes and productivity improvements<br>**Upside**: full recovery already shown in risks |
| Reserves deployed | 1,190 | 1,190 | 1,190 | From reserves schedule |
| **Scenario FOT** | **(19,692)** | **(11,905)** | **(5,404)** | |
| **Prior month** | **(19,316)** | **(8,707)** | **(1,616)** | |

# Industrial Action Summary for M7

East Sussex Healthcare NHS Trust

- Staffing data compiled from information from TWS/Healthroster/ESR
- Income assumptions from Knowledge Management activity combined with contract income tariffs.
- Items highlighted in green estimate while awaiting actual data.
- Approx ledger impact excluding assumptions approx. £1.4m ytd.

| | Month (£) | | | | | | | YTD (£) | |
|---|---|---|---|---|---|---|---|---|---|
| **Cost Reduction from Strikes** | **April** | **May** | **June** | **July** | **August** | **September** | **October** | **Total** | **Key Assumptions** |
| Nursing | | (8,648) | | | | | | **(8,648)** | 1/365th of salary |
| Consultant Shifts | | | | (13,434) | (13,132) | (12,943) | (16,514) | **(56,023)** | 1/365th of salary |
| Junior Doctor shifts | (129,538) | | (77,552) | (76,988) | (73,796) | (62,124) | (46,922) | **(466,921)** | 1/365th of salary |
| | | | | | | | | | |
| **Cost of Cover** | | | | | | | | | |
| Nurse Bank Shifts | 3,032 | 3,032 | 3,032 | 3,032 | 3,032 | 3,032 | 3,032 | **21,226** | Taken from Healthroster IA shifts booked |
| Consultants Cover | 204,778 | | 349,271 | 539,708 | 260,682 | 104,378 | 182,530 | **1,641,345** | Estimate Sept |
| WLI catch up for lost activity | | 67,500 | 67,500 | 67,500 | 67,500 | 67,500 | 67,500 | **405,000** | Average increase in WLI's v 22-23 |
| | | | | | | | | | |
| **Lost Activity Income** | | | | | | | | | |
| Elective | 320,890 | 87,915 | 131,873 | 246,162 | 196,710 | 196,710 | 196,710 | **1,376,971** | Estimate Aug-Oct (data requested) |
| Day Case | 285,165 | 52,237 | 173,839 | 250,055 | 190,324 | 190,324 | 190,324 | **1,332,269** | Estimate Aug-Oct (data requested) |
| Outpatient | 167,455 | 18,691 | 101,846 | 175,274 | 115,816 | 115,816 | 115,816 | **810,715** | Estimate Aug-Oct (data requested) |
| | | | | | | | | | |
| **Non Pay Savings (cancelled Activity)** | (154,702) | (31,769) | (81,512) | (134,298) | (100,570) | (100,570) | (100,570) | **(703,991)** | Estimated @ 20% of income |
| | | | | | | | | | |
| **Absorbed Costs Management** | 85,760 | 85,760 | 64,320 | 64,320 | 42,880 | 42,880 | 42,880 | **428,802** | Assumption costs lower as routine increases |
| | | | | | | | | | |
| **Total Cost + Lost Activity To M7** | | | | | | | | **4,780,745** | |
| Costs Excluding Lost Income | £9,331 | £115,876 | £325,059 | £449,839 | £186,596 | £42,153 | £131,936 | £1,260,790 | |

# Specialty recovery plan monitoring

East Sussex Healthcare NHS Trust

## Background

- As part of the response to the challenging financial position we are requiring certain specialties to develop and implement recovery plans.
- The table below provides and overview of the recovery positions for these specialties (work is ongoing in other specialties, however these currently represent where senior management time and focus is being spent. We are further looking to work with cardiology and T&O at an executive level to finalise their recovery plans.

## Underlying run rate

- There will always be ups and downs in terms of underlying run rates, however over time we would want to see an improvement across these specialties. We should start to see the impact in M7 onwards (later for some specialties)
- Overall, there has been an improvement of c£0.4m from M6, however there is variation within this.

## Forecast Outturn

- YTD variance across these specialties is £8.1m (although it should be noted that the ERF baseline adjustment is being held centrally and not applied to individual specialties.
- An unmitigated FOT is £16.3m adverse variance, to date we have identified recovery actions of £2.6m with an adjusted FOT of £13.7m adverse variance.
- We will begin to track progress around month-by-month delivery (both financially and in terms of actions).

| | M4 | M5 | M6 | M7 | | YTD var | FOT var | Recovery | Adj FOT |
|---|---|---|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | | £'000 | £'000 | £'000 | £'000 |
| **Medicine** | | | | | | | | | |
| Cardiology | (924) | (1,059) | (1,143) | (941) | p | (1,253) | (2,317) | 131 | (2,186) |
| Gastroenterology | (385) | (304) | (281) | (231) | p | (782) | (2,144) | 1,459 | (685) |
| Respiratory | (644) | (629) | (712) | (701) | p | (813) | (1,393) | 301 | (1,092) |
| | **(1,953)** | **(1,993)** | **(2,135)** | **(1,874)** | p | **(2,847)** | **(5,854)** | **1,891** | **(3,963)** |
| **Urgent Care*** | | | | | | | | | |
| Emergency Care | (2,306) | (2,371) | (2,488) | (2,332) | p | (1,248) | (2,320) | - | (2,320) |
| Frailty | (1,465) | (1,543) | (1,539) | (1,383) | p | (672) | (2,658) | - | (2,658) |
| | **(3,770)** | **(3,914)** | **(4,027)** | **(3,715)** | p | **(1,920)** | **(4,978)** | **-** | **(4,978)** |
| **DAS** | | | | | | | | | |
| Theatres | (2,179) | (2,091) | (2,277) | (2,292) | q | (711) | (4,154) | 530 | (3,624) |
| Trauma & Orthopaedics | (123) | 274 | 139 | (144) | q | (2,616) | (1,305) | 167 | (1,138) |
| | **(2,302)** | **(1,816)** | **(2,138)** | **(2,436)** | q | **(3,327)** | **(5,459)** | **697** | **(4,762)** |
| | **(8,025)** | **(7,723)** | **(8,300)** | **(8,024)** | p | **(8,095)** | **(16,291)** | **2,588** | **(13,703)** |

*Urgent care only recently joined process and plans have not crystalised in modelled savings impact

East Sussex Healthcare NHS Trust

# Maternity Overview Report for Q2 2023/24

| | |
|---|---|
| **Purpose of the paper** | This report seeks to assure the Trust Board on our progress/response across two areas:<br><br>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.<br><br>2. The Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) 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.<br><br>This report provides confirmation that **ESHT maternity services have met the criteria for all ten safety actions** in line with guidance provided by NHS Resolution; V1 released March 23 and updated guidance V1.1 released July 23. |
| | For Decision: ; For Assurance: x; For Information: |
| **Sponsor/Author** | Executive Director Vikki Carruth, Chief Nurse<br>Report Author: Brenda Lynes, Director of Maternity Services |
| **Governance overview** | The two areas covered in this report were addressed through monthly Maternity and Neonatal (MatNeo) Governance and Accountability meetings and via MatNeo Assurance monthly meetings with all supporting full reports approved for Trust Board via the Quality and Safety Committee (November 2023).<br><br>The CNST/MIS evidence was audited on 14/11/23 by our auditors, RSM UK Risk Assurance Services LLP, where full compliance was confirmed. Final review and approval with the ICS will take place on 09/01/24. |

| **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** | 1. The Board are asked to take assurance about<br>• The quality and safety of perinatal services<br>• Progress with meeting the perinatal clinical quality surveillance standards<br>• Actions to proactively identify/mitigate quality and safety risks/concerns.<br><br>2. The Board are asked to take assurance that the criteria have been met for all 10 CNST MIS safety actions in line with guidance provided by NHS Resolution; V1 released March 23 and updated guidance V1.1 released July 23. |
| **Executive Summary** | **Quality and safety of perinatal services at ESHT**<br><br>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 in considerable improvement in vacancy rate seen since October 2023. The team has now achieved full compliance with the Ockenden immediate and essential actions (IEAs) |

| | |
|---|---|
| | and perinatal mortality data shows normal variation and no cause for concern. Complexity and acuity within our local population continues to impact our delivery of services. Plans are in place to provide additional training for midwives to help them manage the increasing complexity of patients. Workforce can still prove a challenge within maternity services during high activity/acuity and increasing numbers of cases where medical and social complexities means that despite staffing improvements the clinical floor can feel increasingly busy. A further workforce review (Birthrate+) will take place in Spring 2024. One area of observation is in the avoidance of term admissions to the neonatal unit, where the national benchmark has been surpassed; whilst the majority of admissions were appropriate, there is a correlation between increased elective caesarean sections and admission. A further audit into this is underway.<br><br>**CNST Year 5**<br><br>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.<br><br>The year five CNST MIS was launched on 31 May 2023 to continue to support the delivery of safer maternity care. MIS applies to all acute trusts that deliver maternity services and are members of the CNST. As in previous years, members contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.<br><br>This report provides confirmation that **ESHT maternity services have met the criteria for all ten safety actions** in line with guidance provided by NHS Resolution; V1 released March 23 and updated guidance V1.1 released July 23. It is worth noting that mitigations were communicated to Trusts 23rd October 2023 in relation to pressures experienced as a result of ongoing industrial action, this updated guidance has been indicated within the report under applicable areas (SA1 and SA8). ESHT have however, achieved full compliance against these standards without mitigation. |

| | |
|---|---|
| Next steps | The CNST/MIS year 5 submission is due 25/01/24 January 2024 following approval through the ICS on 07/01/24. An audit by RSM UK Risk Assurance Services LLP was completed on 14/11/23, who confirmed full compliance with all 10 safety actions. Results and actions following the review relating to ATAIN babies and reasons for an increase in SCBU admissions will be reviewed at December's Quality and Safety Committee. |

# Maternity Services Overview Report: Q2 2023/24

## Executive Summary

The Trust Board is requested to note this Q2 report, which covers the four 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**, including an overview of progress in meeting the perinatal clinical quality surveillance standards and actions taken to proactively identify and mitigate any quality and safety concerns or risks. The report provides an overview of Maternity planning and progress and activity during quarter 2, 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 and birthing people, babies and families across maternity and neonatal care settings in England.

    - Contribute to the national ambition set out in the Transformation plan, to reduce 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 our maternity services 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.

The monthly quality metrics and quarterly audits discussed in part one are reviewed and approved in line with national requirement through the Quality and Safety Committee with delegated authority by the Trust Board, in line with the Board Assurance Framework.

2. Part two discusses compliance against the NHS Resolutions Year 5 Maternity Incentive Scheme CNST/MIS presented for approval through the Quality and Safety Committee.

[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

## 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 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.

## Healthcare Safety Investigation Branch (HSIB), renamed Maternity and newborn Safety Investigation programme (MNSI), referrals for Q2

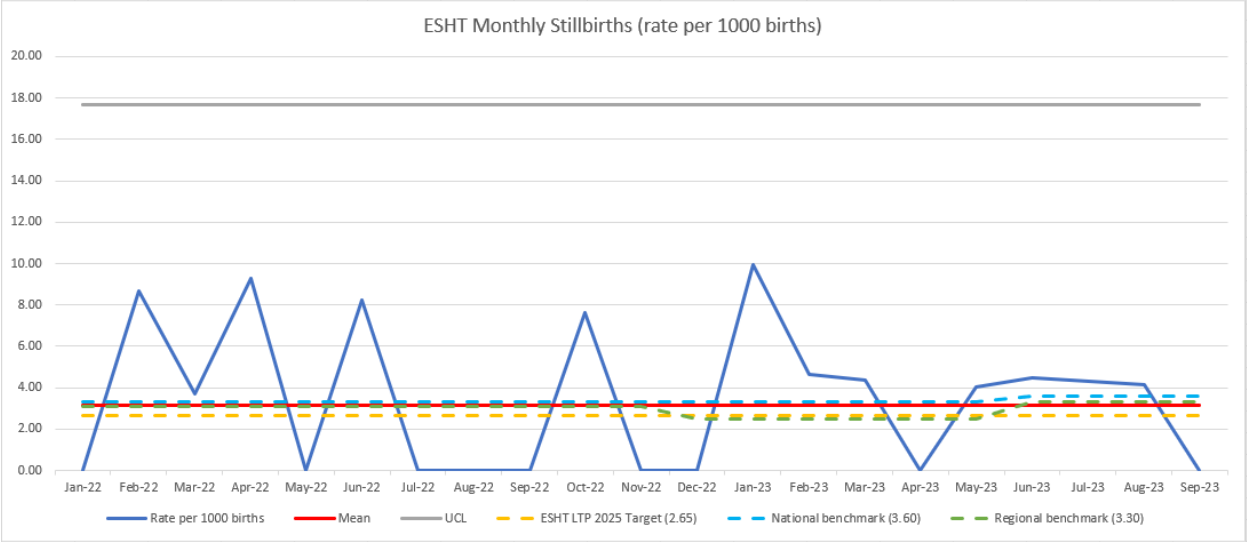
Since 2021, all HSIB/MNSI (now hosted by the CQC since October 2023) cases accepted for investigation are raised as serious incidents (SIs). During Q2 there have been no HSIB referrals. All recommendations have been discussed through clinical forums and Quality and Safety committee.

| Incident type | No of cases Q2 | Recommendations/actions |
|---|---|---|
| Closed Serious Incidents (not HSIB referrals) | 0 | - |
| Completed HSIB referrals/ Serious Incidents | WEB123442:09/08/2021 (Intrapartum stillbirth)<br><br>WEB131579:15/02/2022 (Early neonatal death)<br><br>(2 cases) | Introduction of a reliable maternity triage system<br><br>(BSOTS introduced Jan 22)<br><br>Accurate and contemporaneous evidence-based information provided as per national guidance to women and birthing people (audit of compliance Oct 22 – annual audit programme, showing good compliance)<br><br>Personalised care planning for each birthing person including risk assessment in pregnancy and labour & where an elective LSCS is indicated (robust process in place –audited in Nov 22, audits are repeated annually)<br><br>Robust clinical escalation process in line with RCOG guidance (Guidance in place and discussed as part of Prompt MDT training in 22/23 – (Guideline is audited quarterly with any actions discussed with key groups – no concerns noted in last 2 audits)<br><br>To review ESHT's use of Terbutaline (to reduce contractions in labour). This is administered in circumstances where clinically indicated to do so (guideline in place +medical & midwifery training 2022 completed) |
| Neonatal Brain Injury (HIE) | 0 | - |

## Stillbirth data (Q2)

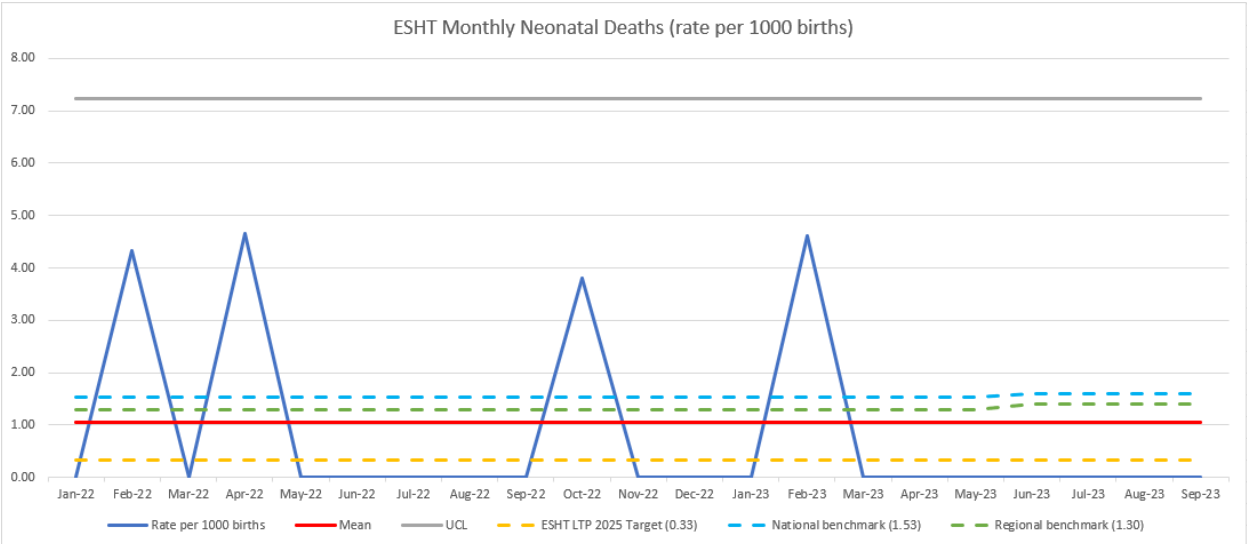
The table below shows the stillbirth rate per 1000 births reported between January 2022 and Sept 2023

- The national & regional benchmark rates for stillbirths were adjusted in June 2023
- Average (mean) is below the national & regional benchmark rates.
- ESHT stillbirth graph highlights no common cause for concern – all data is within normal levels of variation.
- The ESHT Long Term Plan (LTP) target of 2.65 shows where we need to get to by March 2024




## Monthly Neonatal Death Rates

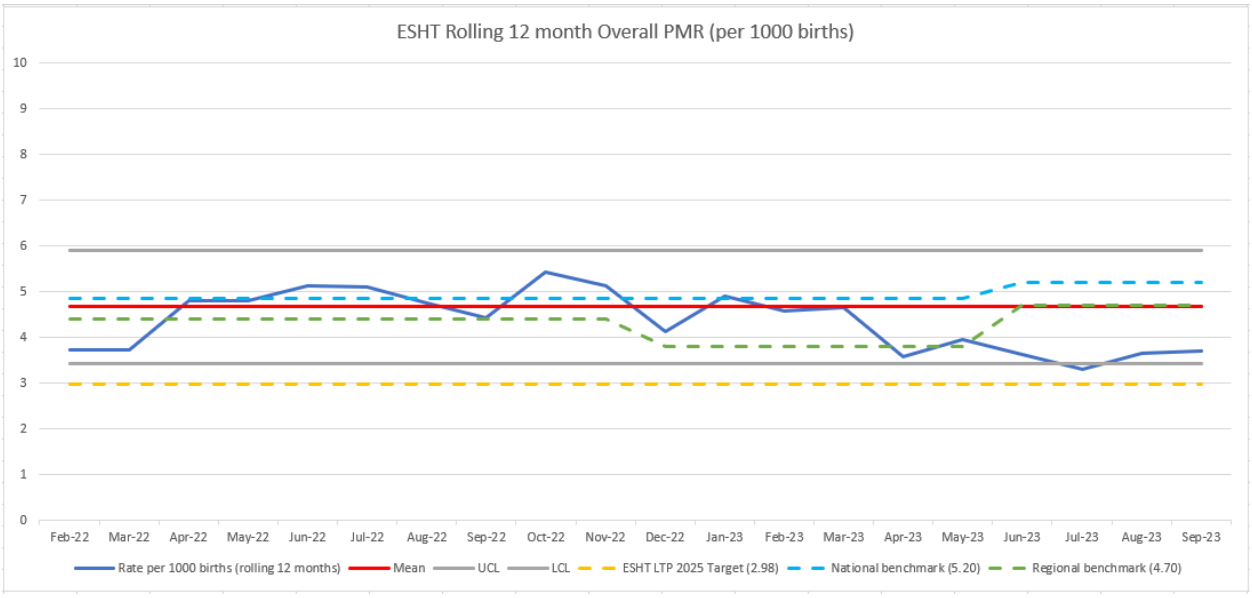
- Average (mean) is below national & regional benchmark rates
- ESHT stillbirth graph highlights special cause improving variation (7 consecutive data points below the Mean (average) line
- ESHT LTP target of 0.33 shows where we need to get to by March 2024



| 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 | Jul-23 | Aug-23 | Sep-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total births | 253 | 231 | 269 | 215 | 260 | 242 | 258 | 237 | 252 | 263 | 214 | 206 | 201 | 216 | 228 | 212 | 247 | 224 | 229 | 241 | 225 |
| Number of stillbirths | 0 | 2 | 1 | 2 | 0 | 2 | 0 | 0 | 0 | 2 | 0 | 0 | 2 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 0 |
| 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 | 4.29 | 4.14 | 0.00 |
| | | | | | | | | | | | | | | | | | | | | | |
| NND | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 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 | 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 | 1 | 1 | 0 |
| 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 | 4.29 | 4.14 | 0.00 |
| | | | | | | | | | | | | | | | | | | | | | |

## ESHT Rolling Perinatal Mortality Rate

- The national & regional perinatal mortality rates (PMR) were adjusted from June 2023
- Average (mean) for ESHT is below national and in line with regional benchmark rates
- ESHT Overall PMR is highlighting special cause improving variation with more than seven consecutive data points below the Mean (average) line
- ESHT long term plan (LTP) target of 2.98 is our aim to achieve by March 2024 and as you can see from the graph below we are moving in the right direction to achieve this target.



## Saving Babies Lives Care Bundle v3

This is a priority national safety initiative to improve practice in areas identified as contributing to adverse outcomes. Implementation of this care bundle has supported ESHT to embed this best practice on a day-to-day basis, this was published in March 2023 and launched during Q2. The Maternity and Neonatal Three-Year Delivery Plan requires that Trusts implement the bundle by April 2024. To support this standard being achieved, in 2023/2024 Trusts are asked to evidence 50% compliance in each element with an overall 70% compliance across the whole bundle at the point of CNST submission (January 2024). ESHT report compliance as noted in part 2 of this paper and as indicated in the below table.

**Implementation Progress**

| Intervention Elements | Description | Element Progress Status (Self assessment) | % of Interventions Fully Implemented (Self assessment) | Element Progress Status (LMNS Validated) | % of Interventions Fully Implemented (LMNS Validated) | NHS Resolution Maternity Incentive Scheme |
|---|---|---|---|---|---|---|
| Element 1 | Smoking in pregnancy | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 2 | Fetal growth restriction | Partially implemented | 95% | Partially implemented | 95% | CNST Met |
| Element 3 | Reduced fetal movements | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 4 | Fetal monitoring in labour | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 5 | Preterm birth | Partially implemented | 85% | Partially implemented | 85% | CNST Met |
| Element 6 | Diabetes | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| All Elements | TOTAL | Partially implemented | 93% | Partially implemented | 93% | CNST Met |

## Transitional Care audits

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 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 2 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.

## Avoiding Term Admissions into Neonatal units

Avoiding Term Admissions into Neonatal units (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)

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, consider the impact service re-design might have on reducing admissions and identify avoidable harm. Our action plan to improve transitional care services has approved through the Quality and Safety committee.

The National Neonatal Audit Programme (NNAP) benchmark is <5% term admissions to the Neonatal Unit. ESHT SCBU did not meet the NNAP benchmark for Q2 at an average of 5.9% compared to 4.6% during Q1. 38 term babies were admitted during Q2, which is a 76% increase on Q1; there appears to be a correlation between caesarean section rates and term admissions and a deep dive is underway to review this. Of the admissions 35 (92%) were categorised as appropriate admissions with 3 (8%) categorised as avoidable. Actions to reduce admissions included continued work on Transitional care pathways, ensuring babies receive steroids in utero where indicated and ensuring escalation of clinical concerns to medical teams in a timely manner.

## Findings from local Perinatal Mortality Review Tool 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 7 working days in line with national requirement.

During quarter 2, four cases were reviewed. In one case there was a recommendation for community teams to use an alert feature on e-searcher to flag when there are multiple non-attendances and staff have been made aware of this. The Child Death Overview panel are facilitating further safe sleeping training sessions for parents. Remaining cases found no care or service delivery issues. Good practice was commended by all parents, noting high quality care from the entire maternity team. Approval of the quarterly report was through the Quality and Safety Committee.

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 work to implement the Patient Safety Incident Response framework (PSIRF), a move away from “what went wrong” to “how to minimise” and learn from risks and incidents, launched in November 2023.

## Maternal Mortality

There were zero maternal death during Q2.

## Triangulation of Incidents, Complaints & Claims (Q2 2023/24)

A thematic review of all serious incidents is undertaken quarterly, including the triangulation of themes and learning from all closed incidents (severity 3, 4 & 5), complaints and claims against the CNST scorecard. All themes identified are collated and discussed and actions approved through the MatNeo Maternity Board in agreement with our MatNeo Safety Champions.

Of the claims received and reviewed from 2013-2023, top injuries by value included cerebral palsy, brain damage, bruising/extravasation, and multiple disabilities. This is similar to injuries identified in the 2022 scorecard (reviewing 10 years of data). The top causes by value centred

around delayed treatment/diagnosis, failure in antenatal screening, failure to carry out patient observations and failure to recognise complications.

Turning to recent closed high-risk incidents and complaints, positively, during the reporting period, there have been no avoidable deaths, brain injuries or Maternity and Newborn Safety Investigation programme (MNSI) referrals and therefore no similar themes could be identified in relation to injuries by value or cause.

Actions to reduce future risk includes work with teams to ensure pre-term births receive intrapartum antibiotics as per guidance and work with community teams with regards to accuracy and timeliness of consultant referrals.

## Maternity Staffing (workforce)

During the reporting period, appropriate mitigations have been implemented to ensure the department is providing and maintaining, safe and consistent maternity services, whilst ensuring positive perinatal outcomes. We are working closely with our HR team to produce a 3-year recruitment and retention plan.

### Red Flag Incidents

A Birthrate+ web-based application is used to report and monitor acuity and red flag incidents. This information is entered every four hours. To ensure data confidence, a compliance rate of 85% is recommended (ESHT compliance 86%)

Forty-Seven red flags were reported between April and September 2023, 19 less than in the previous report. Themes remain consistent for Q1 and Q2, there have been no formal complaints as a result.

### Themes Q2

| | |
|---|---|
| **Delay between admission for Induction of Labour (IOL) and commencement of procedure (39%) - 20 cases** | No harm occurred because of these delays and mitigation appropriately implemented. Clinical risk assessments were carried out for all cases |

### Supernumerary labour ward coordinator

In this reporting period (April-September 2023), there have been a couple of one-off individual instances in which the labour ward coordinator has reported they are unable to maintain supernumerary status (this has not been a regular occurrence). This was due to providing clinical support for short duration assessments. There have been zero instances in which the labour ward coordinator had had to provide 1:1 care for a woman/birthing person in labour.

### One to One care in Labour

1-1 care in labour has been maintained at 100%

| 1-1 care in labour | April | May | June | July | Aug | Sept |
|---|---|---|---|---|---|---|
| **1:1 care in labour provided for those eligible & delivered in ESHT** | 100% | 100% | 100% | 100% | 100% | 100% |

The average midwifery vacancy rate over the reporting period was 6.16%. Based on trajectory of current recruitment, we anticipate most vacancies will be filled by January 2024. There are 3% of

staff on secondment currently, this is under review to ensure clinical posts do not remain vacant for significant periods.

**Sickness**

| Apr-23 | May-23 | Jun-23 | Q1 Average | Jul-23 | Aug-23 | Sep-23 | Q2 Average |
|---|---|---|---|---|---|---|---|
| 3% | 8% | 7% | 6% | 8.00% | 7.00% | 6.70% | **7.23** |

Sickness mean average was 3.4% in Q3/4, this has risen to 5% during Q1/2. A similar increase has been reported across the country.

**Parental Leave**

| Apr-23 | May-23 | Jun-23 | Q1 Average | Jul-23 | Aug-23 | Sep-23 | Q2 Average |
|---|---|---|---|---|---|---|---|
| 4.3% | 3.5% | 4.60% | 4.13% | 4.80% | 6.1% | 6.90% | **5.93** |

Parental leave is showing a decreasing trend as per the above table.

**Maternity Workforce Fill Rates**

Maternity workforce fill rates on the acute hospital site have remained at a consistent rate of around 82%. This is slightly higher than Q1.

| Apr-23 | May-23 | Jun-23 | Q1 Average | Jul-23 | Aug-23 | Sep-23 | Q2 Average |
|---|---|---|---|---|---|---|---|
| 79.30% | 83.20% | 82.90% | 81.8% | 87.20% | 80.40% | 80.2 | 82.6 |

Challenges within the midwifery department remain related to the increasing complexity of our women and birthing people, there is increasing demand on Safeguarding and Mental Health teams (both services are currently under review). There is a requirement (in line with NHSE guidance) to educate midwives to manage enhanced complexity. The department have a plan to provide a higher dependency bed on delivery suite, Midwives will attend a four-day Care of the Critically Unwell Woman during the Childbirth Continuum course during the next year in preparation for implementation.

## Obstetric staffing

We have ensured that the Royal College of Obstetricians and Gynaecologists (RCOG) criteria has been met for the employment of short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas within the maternity unit:

ESHT currently employ two long term locums and can confirm implementation of the RCOG guidance on engagement of long-term locums (rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf) within maternity services.

The Maternity department fully implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.

The duties of the Hot Week Consultant guidelines incorporate the principles outlined in the RCOG Workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'. Good compliance with the recommendations within the guideline

has been demonstrated in a recent audit, an action plan is in place to support improvement specifically regarding one occasion where escalation to the on call consultant was delayed out of hours.

The maternity department remains compliant with the requirement for twice daily consultant ward rounds, 7 days per week. The Consultant body for Obstetrics and Gynaecology currently have 1wte vacancy.

Minor challenges have been reported within the obstetric workforce regarding middle grade appointments, we have new staff commencing in early 2024. Overall, cohesive and collaborative working of the Consultants has ensured a safe and consistent service delivery. This has at times been challenging with the multiple doctors strikes but thorough and pre-emptive plans were put in place early to avoid disruption.

### Anaesthetic Workforce

A duty anaesthetist has been available throughout the reporting period as per national requirements. Duty rotas are available on a weekly basis in line with Anaesthesia Clinical Services Accreditation (ACSA) requirement.

### Neonatal Medical Workforce

The neonatal medical workforce is fully compliant with the British Association of Perinatal Medicine (BAPM) workforce standards as required for a level 1 neonatal unit. Medical workforce rotas are available on a weekly basis and provide evidence of compliance.

### Neonatal Nursing Workforce

Neonatal nursing levels currently meet the requirement in line with the Operating Delivery Network (ODN) workforce calculator. As per the Department of Health Toolkit, a minimum of 70% of registered nursing workforce establishment should hold a QIS (Qualified in Speciality) qualification. At ESHT, new to service staff do not come with a qualification. A robust plan of training is in place and approved by the ODN and in line with national requirement. Currently 56% of SCBU nursing staff hold the post registration qualification (reviewed Sept 23), with remaining staff on the training programme. The action plan supports new staff in post to achieve the qualification within the next 12-18 months. Over the past six months zero shifts fell short for QIS trained staff per shift (Badgernet data). Excellent multidisciplinary team (MDT) working continues between the medical, nursing and maternity team. Vacancy rate is currently 4.7% (1.2WTE staff), with an active recruitment plan in place.

### MDT Training

Compliance with CTG and fetal monitoring training competency has improved overall by 2% from Q1, no cause for concern.

| Q2 2023/24 | |
|---|---|
| **CTG compliance** | % Compliance |
| Medics | 96% |
| Midwives | 98% |
| Combined | 97% |

Combined professional compliance with MDT training has improved from Q1 (91%). With a combined percentage now at 95%. 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 and Appraisal rates continue to improve with both currently above 80%, the expectation is to achieve 90% in all areas.

| Q2 2023/24 | |
|---|---|
| **PROMPT compliance** | % Compliance |
| Medics | 98% |
| Midwives | 95% |
| Combined | 95% |

## Culture within maternity services

The SCORE (Safety Culture, Operational Risk, Reliability/burnout and Engagement) survey is undertaken by trusts every 4-5 years. The ESHT SCORE survey closed in mid-May 2023 with a good response rate of 43%. The survey aims to assess aspects of our local team culture, including safety, communication, and teamwork. National support is being provided for deep analysis of results.

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 by our external survey lead (Korn Ferry) to co-produce a plan of action. A report will be provided in Q3.

General listening events for all maternity staff continue every six weeks; staff continue to attend and report that they are a useful forum for raising any concerns and making suggestions. During Q2, staff reported 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. Complexity of service users has also been raised as noted earlier in this paper. We are also progressing with our three-year recruitment and retention plan with support from our workforce department.

The Professional Midwifery and Neonatal Partner team provide on-line, unit based and off-site safe spaces to hear staff views. Current actions include a consideration around self-rostering (for which work is progressing) and work to encourage any hours working where additional resource is required. Our Equity and Equality lead has set up a MatNeo staff forum to hear from more seldom heard voices.

## The Service User Voice

During Q2 Maternity continued to make improvements within the department, this is discussed on a monthly basis at the Quality and Safety Committee where improvement plans are shared.

Areas of improvement include;

- The introduction of a 24-hour visiting pilot
- Improvement to the Infant feeding room
- Improving visual displays of information within the department, including signposting for help and support whilst on the maternity and neonatal units
- A new and improved Maternity website

Positive feedback included;

> *"I was desperate to use the birthing pool. It ended up not being available, so they erected the blow-up version. They then struggled to find a hose to fill it up so went to Wickes to get one. It really was above and beyond!"*

> *"The midwives and doctors working that night /morning couldn't have been more amazing Thank you to them!"*

*"The anaesthetist offered a head massage, kept me talking and really made the experience (elective caesarean section) a happy calm one".*

Areas where we continue to improve include;

- Postnatal Care, with the aim to reduce variables through improving standardised practice and the introduction of discharge coordinators.

- Review of Induction of labour processes, with a plan to introduce new processes in early 2024

### Ockenden Recommendations/East Kent Report/NHSE Insight visit

There were 11 actions for ESHT from the final report are now complete and signed off, with no further outstanding actions. This action plan will now be closed and signed off by the Quality and Safety Committee.

## Perinatal Quality & Safety conclusion

Maternity services are managed effectively and safety is maintained clinically. At minimum a daily review of staffing levels takes place and our escalation plan is activated when required to ensure we maintain safe services, Recruitment and retention planning is an ongoing key part of service planning.

Robust governance processes have been maintained in line with our Perinatal Quality Surveillance process during the reporting period. Our overall Perinatal Mortality rate is highlighting special cause improving variation with more than seven consecutive data points below the Mean (average) line.

There is good evidence to support that 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 in line with national requirements for maternity specific training has been maintained. A robust plan of action is underway to ensure Trust targets are met with regards to trust mandatory training.

One area of concern for Q2 are our Atain rates, which will continue to be monitored closely with a further deep dive into possible causes.

# 2. Maternity Incentive Scheme (MIS) Year 5

The Clinical Negligence Scheme for Trusts (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.

The year five CNST Maternity Incentive Scheme (MIS) was launched on 31 May 2023 to continue to support the delivery of safer maternity care. MIS applies to all acute trusts that deliver maternity services and are members of the CNST. As in previous years, members contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

This report provides confirmation that **ESHT maternity services have met the criteria for all ten safety actions** in line with guidance provided by NHS Resolution; V1 released March 23 and updated guidance V1.1 released July 23. It is worth noting that mitigations were communicated to Trusts 23rd October 2023 in relation to pressures experienced as a result of ongoing industrial action, this updated guidance has been indicated within the report under applicable areas (SA1 and SA8). ESHT achieved full compliance against these standards without requiring mitigation. The majority of our CNST/MIS requirement is now business as usual for maternity, with new requirements such as SBLv3 and management of locum doctors effectively managed since publication of requirement. An external audit on 14/11/23 by RSM UK Risk Assurance Services LLP confirmed compliance in all ten safety actions.

| Safety Action | Requirement/Evidence | Compliance |
|---|---|---|
| **SA1**<br>Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths to the required standard? | a) All eligible perinatal deaths have been notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information was completed within one calendar month of the death.<br>b) For 95% of all the deaths of babies in ESHT eligible for PMRT review, parents had their perspectives of care and any questions they sought discussed as part of the review<br>c) For deaths of babies who were born and died in ESHT, a multi-disciplinary review using the PMRT was carried out (from 30 May 2023). 100% of reviews were started within two months of the death, and a minimum of 100% of multi-disciplinary reviews were completed to the draft report stage within four months of the death and published within six months.<br>d) Quarterly reports were submitted to the Trust Executive Board (from 30 May 2023). | |
| **SA2**<br>Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? | This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.<br>1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023.<br>2. July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)<br>3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data | |

| | | |
|---|---|---|
| | submissions relating to activity in July 2023 for the following metrics: For ESHT July data was confirmed by NHSE as fully compliant.<br><br>5. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust (ESHT have 3 staff registered) | |
| **SA3**<br>Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies? | a) Pathways of care into transitional care (TC) have been jointly approved by our maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.<br>b) A robust process is in place with a joint maternity and neonatal approach to auditing all admissions to SCBU of babies equal to or greater than 37 weeks.. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director, or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB<br>c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, ESHT continues to improve our transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. | |
| **SA4**<br>Can you demonstrate an effective system of clinical workforce planning to the required standard? | a) **Obstetric medical workforce**<br>1) ESHT has ensured ensure that the following criteria has been met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:<br>a. currently work in their unit on the tier 2 or 3 rota or<br>b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or<br>c. c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.<br>2) ESHT has implemented the RCOG guidance on engagement of long-term locums and we have provided assurance and evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf<br><br>3) ESHT has implemented the RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, a guideline has been approved by the consultant body. rcog-guidance-on-compensatory-rest.pdf<br><br>4) ESHT monitors compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person. A quarterly audit is completed with positive findings, an action plan is in place with one action in progress.<br><br>**b) Anaesthetic medical workforce** | |

| | | |
|---|---|---|
| | Within ESHT, 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. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients in line with guidance. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)<br><br>**c) Neonatal medical workforce**<br>The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing.<br><br>**c) Neonatal nursing workforce**<br>The neonatal team are working to meet the BAPM neonatal nursing standards.<br>As requirements **have not been met** in year 3 and or year 4 and 5 of MIS, The Trust Board is advised that progress continues to achieve 70% QIS. Our action plan outlines the plan to improve from 56% to 70% through a robust training plan.<br>Action plans have been shared with the LMNS and Neonatal Operational Delivery Network (ODN). | |
| **SA5**<br>Can you demonstrate an effective system of midwifery workforce planning to the required standard? | a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed 3 yearly at ESHT (BR+).<br>b) The Trust Board has evidence that the midwifery staffing budget reflects establishment as calculated in a) above.<br>c) The midwifery coordinator in charge of labour ward has supernumerary status; (defined as having no caseload of their own during their shift) this ensures there is an oversight of all birth activity within the service.<br>d) All women in active labour in the unit receive one-to-one midwifery care.<br>e) We submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period. | |
| **SA6**<br>Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three? | 1) ESHT has provided assurance to the Trust Board (Quality and Safety Committee) and the ICB that we are on track to fully implement all 6 elements of SBLv3 by March 2024.<br>2) ESHT hold quarterly quality improvement discussions with the ICB, using the new national implementation tool (see page 5 of this report) | |
| **SA7**<br>Listen to women, parents and families using maternity and neonatal services and coproduce services with users | 1. We have a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance. Parents with neonatal experience provide feedback via the MNVP and Parent Advisory Group.<br>2. We have a coproduced action plan with the MNVP following annual CQC Maternity Survey data publication (due each January), which includes analysis of free text data. Progress is monitored regularly by safety champions and LMNS Board.<br>3. Neonatal and maternity service user feedback is collated and acted upon within our neonatal and maternity services on a monthly basis, we provide evidence of reviews of themes and subsequent actions which is monitored by our local safety champions | |

| | | |
|---|---|---|
| **SA8**<br>Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? | 1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.<br>2. The plan was agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.<br>3. The plan is developed based on the "How to" Guide developed by NHS England. | |
| **SA9**<br>Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues? | a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model have been be fully embedded.<br>b) Discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings continues monthly and quarterly.<br>c) Our Maternity and Neonatal Board Safety Champions (BSC) continue to support the perinatal quadrumvirate in our work to better understand and craft local cultures. | |
| **SA10**<br>Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023 | A) We confirm compliance of reporting all qualifying cases to HSIB/ MNSI from 6 December 2022 to 7 December 2023.<br>B) We confirm compliance of reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until 7 December 2023.<br>C) For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, we have assured the Trust Board (via the Quality & Safety committee) that:<br>i. the family have received information on the role of HSIB//MNSI and NHS Resolution's EN scheme; and<br>ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour. | |

East Sussex Healthcare NHS Trust

# Winter Preparedness 2023/24: Update November 2023

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|---|---|---|---|---|---|---|---|
| **Purpose of the paper** | This paper seeks to provide an update on the development of the trusts 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** | Update on Winter Preparedness previously presented to the Trust Board on 10th October 2023 | | | | | | |

| **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:<br>• **Note** the work undertaken to date to develop the winter plan and the further work required to finalise the plan.<br>• **Note** that the Plan is a live document and will be updated on an ongoing basis to reflect emerging changes throughout the winter.<br>• **Note** that the following area of the plan is continually being reviewed:<br>  ○ Bed model to reflect lower Covid demand and quantification of admissions avoidance and demand management schemes. |
|---|---|

| **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.<br><br>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.<br><br>As a trust we have undertaken comprehensive demand and capacity modelling which enables us to quantify predicted bed requirements (including that required to maintain our elective activity) throughout the year and considers 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. The modelling includes assumptions in relation to covid, flu and respiratory syncytial virus (RSV) that will adversely affect demand through the winter and the positive impact of proposed schemes to close the capacity shortfall.<br><br>To support sustained delivery of the emergency access clinical standard, the trust has an improvement plan in place which focuses on several key areas aimed at supporting delivery of the standard in March 2024 in line with the H2 planning refresh submitted in November 2023. |
|---|---|

| **Next steps** | • Plan to be reviewed and updated on an ongoing basis (reflecting emerging changes over the winter months).<br>• Mobilise additional capacity |
|---|---|

## 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, like 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 an 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%) and October was a more challenging position driven in part by an increased acuity of patients as we head into the winter period. 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, 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 several 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 Trusts 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, 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

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

- Elective activity at 103% of 2019/20 actual
- Non-Elective 2022/23 demand plus additional Growth at 4.75% (against planned 3%) and reflective of actual growth seen year to date
- Covid/Flu Surge assumptions
- 2022/23 Length of Stay as a baseline

### 3.1 Summary of bed Modelling

| Conquest | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|
| Bed gap based on 96% occupancy before any mitigation is applied | 51 | 42 | 21 | 13 |

| | | | | |
|---|---|---|---|---|
| Additional capacity created via use of 'Surge ' areas | *15* | *15* | *15* | *15* |
| Minerva Bridging service | 15- 30 | 30 | 15 | 0 |
| Final Bed Gap | 6- 21 | 0 | 0 | 0 |

At the height of our winter pressures the Trust assumption is that there will be a gap of 51 beds at the Conquest. The additional requirement for additional medical bed capacity will need to be achieved by using and implementing the following initiatives:

- Continued use of escalation beds on Murray ward.
- Length of Stay savings opportunities in Geriatric Medicine, General Medicine, Gastroenterology and Cardiology.
- Utilisation of 15 beds in 'Super Surge' which have been risk assessed and approved for usage.
- Introduction of the Minerva bridging service which would provide additional care capacity to Urgent Community Response (UCR) to support same day / next day care at home for Pathway 1 patients.

The modelling also indicates there is a need to increase Trauma and Orthopaedic capacity, and plans are in place to support this.

| EDGH | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|
| Bed gap based on 96% occupancy before any mitigation is applied | 24 | 25 | 1 | 0 |
| Additional capacity created via use of 'Surge ' areas | *15* | *15* | *15* | *15* |
| Final Bed Gap | 9 | 10 | 0 | 0 |

The bed modelling predicts that Eastbourne will see its height in demand across December and January, with bed gaps of 24 and 25 respectively. Since July 2023 it has been possible to close a 28 bedded ward following 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 (28 beds on Litlington ward), whilst continuing to focus on optimising length of stay. Although the opening of Litlington ward will bridge a large element of the bed gap, there will still be the need to utilise 15 beds in 'Super Surge', which again, have been risk assessed and approved for usage.

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 have made good progress with implementing and expanding the Virtual Ward service. There is now capacity to manage 54 patients within their own homes and funding to implement the Transfer of Care Hub, which will improve discharge processes across the organisation has been secured.

Divisional teams have finalised 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.

Demand and Capacity modelling for the whole of Sussex this Winter indicates a deficit in available acute beds in the 3 weeks from 30th December 2023. In addition to the escalation planning, the trust will be working closely with the ICS and system partners to recalibrate and decompress congested services following Christmas and New Year.

The 'Reset' process commences the week beginning 8th January 2024 and aims to generate energy for change by doing things differently to support patient flow and consequently improve patient experience, safety and staff morale. The underlining principle is that if the patient needs to be admitted then its: 'Right bed first time'. Or if the patient can be managed out of hospital they access the right service for their needs.

In preparation for this the trust will be running a Community Multi Agency Discharge Event (MADE), week commencing 11th December, with a follow up event week commencing 2nd January. The acute trust will run

an internal MADE week commencing 2nd January which will feed into the Community event, and also position the trust ready for the system wide reset event on the 8th January.

# Establishment of the Inequalities sub-Committee

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Purpose of the paper** | Board members are aware of the intention to create an additional sub-committee that enables scrutiny of our progress regarding how we support our own diverse staff groups and how we support patients and NHS Sussex ambitions to tackle the inequalities experienced across our communities. | | | | | | |
| | For Decision | | For Assurance | x | For Information | | |
| **Sponsor/Author** | Chief of Staff | | | | | | |
| **Governance overview** | The Terms of Reference attached were drafted, developed and reviewed by core members of the committee. These were agreed at the inaugural meeting of the Inequalities sub-Committee in November 2023. | | | | | | |

| **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 approve the Terms of Reference of the Inequalities sub-Committee |
| **Executive Summary** | Board members have previously discussed the broad rationale for the establishment of this new committee.<br><br>It is clear that both in terms of the culture and working environment we create for staff as well as how we provide care for patients, a recognition that the experience of minority communities and/or those experiencing complex deprivation is different and possibly negative, is essential.<br><br>Typically, these are not data cohorts that the NHS has focused on in detail when considering questions of access, but the covid pandemic and cost of living crisis has brought these concerns to the fore.<br><br>In terms of staffing, our workforce is almost three times as diverse (non-white) as the East Sussex 2021 census data and, as regards our patients, the Chief Medical Officer's annual report in 2021 noted that, in terms of complex deprivation, Hastings has more in common with Hartlepool than other local Sussex resorts.<br><br>These aspects are compounded by the more widely-known statistic of the high levels of older members of the population already compared to the national average. The over 65 age group is also expected to be the fastest growing cohort of the Sussex population over the next five years. |
| **Next steps** | The notes from this committee (to be held every two months) will be brought to the Trust board, as per the other board sub-committees. |

**East Sussex Healthcare NHS Trust**

**Inequalities Subcommittee - Terms of Reference**

## 1. Purpose

The purpose of the Inequalities Subcommittee is to provide a Board level focus on the Trust's broad approach to equality, both in staffing and service delivery.

In the first instance the Committee will prioritise: -

- Oversight of the implementation of the NHS England equality diversity and inclusion high impact actions.
- Seek assurance that the Trust is ensuring an inclusive and equitable work environment that values diversity and promotes a culture of respect, fairness, and collaboration. This will include action plans relating to WRES, WDES and EDI aspects of the staff survey
- Oversight of the trust programme of work in relation to health inequalities; its direct responsibilities relating to service provision and its contribution to the wider programme of multi-agency health improvement programmes in East Sussex
- Providing a direct Board level link to Staff Networks and their work

## 2. Duties

Oversee the progress of specific objectives related to the high impact actions (HIA); on WRES and WDES and on appropriate elements of the staff survey.

HR Practice: Monitor recruitment and talent management practices that ensuring that all employees have equal access to opportunities for career development, training, and support target under across all levels of the organisation.

Pay Gap Reduction: Monitor improvement plans to eliminate earnings gaps within the workforce, addressing disparities based on gender, ethnicity, and disability, where applicable

International Staff Induction: Continue to improve and develop comprehensive induction, onboarding, and development programmes specifically designed for internationally recruited staff, promoting their integration and success within the organisation.

Safe and Respectful Environment: Create an environment that eliminates conditions fostering bullying, discrimination, harassment, and physical violence at work. Promote policies and practices that encourage respectful behaviour and zero tolerance of inaction when dealing with incivility and poor behaviours.

Health Inequalities: Ensure the Trust has appropriate data to assure the Board it is providing fair access to its service. To monitor an action plan ensuring the Trust is taking relevant action with other agencies to help reduce inequalities in East Sussex.

## 3. Membership

Trust Chair
Deputy Chief Executive and Chief People Officer
Chief of Staff
Chief Operating Officer
3 x Non-Executive Directors, one of whom will be Chair of the People & OD Sub Committee.
5 x Network Chairs
Partnership Forum Lead

Deputies will be accepted at the meeting and other people may be invited to attend all or parts of meetings.

Administration: The meeting will be administered by the Trust EDI Lead. Other Trust staff may participate as appropriate.

## 4. Chair

The meeting will be chaired by the Trust Chair

## 5. Quorum

A quorum will be formed when at least six of the Subcommittee's members are present, including at least one of the NEDs, one Executive, and two of the Network Chairs. Deputies will be counted towards making the meeting quorate.

## 6. Frequency

The Inequalities Subcommittee will meet quarterly and is not time limited.

## 7. Authority

The Inequalities Subcommittee has been commissioned to oversee the implementation of NHSE's HIAs.

## 8. Reporting arrangements

The Inequalities Subcommittee reports directly to the Trust Board and provides regular updates on its progress to the high impact actions initiatives and outcomes. The Chair of the Inequalities Subcommittee will present quarterly reports during the Trust Board meetings, highlighting achievements, challenges, and recommendations. Reports will be sent to NHSE as requested on the progress of delivery of the HIA.

The Inequalities Subcommittee will receive minutes from the Workforce Equality Steering Group for review and consideration in its meetings and may ask the Group to carry out pieces of work or produce reports. Additionally, the Inequalities Subcommittee should receive updates during every other meeting (twice annually) on the SDP health inequalities workstream and on the delivery on the four annual priorities.

## 9. Notice of meetings

Agendas and supporting papers for Inequalities Subcommittee meetings will be sent out to members seven days before the meeting. At the discretion of the Chair papers may be tabled at the meetings.

## 9. Conduct of meetings

Meetings of the Inequalities Subcommittee shall be conducted in accordance with its Terms of Reference and the provisions of the Standing Orders, Reservation and Delegation of Powers, and Standing Financial Instructions approved by the Board of East Sussex Healthcare NHS Trust.

## 10. Meetings behaviours

Meetings will be conducted in line with Trust Values, with a mutual respectfulness for all participants.

Behaviour deemed to be disrespectful, inappropriate, negative or aggressive will be challenged. This is the responsibility of all participants.

A successful meeting should be supportive, positive, timely and provide an outcome where there is progress made and actions allocated.

## 11. Notes of meetings

The Secretary shall take notes of all meetings of the Subcommittee, including recording the names of those present and in attendance. Notes of the meeting will record actions arising from the meeting.

East Sussex Healthcare NHS Trust

# Freedom to Speak Up Guardian Report November 2023

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Purpose of the paper** | This report seeks to provide an overview of the activity of the Freedom to Speak Up Guardians (FTSUGs) and includes the nature of concerns raised and an analysis of trends. We last reported to Trust Board in June 2023. The FTSUG's are required to report to Trust board twice a year as a minimum and this report is presented at POD pre Board.<br><br>This report focuses on Quarter 1 and Quarter 2 data (Data from April – June 2023 and July - September 2023). In accordance with reporting requirements for the National Guardian office, the Guardians have been compliant with submitting anonymised, quarterly data to the National Guardians Office. | | | | | | |
| | For Decision | | For Assurance | x | For Information | | |
| **Sponsor/Author** | Sponsor: Steve Aumayer, Deputy Chief Executive and Chief People Officer<br>Authors: Ruth Agg and Dominique Holliman, Speak Up Guardians | | | | | | |
| **Governance overview** | Presented at POD pre Trust 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** |
|---|
| • For Executive support to increase the training and compliance in speaking up and listening up modules as figures indicate the mandatory requirement for this to be completed has not been achieved.<br>• Continued communication from the senior leadership to support a psychologically safe culture where staff can speak up and do not fear futility or detriment.<br>• Feedback on draft poster for launch across ESHT.<br>• Ongoing support to ensure consistency in timely responses; thanking staff and providing feedback. |

| **Executive Summary** |
|---|
| • The Board can be assured that the Freedom to Speak Up Guardians continue to undertake both reactive and proactive work to ensure that all ESHT colleagues, including students, temporary workforce and volunteers feel able to raise concerns and/or to make suggestions for improvement. The Guardians endeavour to ensure that the reach extends to minority groups and those that face barriers to speaking up.<br>• Guardians confirm that the trust's FTSU arrangements are compliant with guidance from the National Guardian and data is submitted quarterly in a timely way to the National Office.<br>• Key progress has been made in increasingly visibility, facilitating training, using promotional materials and awareness sessions and maximising the exposure of National Speak Up month in October.<br>• The Board can be assured that Guardians work closely with key groups and networks to share intelligence and scrutinise data and trends to inform proactive pieces of work and collaboration.<br>• Case studies included in this report highlight the diversity of cases that Guardians support and demonstrate how the involvement of the Guardians has helped to improve patient and staff safety and improved working lives.<br>• Learning from the Countess of Chester case and the National Guardian Office commitment are explored in this report. |

| | |
|---|---|
| **Next steps** | • FTSU Guardians will continue to support staff in the Trust in raising their concerns<br>• One page Speak Up strategy to be drafted in line with National Guardian office recommendations<br>• Review of poster and agreement to launch<br>• Ensuring training for Managers is compliant with the speak up modules<br>• Executive communication regarding speak up we will listen up |

# Freedom to Speak Up Guardian Report

East Sussex Healthcare NHS Trust

**Introduction**

Freedom to Speak Up Guardians (FTSUGs) support workers to speak up and work within their organisation to tackle barriers to speaking up. FTSUGs are expected to operate independently, impartially and objectively, whilst working in partnership with individuals and groups throughout their organisation, including their senior leadership team.

The National Guardian's Office (NGO) provides support and challenge to the healthcare system in England on speaking up. The NGO leads, develops and supports FTSUGs. FTSUGs submit non-identifiable information to the NGO about the speaking up cases raised with them. Dominique and Ruth submit ESHT data on a quarterly basis and this report will comment upon the national picture for 2022/23 and the speak up trends at ESHT.

Nationally, FTSUGs have handled over 100,000 cases since the National Guardian's Office first started collecting data in 2017. The number of cases brought to them last year was the highest recorded, a 25% increase on the previous year. In 2022/23, the ESHT Guardians handled 238 cases and this was marginally higher than the previous year.

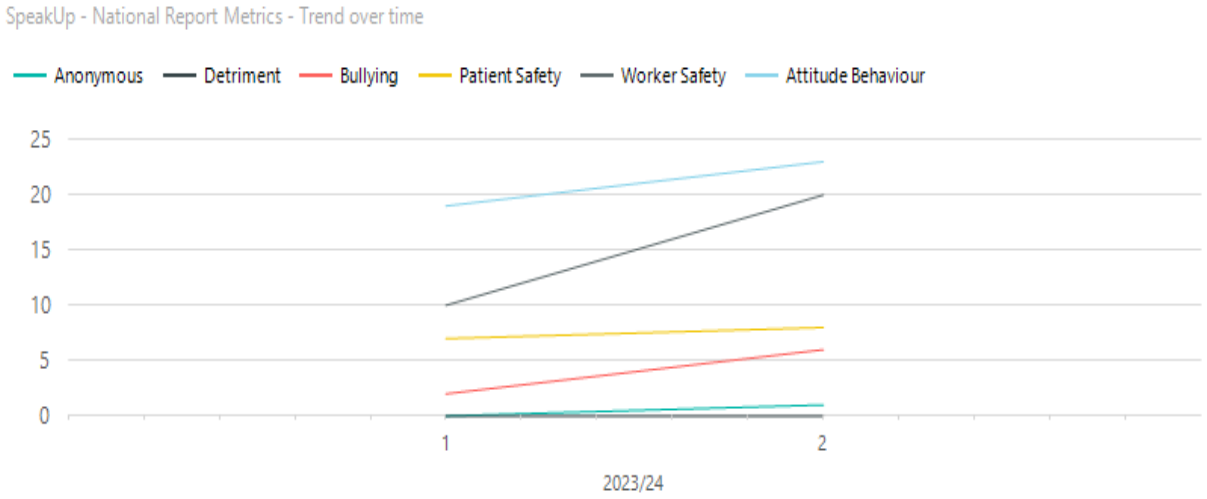
**Data and trends**

The latest annual speaking up data report from the NGO reveals a decline in the proportion of cases reported anonymously, indicating a growing confidence in the guardian route. In 2022/23, 9.3 percent of cases were reported anonymously. This continues the downward trajectory from 2017, when 17.7% of cases were raised anonymously. In ESHT, our anonymous reporting rates have always been significantly lower than the national figure – we had 4 anonymous cases in 2021/22 and none reportedly anonymously in 2022/23.

Poor behaviour and its impact remains a cause for concern nationally, with the highest proportion of cases – 30 percent – involving inappropriate behaviours and attitudes. A decrease in the percentage of cases related to bullying or harassment (31.8 percent in 2021/22 to 21.7 percent in 2022/23) can be attributed to cases being reported against this new category. At ESHT, we also noted that the number of cases categorised as being related to bullying and harassment decreased in 2022/23 and this is likely to be attributable to the new category of inappropriate attitudes and behaviours being introduced. 13% of all cases cited bullying and harassment and 42% related to inappropriate behaviours and attitudes.

**Speak Up - National Report Metrics**

| FYYear | FYQuarter | Anonymous | Detriment | Bullying | Patient Safety | Worker Safety/wellbeing | Attitude Behaviour | Total Issues Logged |
|---|---|---|---|---|---|---|---|---|
| 2023/24 | 1 | 0 | 0 | 2 | 7 | 10 | 19 | 56 |
| | 2 | 1 | 0 | 6 | 8 | 20 | 23 | 69 |
| | Total | 1 | 0 | 8 | 15 | 30 | 42 | 125 |
| **Total** | **Total** | **1** | **0** | **8** | **15** | **30** | **42** | **125** |




We have a similar trend with the reduction of bullying and harassment cases raised in quarter 1 and 2 but attitudes and behaviour are the highest reporting concerns. These have included concerns regarding undermining, humiliation, shouting, perceived poor conduct and inappropriate or offensive language.

The new category for worker safety and wellbeing has increased with the number of staff concerns. This has included staff advising they are off sick as a result of work or an incident/event. It also includes if staff have raised concerns regarding perceived abuse aggression or sexual harassment/racial discrimination.

Patient safety concerns were 7 for quarter 1 2023 (18 in 2022) and 8 for Quarter 2 2023 (9 in 2022) There is a reduction in these concerns and intelligence from the staff survey indicates colleagues in our trust have confidence in our Trust's ability to address concerns of unsafe clinical practice when compared with other Trusts that are acute and community.

**I would feel secure raising concerns about unsafe clinical practice:**
Whilst there was a decline from the 75% in 2021, 71.1% of staff at ESHT reported feeling secure raising concerns about unsafe clinical practice. in 2022 the average across Trusts was 70.8%, so ESHT was marginally higher.

Key data indicates again that concerns involving system and process are frequently reported and a significant number of the 22 cases in Quarter 1 and 26 in Quarter 2 were in relation to policy and guidance including attendance management and retire and return cases. Several staff raised concerns in relation to the Resolution policy and guidance and not feeling assured when they perceived the concerns were in relation to Disciplinary standards or requiring a more formal process.

- Using offensive language.
- Other actions considered a breach of good conduct and/or likely to bring the Trust into disrepute
- Any assault or attempt to cause injury (including verbal assault) upon a patient member of the public, or other employee that takes place on Trust premises or whilst on duty, including threats of serious assaults.
- Any acts of harassment or discriminating behaviour so as to prejudice the health, safety and well-being of staff or others.

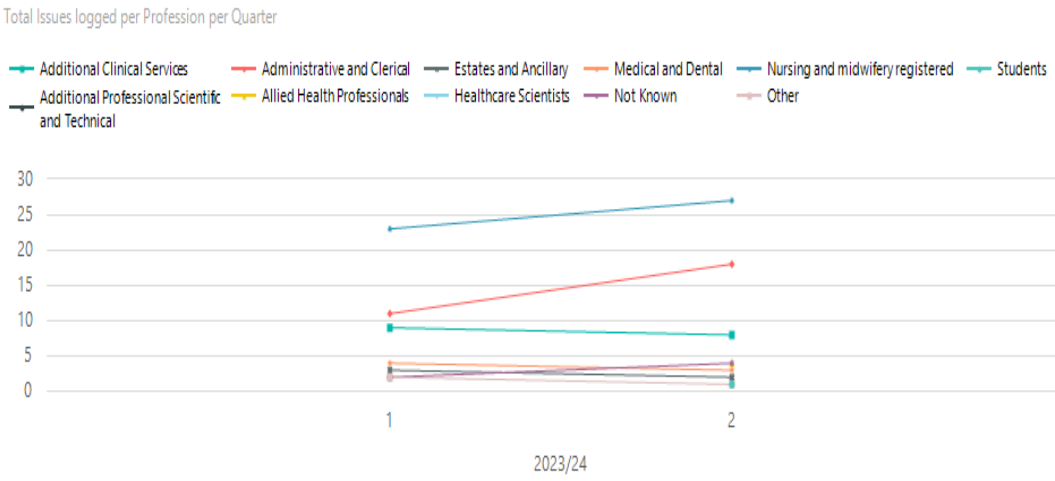
A number of staff have been advised to fill in Appendix C in relation to some of the above disciplinary standards with some cases advising these have been repeated concerns. Whilst there is a keenness to ensure timely, appropriate resolution the FTSUG's have raised with the Deputy Chief Executive and Chief of People that staff are not assured with this process but have felt "pressured to do this". Some of the forms have had significant information regarding perceived disciplinary concerns but have not been reviewed as this. Staff have concern that repeated poor behaviour managed via resolution does not give assurance when it is subsequently repeated or there is no evidence of any learning and improvement.

*Detail Available - ESHT Disciplinary Policy - Appendix 2 – Disciplinary Standards*

Discussion about the details of cases will take place at the Private Board to provide further assurance on learning and improvement.

## SpeakUp - Professions Report Metrics

| FYYear | Quarter | Profession | Anonymous | Detriment | Bullying | Patient Safety | Worker Safety | Attitude Behaviour | Total Issues Logged |
|---|---|---|---|---|---|---|---|---|---|
| 2023/24 | 1 | Additional Clinical Services | 0 | 0 | 1 | 0 | 2 | 2 | 9 |
| | | Additional Professional Scientific and Technical | 0 | 0 | 0 | 1 | 1 | 1 | 2 |
| | | Administrative and Clerical | 0 | 0 | 0 | 1 | 2 | 3 | 11 |
| | | Estates and Ancillary | 0 | 0 | 0 | 0 | 0 | 1 | 3 |
| | | Medical and Dental | 0 | 0 | 0 | 0 | 0 | 0 | 4 |
| | | Not Known | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| | | Nursing and midwifery registered | 0 | 0 | 1 | 5 | 4 | 12 | 23 |
| | | Other | 0 | 0 | 0 | 0 | 1 | 0 | 2 |
| | | Total | 0 | 0 | 2 | 7 | 10 | 19 | 56 |
| | 2 | Additional clinical services | 0 | 0 | 3 | 1 | 2 | 2 | 8 |
| | | Administrative and Clerical | 0 | 0 | 2 | 2 | 5 | 5 | 18 |
| | | Allied Health Professionals | 0 | 0 | 0 | 0 | 0 | 2 | 4 |
| | | Estates and Ancillary | 0 | 0 | 0 | 0 | 1 | 2 | 2 |
| | | Healthcare Scientists | 0 | 0 | 0 | 1 | 1 | 0 | 1 |
| | | Medical and Dental | 0 | 0 | 1 | 2 | 1 | 1 | 3 |
| | | Not Known | 1 | 0 | 0 | 0 | 0 | 2 | 4 |
| | | Nursing and midwifery registered | 0 | 0 | 0 | 2 | 8 | 9 | 27 |
| | | Other | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| | | Students | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| | | Total | 1 | 0 | 6 | 8 | 20 | 23 | 69 |
| | Total | Total | 1 | 0 | 8 | 15 | 30 | 42 | 125 |
| **Total** | | | **1** | **0** | **8** | **15** | **30** | **42** | **125** |




- Nursing and Midwifery registered staff continue to be the highest reporters of concerns with fits with the NMC code of conduct.

“Speaking up on behalf of people in your care and clients is an everyday part of your role. Just as raising genuine concerns represents good practice, ‘doing nothing’ and failing to report concerns is unacceptable. We recognise that nurses, midwives and nursing associates who raise a genuine concern and act with the best of intentions and in line with the principles laid down in this guidance are meeting their professional responsibilities and keeping to the Code.

Failure to report concerns may bring your fitness to practise into question and put your registration at risk.”

The FTSUG’s regularly attend and contribute to the work of the bullying and harassment resolution group. Additionally, we engage in monthly multi-disciplinary meetings with colleagues from HR, staff engagement &

wellbeing, occupational health, our EDI lead, people potential manager and the people experience manager to share soft intelligence about any topics or areas of concern and to discuss where trends indicate that proactive speak up involvement and awareness raising may be beneficial.

Recent Trust wide engagement events inviting colleagues to contribute to new Trust values have also generated interest and discussion around acceptable and respectful behaviours. This has afforded a further opportunity for the Guardians to support and engage colleagues in discussing these values and setting the tone for how we can expect to be treated in the workplace and contribute to a work environment in which colleagues can thrive and feel heard.

Nationally, one in every four cases raised (27.4%) involved an element of worker safety or wellbeing. At ESHT in 2022/23, this was much lower at 2%.

Poor behaviours also have an impact on patient safety. Nationally, 19.3% of cases involved an element of patient safety/quality in 2022/23, up from 18.8% in 2021/22. At ESHT 11% of cases involved patient safety/quality, a marginal increase from the 10% recorded here in 2021/22 but still markedly lower than the national figures.

Despite the improvement in levels of anonymity nationally, detriment for speaking up remains a concern. Although there has been a drop in percentage (to 3.9%) given the rise in numbers, this equates to 1,000 cases.

Dr Jayne Chidgey-Clark, National Guardian for the NHS, said,

*"No one should be punished for doing the right thing. When people speak up it is because they want things to improve – whether that is for the safety and quality of care for patients or the working environment for colleagues.*

*"Over four-fifths (82.8%) of those who gave feedback to their guardian about their experience said they would speak up again. It is their comments which highlight why the Freedom to Speak Up Guardian role is so important and the benefits it can bring for worker wellbeing, staff retention and patient care."*

In ESHT, 6 staff members cited detriment for speaking up in 2022/23, this represents half the number that cited detriment in 2021/22.

Ruth and Dominique always ask whether raising a concern has resulted in detriment for our colleagues and we are pleased to report that, at the time of writing this report, no-one has cited detriment for speaking up in the last 6 months. We will continue to monitor any perceived detriment to ensure timely support, review and appropriate actions.

**Proactive work**

Speak up events and proactive involvements across ESHT are integral to promoting the message of speaking up being 'business as usual'. Ruth and Dominique have held many awareness sessions with teams, at team meetings and at drop-in opportunities. Since we last reported, these have included Rye Hospital, Bexhill Hospital, Irvine Unit, cross-site Clinical Secretaries, AMU, AAU, IV access team, Pathology & Biochemistry, Scott Unit, SDEC, Sussex Premier Health, ED at both sites, Reception teams, Finance, Conquest Maternity, Discharge Lounge, Egerton, Conquest Bereavement team, JCR and Ophthalmology.

We have also supported induction events and spoken on the topic of speaking up to newly qualified nurses at the University, newly recruited nurses, those new to care work and our international nurses. We endeavour to attend as many staff network groups as possible to share speak up updates and to explore any barriers to speaking up within the workforce. This year, we met with leadership graduates and those undertaking their leadership module to help contextualise speaking up as part of their leadership development.

Encouraging colleagues to undertake their Speak Up training continues to be a priority. Over 60% of managers have now completed the 'Listen Up' training which equips them with the appropriate skills and knowledge to receive speak up concerns and to respond to them in a robust and timely fashion. This training is mandatory for those with line management responsibilities and reminders have been sent to those colleagues who are yet to complete the module. The training was also highlighted in this months Integrated Education learning opportunities bulletin.

**National Speak Up Month**

The theme of National Speak Up month in October was Breaking down Barriers. Highlights included bespoke Speak Up awareness & update sessions for the FY2's, Urgent care, all staff at Sussex Premier Health and a cohort of new to care staff. We also presented at the inaugural GMC Professional behaviours and patient safety

workshop and at an event celebrating Black History month. A feature article was published in the Communications briefing and in the Core Services Divisional newsletter. Communications were shared on the extranet and on Twitter throughout the month, online speak up training modules were promoted and Dominique and Ruth were pleased to share promotional items with teams during team walkabouts. These included newly designed badges with the slogan 'I have the freedom to speak up'. These have been well received and will help to spread the speak up message as we see them pinned on uniforms and lanyards across the Trust. Promotional badges, pens and trolley key rings with the speak up message are also being added to welcome packs for internationally recruited staff. A new 'Speaking Up at ESHT' poster is being designed which will signpost colleagues to the routes available for speaking up and will include photos of the Guardians to aid visibility and awareness. We will also be introducing separate speak up posters in a variety of languages, making speaking up accessible to all whose first language may not be English.

**Countess of Chester case**

The recent conviction of Lucy Letby has generated much discussion around speaking up and the case illustrated the dreadful consequences that can occur if people speak up and they are not listened to, or if appropriate, timely and proportionate action is not taken. The NGO commented that the case underlines how vital the availability of an impartial speak up guardian is - but also acknowledges that our role cannot be effective in isolation. The NGO have welcomed the public inquiry in order that we can understand the barriers that prevented people listening to those who raised serious concerns and that we can continue to work to overcome them. Dominique represented ESHT at a national meeting of Guardians to discuss learning from the case and our National Guardian, Dr Jayne Chidgey-Clark, is now a member of the National Patient Safety Committee and will be attending the National Quality Board. Any further updates from these forums will be shared in due course.

National Guardian
Freedom to Speak Up

**Response to the verdict of the trial of Lucy Letby – National Guardian's Office**

www.nationalguardian.org.uk/2023/08/18/response-to-the-verdict-of-the-trial-of-lucyh-letby/

Dr Jayne Chidgey-Clark, National Guardian for the NHS, said:

"My thoughts are with everyone whose lives have been affected by the actions of the nurse found guilty of murdering seven babies – both families and colleagues.

"These terrible events, though rare, underline why it is so vital that everybody feels safe to speak up about anything which gets in the way of delivering great care.

"I welcome the Secretary of State's announcement of an independent inquiry, as it is vital that improvements are made so that this never happens again.

"Confidence to speak up comes from knowing that when you speak up, what you raise will be actioned appropriately. It is vital that leaders listen to concerns raised to them. If actions are not taken, workers may remain silent, and that silence can be dangerous."

**National Guardian's Office Actions taken**

*See Appendix 1*

**Anonymised examples of cases, outcomes and learning: Shared at Private Board**

As previously discussed staff are asked on first contact if they have shared the concerns previously. We continue to see that most of our contacts have raised the concerns prior to seeking to speak to the FTSUG. Comments below are taken from the anonymous survey, which is sent to the person speaking up, when the case is closed:

- I had written emails and spoken to my line manager and my concerns were not being addressed.
- I felt that my genuine reasons for concern were pushed aside and not heard.

- Raised with managers, no response.

Continued education and support for Managers to respond to concern in a timely way thanking staff and committing to review the concerns in partnership will address this matter.

“Ruth encouraged me to speak up and supported me with how to do this. Without her invaluable help, I would be in a very difficult position. Her help meant that I had a positive outcome which I would have otherwise given up on. Thank you so much Ruth for being there”

“I would be more than happy to raise concerns now”

“Ruth has been incredibly supportive to me during a very difficult time. She not only listened to my concerns and helped me address them, but she checked in with me on a regular basis which I really appreciated”

“FTSUG quickly escalated issues and took them seriously, has made management start to action changes”

**Planned ongoing work streams**

- Further training events at Brighton University for Student Nursing staff
- Ongoing discussion sharing of Datix concerns as FTSUG’s contacted about these. Following a recent review of Datix by the Deputy Director of Culture we have not been involved in reviewing this, but staff are still not assured with the feedback/time scales and are contacting the FTSUG. Some of these Datix have had perceived sexual harassment/aggression and physical contact. Steve Aumayer is aware and is also in discussion about the concerns with Datix.
- Completion of a one page Strategy in line with National Guardian office recommendations.
- Ongoing visibility and attendance at team meetings, events and huddles to promote speaking up as part of everyday business.
- New poster draft for review

NHS
East Sussex Healthcare
NHS Trust

# We are committed to listening to and acting upon concerns

## Who do I speak to?

If you feel unable to raise concerns through your reporting lines or other routes, speak to the Guardians

**Your line manager or professional or clinical lead**

**Your divisional leadership**

We support and train our managers to receive concerns and recognise the importance of listening

**Your tutor or supervisor**

**HR Solutions**

We use your feedback to make improvements in patient care and the workplace

**Staffside or other union representative**

**Freedom to Speak Up Guardians**

Freedom to Speak Up Guardians support you to speak up when you feel unable to do so

**Senior leaders and our board**

Our leaders are committed to an open and honest culture. They will look into what you say and support you

Speak up and we will listen up and feedback

## Freedom to Speak Up Guardians


**Dominique Holliman**
07812 494704

**Ruth Agg**
07920 087059

esh-tr.speakupatESHT@nhs.net


For more information visit: nww.esht.nhs.uk/ftsu

National Guardian
Freedom to Speak Up

**Appendix 1**

# National Guardian's Office Update on actions being taken in the wake of Lucy Letby verdict

## Context:

Sir Robert Francis's Freedom to Speak Up Review was published in 2015, and the murders first began in 2014-5.

Freedom to Speak Up Guardian roles were not yet being implemented, and although there were other routes for clinicians to raise concerns, we await the results of the inquiry and what appears to have prevented the leadership from taking appropriate and timely action.

In 2016, when the Freedom to Speak Up Guardian role was first beginning to be established, the Countess of Chester board papers noted that it had nominated freedom to speak up/ safety officers, including some of the senior leaders that were named in in potentially not taking appropriate action. There was no established role description or formal training for Freedom to Speak Up guardians at that point.

The NGO does not have a record of any of the managers named in the media reports as having been trained as Freedom to Speak Up Guardians, and this is probably a reflection of this early implementation stage.

## NGO response

In reaction to the verdict there has been a lot of media scrutiny of Freedom to Speak Up and the National Guardian has been talking about the role of Freedom to Speak Up guardians as an additional route, but also the responsibility of leadership to listen and act appropriately on matters raised.

## Government engagement

The National Guardian met with the Secretary of State to discuss the implications of the investigations in to the Countess of Chester. After their discussion, Jayne followed up with a letter recommending the Secretary of State consider four priorities:

1. Leadership – including increased investment in training and mandating the Speak Up, Listen Up, Follow Up training
2. Compliance levers, and concerns that there is a lack of assurance or enforcement, on a routine basis, regarding Freedom to Speak Up and the implementation of guardians.
3. Escalation routes and individual investigations, including the power of the NGO to escalate concerns and further escalation if it does not feel appropriate action has been taken, escalation routes for guardians and enhanced guidance on external investigations.

4. Strengthening the role of the National Guardian's Office and Freedom to Speak Up guardians, including a review of the job description and funding for research to explore the impact of the role. She also requested a review of support and protection for Freedom to Speak Up Guardians who feel threatened for doing their jobs.

### Patient safety training for guardians

The Patient Safety Commissioner had raised with the Secretary of State whether guardians should receive patient safety training. The National Guardian considered that the current Freedom to Speak Up Foundation Training was robust, and that the guardian role is different to that of a patient safety specialist, but that additional explicit patient safety elements may be brought into future refresher training.

### Cross-party engagement

This has also been an opportunity to write to opposition shadow health ministers to ensure that there is cross-party support for improving the Speak Up culture in the NHS.

## NHS England

The Secretary of State mentioned the 'strengthened NHS Freedom to Speak Up policy. This refers to the policy launched last year. By January 2024, all trust boards are required to have assessed where they have their action plans against the new national policy. This is not a new requirement, but an emphasis following the verdict.

The Chief Executive of the NHS, Amanda Pritchard, pulled together a meeting of patient safety leaders, including the National Guardian to have initial reflections discussions on the type of work areas we need to be looking at now.

Jayne raised the importance of leadership training, the Kark framework implementation and escalation routes.

NHSE's Vice Chair, Sir Andrew Morris, who is also on the NGO's Accountability and Liaison Board, has been asked to lead a task and finish group, which includes the National Guardian, on what more can be done in terms of Freedom to Speak Up including improvements to escalation routes and governance on boards.

The National Guardian has also been asked to join the National Patient Safety Committee and present to the National Quality Board.

## Professional bodies

The National Guardian has written to NMC and GMC and the Healthcare Professions Council about the potential to work together to strengthen guidance for professionals on both speaking up and listening up.

There is a challenge as they work across the Four Nations, and Freedom to Speak Up is for England only at this time.

We proposed appendices outlining what the local English, Scottish, Welsh, Northern Irish roots for escalation around speaking up are.

## ALB Safety and risk workstream

NHSE are leading on a framework for looking at smart recommendations. The National Patient Safety Independent Investigations Team (NPSIIT) will be compiling a repository of all recommendations from recent reports, looking at trends and themes, for learning and where there is duplication. They will also look at how recommendations are created. The National Guardian's Office will be part of this work developing a framework to ensure that recommendations are implemented in a timely manner and have a real impact. The timescale for this work to be undertaken has not been finalised.

East Sussex Healthcare NHS Trust

# Violence and Aggression SBAR report



| | |
|---|---|
| **Purpose of the paper** | This paper provides an explanation as to the current Situation, Background, Assessment and Recommendations (SBAR) in relation to Violence Prevention and Reduction progress and issues at a Trust wide level. |
| | For Decision: ; For Assurance: ; For Information: x |
| **Sponsor/Author** | Sponsor – Jacquie Fuller (Assistant Director HR- Engagement and Wellbeing and VPL) / Steve Aumayer ( Chief People Officer/ Deputy CEO)<br>Author –Stacey Bolingbroke ( People Wellbeing and Engagement Manager) |
| **Governance overview** | This paper will be discussed and shared with colleagues in Violence and Aggression Reduction Group (VARG) |

| **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 contents of the report which provides details and assurance of the on-going work. Feedback and suggestions on progress are welcomed. |

| | |
|---|---|
| **Executive Summary** | Providing a safe environment for our people to work in and to deliver safe care to patients is imperative and remains a key focus for the Trust. Reducing and preventing violence within the workplace supports and maintains the health, safety and wellbeing of our people. This will lead to decreased absence, reduce turnover and increase retention, as well as improving the morale and psychological safety of our people which in turn has been proven to increase and improve productivity and patient care.<br><br>This report provides the Board with an overview of our current position, the progress made to date following the HSE visit in 2019 and highlights any issues to increase awareness of ongoing challenges. |

| | |
|---|---|
| **Next steps** | The Violence Prevention Lead (VPL) will provide assurance reports to the Board as required and will provide a verbal update on a monthly basis to the VARG group.<br><br>We welcome any comments and suggestions to support continuous improvements in this area of our work. |

## 1. Situation

Following a Health and Safety Executive (HSE), visit in 2019, a Violence and Aggression Steering Group was established to lead on the implementation of actions to address their recommendations. Going forward the group was also tasked with meeting the NHSE/I Violence Prevention Standards and the key deliverables within those standards.

Reducing the incidence of violence and aggression within the workplace is a key priority for the Trust. The Violence and Aggression Steering Group has responsibility for engaging with staff and progressing improvements and innovations that will lead to a safer working and caring environment for all.

Although progress was made initially, the COVID pandemic disrupted the flow of work being carried out by this group. Following that time, the nature of violence and aggression witnessed and experienced by our people within the workplace has changed significantly due to the altered complexity and presentation of many of the patients (and relatives) accessing our services.

In view of this, the group has recently been refreshed and is now the Violence and Aggression Reduction Group (VARG). The group is currently accountable to the Trust Health and Safety Steering Group but also works closely with the ICB and regional partners in attempts to address the challenges faced by all services around the reduction and prevention of violence.

## 2. Background

Following the HSE visit the VARG chair has held regular meetings to assess the current position of the Trust.

The trust has now appointed a nominated VPL lead and Workstream leads are also in place. Service matter experts within the organisation have continued to lead on specific workstreams but without a lead progress has been more fragmented and less well recorded as an overall workstream.

Since 2019 and in response to the changing situation, the terms of reference, including representation within this group have now been reviewed.

## 3. Assessment

There are currently a number of workstreams with project plans, action logs and Gantt Charts to describe activity and to work towards achieving standards.

These workstreams include incident reporting, risk assessment, training, staff engagement and the Violence and Aggression Reduction (VAR) Policy.

Whilst there has been significant work within the workstreams, the discipline in creating a portfolio of evidence to support activity has been an area of weakness. Additionally, not all workstreams have set KPIs and some have outstanding actions.

Based on all of the above, it was identified earlier in the year that additional capacity was required to support efficient progress of the VPR workstreams and to lead on this Project. Initially the ICB suggested that a senior role should be created within the organisation to lead on this work. However, by reviewing the true requirements of this role, and taking into account the number of existing service matter experts within the trust, it was agreed that a project management post would be more appropriate to meet this gap.

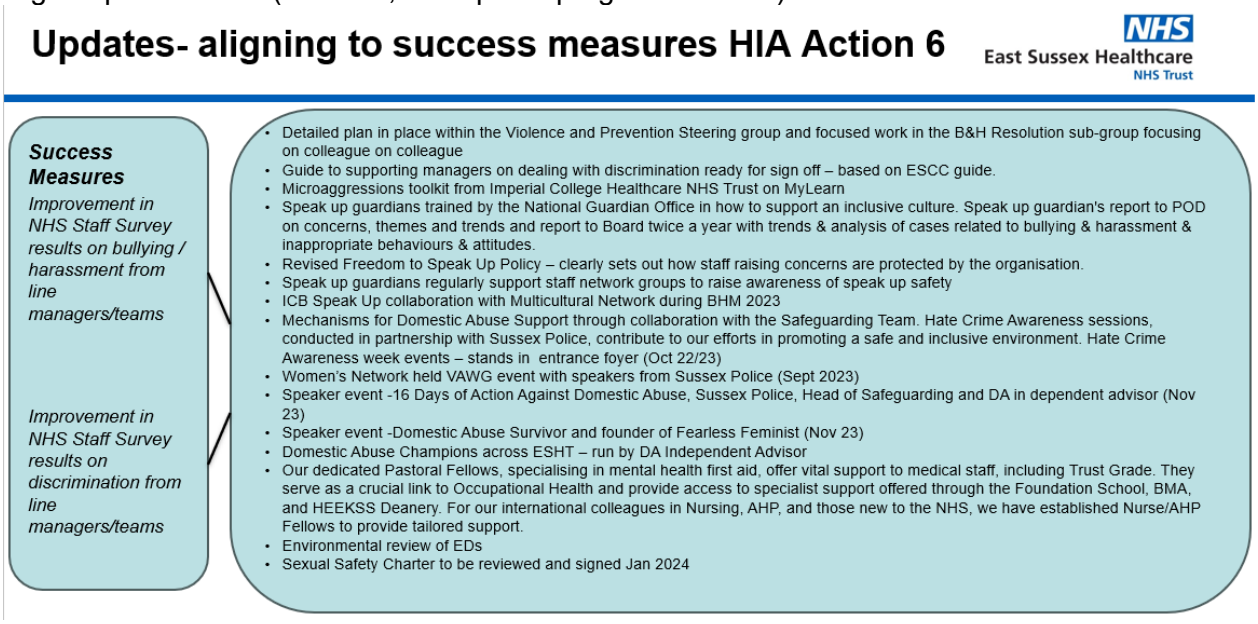
Via a skill mix review of vacancies within the Engagement and Wellbeing team, a Project Support Manager post has now been created which will focus on progressing this work. In the interim, until the postholder commences, the People Wellbeing and Engagement Manager has picked up outstanding actions and workplans, compiling this into a logical and practical project to follow.

The Governance framework and reporting requirements are to be re-reviewed and agreed.

Current position-

- ✓ Collating V&A data and undertaking analysis, particularly in terms of protected characteristics
- ✓ Encouraging staff to feel safe in speaking up about bullying and harassment- working in collaboration with Freedom to Speak up Guardians (FTSUG).
- ✓ Updated Trust VAR policy and procedures in relation to domestic abuse and sexual violence
- ✓ Monthly Bullying and & Harassment (B&H) Resolution group - discussing themes/ trends/ sharing best practice (Linking into VARG group)
- ✓ Monthly VARG group - discussing themes/ trends/ sharing best practice
- ✓ POD Meeting (reviewing progress and updates from VARG/ B&H group)
- ✓ Reviewing current action plans and workplans (aligning to HSE visit, V&A National Reduction Standards)
- ✓ Guidance developed to support managers in dealing with discrimination and poor behaviours in the workplace
- ✓ Offering Psychological Support (TRiM/G-REP/ G-TEP)
- ✓ Exploring disciplinary and employee relations processes
- ✓ Whistle Blowing Policy and Guidance

NHS equality, diversity and inclusion (EDI) improvement plan
High Impact Actions (Action 6; example of progress to date )



## 4. Recommendation

**High level Overview:**

A number of possible solutions have been considered and are being taken forward for discussion at the next VARG group meeting and these include.

- Streamlining current action plans, action logs, work plans, project plans and aligning recommendations following the HSE visit and NHSE/I Violence Prevention Standards.
- Creating and agreeing a suite of KPIs that are SMART and benchmarked where relevant
- Developing a dashboard to enable continuous review and improvements. This will include a suite of agreed KPIs; H & S Audit %, risk assessment compliance, reported incidents, environmental improvements and training compliance.

**Next Steps**

It is proposed that a full and detailed update on progress, plans and progress status is presented to the Public Board in February 2024 to provide further assurance on progress.

East Sussex Healthcare NHS Trust

# Delivering Improving Lives Together: Partnership Working Update

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Purpose of the paper** | This paper summarises the full Delivering Improving Lives Together paper, presented to the 29th November Sussex Integrated Care Board (ICB), which sets out the latest position on how Sussex organisations will work to support/enable the delivery of the Sussex five year strategy 'Improving Lives Together'. | | | | | | |
| | For Decision | | For Assurance | | For Information | x | |
| **Sponsor/Author** | Joe Chadwick-Bell, Chief Executive | | | | | | |
| **Governance overview** | NHS Sussex Integrated Care Board, 29th November 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 note the update. |
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**Executive Summary**

**Delivering Improving Lives Together: Partnership Working Update**

**1. Purpose**

1.1 This paper summarises the Delivering Improving Lives Together paper, presented to the 29/11 Sussex ICB and appended here.

1.2 The full paper sets out the latest position on how Sussex organisations will work together to support/ enable the delivery of the Sussex five-year strategy 'Improving Lives Together' (ILT).

1.3 Our paper summarises the paper contents, set out some issues for discussion and outlines the likely implications for our organisation. For the purpose of brevity, it omits the national context and much of the background.

**2. System Architecture**

2.1 The paper recognises that there will be broadly three layers of focus for working together; system, place and community/neighbourhood. The key features of each are set out below:

**As a System**

- The new system architecture will be formalised in the NHS Sussex Target Operating Model
- Systems will set strategic direction, manage performance, planning and resources
- All NHS providers will work together in a more planned/coherent way through two formal Provider Collaboratives
- There will be a system sustainability committee in common set up to ensure Sussex has a healthcare model which is sustainable in terms of clinical services, addresses health inequalities but is affordable within the financial envelope
- NHS Sussex will transition to a strategic commissioning role

- The Sussex Health & Care Assembly (the Integrated Care Partnership in Sussex) will expand its membership and appoint an independent Chair
- Engagement with the community, primary, hospice and voluntary/third sector partners remains central to the overall plan

**As a Place**

- The ICB will reorient commissioning and planning so as to be clear about the arrangements of health service at Place – and this will include a re-statement of joint commissioning arrangements with the local authorities
- This will be a partnership of health and care organisations at county, town and district level
- The ICB notes a reinvigoration of the current Place Executive meetings to drive more co-ordinated design, planning and delivery/changes in services
- East Sussex will remain the Place most relevant to this Trust

**As Communities/Neighbourhoods**

- These will be populations of 30k – 50k, where GP practices, community teams, social care teams and other providers deliver preventive, co-ordinated services
- These will be co-ordinated through Primary Care Networks (PCNs) and multi-agency teams
- There will be 16 integrated community teams (ICTs) across Sussex and these will cohere with borough and district populations. The paper notes that "we have agreed to integrate services around district and borough footprints"
- There will be 5 ICTs in East Sussex (Lewes, Wealden, Eastbourne, Rother and Hastings
- Partnerships that extend beyond traditional health and care providers (third sector etc.) will be central to these

**3. The role of Provider Collaboratives**

3.1 Of all the changes that this paper seeks to herald, perhaps this is the most fundamental from our perspective and service coverage across East Sussex.

3.2 The report notes that NHS provider organisations "…are increasingly being expected to look beyond their organisational priorities to focus on system-wide objectives, improving outcomes and reducing inequalities for the communities they serve". It also reflects that the duty to collaborate was set down in the 2022 Health & Social Care Act.

3.3 As organisations look beyond the boundaries of their sovereign entities, so the provider/commissioner split blurs and, in Sussex, is formalised in the composition of the ICS – where commissioners and providers drive key decisions together.

3.4 Provider Collaboratives (PC) will bring together providers to consider best use of resources, clinical pathways and service design to ensure that the best models of care are delivered within the available resources, deliver great outcomes and build on best practice. ESHT will work into both the community and acute collaboratives and as the name suggests these are provider led.

3.5 There will be two PCs, one covering the community – to design a model of care that is used as a standard template for each of the 16 ICTs, but which also allows for variation, depending on the health populations covered. The aim is for this model to be established by 01/04/2024. All providers (excluding UHSx) will collaborate on this model and will bring in additional primary and community networks of providers.

3.6 The second PC will cover acute model of care – looking at ensuring evidence-based, collaborative acute pathways, alongside the transferral of services and funding to the new community model. As with the community PC this is due to be in place from 01/04/2024. It involves QVH, UHSx, ESHT, SPFT and Surrey and Sussex Healthcare NHS Trust.

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| | 3.7 Ongoing discussions are also taking place to consider how to ensure that transformation programmes currently within NHS Sussex can transfer to these PCs and also how to ensure that partner providers (e.g. hospices) are involved in the planning.<br><br>**4. Fit with financial sustainability**<br>4.1 The paper notes the scale of the challenge over the coming five years and that system leaders and finance directors have agreed a collaborative approach, developing a pipeline of transformational initiatives. All NHS organisations have noted that the current model of care delivery is unsustainable and that the aim is financial sustainability by 2025/6.<br><br>4.2 As per the structural changes envisaged in section three, we recognise that only through fundamentally different approaches to collaboration will the system resolve the financial gap.<br><br>4.3 A revised financial sustainability and productivity programme will be established and will be governed by a programme committee that works as a committee-in-common. This means that members will be drawn from individual NHS organisations and will come together to make decisions. The SRO will be shared between the ICB Chief Officer and a Trust Chief Executive. This however does not undermine or cut across existing organisation governance or board accountability.<br><br>**5. Implications for ESHT**<br>5.1 We are fully supportive of this paper and have been involved in the development of the content in it.<br><br>5.2 The establishment of the two Provider Collaboratives presents us with a significant opportunity to identify and address the issues we face collectively and help resolve challenges where as an individual organisation we may not be able to effect the required changes. We welcome that these will rely upon provider leadership and direction.<br><br>5.3 The establishment of a Committee-in-Common for the financial sustainability programme will need further discussion, but Chairs and CEOs will sit on the new committee and this does not undermine organisational governance and decision making.<br><br>5.4 Recognising that organisations and service delivery may need to change in the future we will need to ensure that we have strong clinical leaders in place to work across the system as well as into organisations. |

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| **Next steps** | This is an evolving set of arrangements and as such will take time to embed and set up the governance, which is aimed to be in place by April.<br><br>Next steps are to set up the new committee in common, the two collaboratives and review the 11 SDP workstreams to avoid duplication, ensure resource and leadership are in the correct place and reflect available time and align with priorities. |

| | |
|---|---|
| **Report to:** | NHS Sussex Integrated Care Board |
| **Meeting date:** | 29 November 2023 |
| **Report Title:** | Delivering Improving Lives Together |
| **Key question:** | What changes are required in our system and partnership working to deliver Improving Lives Together? |
| **Sponsor:** | Adam Doyle, Chief Executive Officer; Stephen Lightfoot, Chair |
| **Author:** | Adam Doyle, Chief Executive Officer |
| **Item number:** | 3.1 |

**Outcome/ action requested:**

For the Board to **endorse** the latest position on partnership working to deliver our strategy and **agree** a formal timeline to produce the implementation and risk management plan to implement all the proposed system changes for presentation at the next NHS Sussex Board Meeting held in Public on 31 January 2024.

**Executive summary:**

This paper details the national context for integrated care and the substantial financial challenges facing the Sussex Health and Care system, with a decisive proposal to respond to them and deliver our strategy. It details the key components of our response, namely:

- The establishment of 16 Integrated Community Teams and partnership working with Local Authority partners to deliver them.
- The accelerated development of a new model of collaborative care in NHS community and acute services.
- Moving at pace to change NHS Sussex into a strategic commissioning organisation.
- The continued engagement with primary care providers in all sectors and with other key partners (e.g. Voluntary, Community and Social Enterprise (VCSE), hospice sector) at all levels of the system.
- The provision of resources by NHS Sussex to support the development and implementation of this new system architecture in line with the NHS Sussex Target Operating Model.
- The establishment of a revised Financial Sustainability and Productivity Programme, which will be overseen through a Financial Sustainability and Productivity Programme Committee-in-Common.

| What happens next? |
| --- |
| Subject to agreement, this plan will be developed and presented to the Board in January 2024. |

# Delivering Improving Lives Together

## Introduction

1. This paper sets out the national context for integrated care and how the Sussex Health and Care System is responding to this. The paper also sets out the commitments that have been made across the health and care system and articulates the system architecture for Sussex.

2. This paper builds on the work of several organisations – NHS England, The Kings Fund, The Health Foundation and Nuffield Trust.

## Background

3. Integrated Care Systems (ICSs) are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas.

4. Following the passage of the 2022 Health and Care Act, ICSs were formalised as legal entities with statutory powers and responsibilities. Statutory ICSs comprise of two key components:
   - **Integrated Care Boards (ICBs):** statutory bodies that are responsible for planning and funding most NHS services in the area.
   - **Integrated Care Partnerships (ICPs):** statutory committees that bring together a broad set of system partners (including local government, the voluntary, community and social enterprise sector (VCSE), NHS organisations and others) to develop a health and care strategy for the area.

5. Working through their ICB and ICP, ICSs have four core aims:
   - Improving outcomes in population health and health care.
   - Tackling inequalities in outcomes, experience and access.
   - Enhancing productivity and value for money.
   - Helping the NHS to support broader social and economic development.

6. An integrated health and care system is just one of the pillars of a population health system. Evidence shows that it is the wider determinants of people's lives (housing, financial resources, opportunities for education and employment, access to public services and the environments in which they live) that have the greatest impact on health and wellbeing.

7. Health inequalities are wide and growing but they are not inevitable, as evidence shows that a concerted approach, combining the NHS and wider policies to address the social and economic causes of poor health, can make a difference. ICSs therefore also have a critical role to play in driving forward efforts to improve population health and tackle inequalities in their local areas.

8. These goals are clearly set out in the four core functions of ICSs (see above), and the new Triple Aim for NHS bodies (which was amended to specifically include consideration of inequalities).

9. The Triple Aim is a legal duty on NHS bodies which requires them to consider the effects of their decisions on:
   - The health and wellbeing of the people of England (including inequalities in that health and wellbeing).
   - The quality of services provided or arranged by both them and other relevant bodies (including inequalities in benefits from those services).
   - The sustainable and efficient use of resources by both them and other relevant bodies.

10. To meet these objectives, ICSs need to reach beyond the NHS to bring together local authorities, VCSE organisations and other local partners.

## Role of the Integrated Care Board

11. The role of the ICB is to allocate the NHS budget and commission services for the population, taking over the functions previously held by clinical commissioning groups (CCGs) and some of the direct commissioning functions of NHS England. The ICB is directly accountable to NHS England for NHS spend and performance within the system. ICBs may choose to exercise their functions through delegating them to place-based committees (see below) but the ICB remains formally accountable.

12. Each ICB must prepare a five-year system plan setting out how they will meet the health needs of their population. In developing this plan and carrying out their work, the ICB must have regard to their ICP's integrated care strategy and be informed by the joint health and wellbeing strategies published by the health and wellbeing boards in their area. In addition, the ICB and its partner NHS Trusts and Foundation Trusts must develop a joint plan for capital spending (spending on buildings, infrastructure and equipment) for providers within the geography.

## Role of the Integrated Care Partnership (ICP)

13. The ICP is a statutory joint committee of the ICB and upper tier local authorities in the area. It brings together a broad set of system partners to support partnership working and develop an 'integrated care strategy', a plan to address the wider health care, public health and social care needs of the population. This strategy must build on local joint strategic needs assessments and health and wellbeing strategies and must be developed with the involvement of local communities and Healthwatch. The ICB is required to have regard to this plan when making decisions.

14. There is significant flexibility for ICPs to determine their own arrangements, including their membership and ways of working. Membership must include one member appointed by the ICB, one member appointed by each of the relevant local authorities, and others to be determined locally. This may include social care providers, public health, Healthwatch, VCSE organisations and others such as local housing or education providers.

## Neighbourhoods, Places and Systems

15. A key premise of ICS policy is that much of the activity to integrate care, improve population health and tackle inequalities will be driven by commissioners and providers collaborating over smaller geographies within ICSs (often referred to as 'places') and through teams delivering services working together on even smaller footprints (usually referred to as 'neighbourhoods').

16. This three-tiered model of neighbourhoods, places and systems can be seen as an over-simplification of the diverse set of arrangements seen in reality, but the terminology is now in widespread use within the health and care system. In our Sussex ICS our approach has been to work with these definitions flexibly – the standard population descriptors don't perfectly match Sussex - to ensure we get the best economies of scale from our collective resources available across the NHS and local government, to meet needs and improve outcomes for our population and ensure services are sustainable.

    - **Neighbourhoods** (covering populations of around 30,000 to 50,000 people): where groups of GP practices work with NHS community services, social care and other providers to deliver more co-ordinated and proactive care, including through the formation of primary care networks (PCNs) and multi-agency neighbourhood teams.

- **Places** (covering populations of around 250,000 to 500,000 people): where partnerships of health and care organisations in a county, town or district – including local government, NHS providers, VCSE organisations, social care providers and others – come together to join up the planning and delivery of services, redesign care pathways, engage with local communities and address health inequalities and the social and economic determinants of health. In many (but not all) cases, place footprints are based on local authority boundaries.
- **Systems** (covering populations of around 500,000 to 3 million people): where health and care partners come together at scale to set overall system strategy, manage resources and performance, plan specialist services, and drive strategic improvements in areas such as workforce planning, digital infrastructure, and estates.

## What does this mean for NHS Commissioners?

17. The 2022 Health and Care Act entailed significant structural change for NHS commissioning. CCGs were abolished, with their functions and many of their staff transferred into ICBs. The ICBs also took on some commissioning responsibilities from NHS England, including the commissioning of primary care and some specialised services, giving local systems greater influence on these services.

18. These shifts build on changes to commissioning that have been underway for several years. Before their abolition, many CCGs had been working more closely together at a system level through joint management structures or formal mergers and the number of CCGs had fallen significantly. At the same time, many CCGs were working more closely with local councils at 'place' level to align and integrate commissioning for NHS and local authority services, and some larger CCGs were organising some of their functions across a system-wide footprint and other functions around place footprints.

19. The legislation has also changed procurement and competition requirements for the NHS removing the requirement for mandatory competitive retendering (supported by a new provider selection regime, due to be implemented by January 2024). This also presents additional options for councils.

20. This is all part of a shift towards strategic commissioning and a more collaborative approach to planning and improving services. This means that, instead of focusing on procurement and contract management, the role of NHS commissioners is to work closely with key partners across the system (including with NHS providers) to understand population needs, determine key priorities and design, plan and resource services to meet those needs.

## What does this mean for NHS Providers?

21. NHS providers are increasingly being expected to look beyond their organisational priorities to focus on system-wide objectives and improving outcomes and reducing inequalities for the communities they serve. While the legal functions and duties of NHS Trusts and Foundation Trusts remain largely unchanged under the recent reforms, they are also expected to participate in multiple collaborative forums, including membership of the ICB and forming collaboratives with other providers. Provider collaboratives are partnerships between two or more NHS Trusts aimed at working together to enhance services for their populations and foster collaboration. NHS Trusts and Foundation Trusts are also now bound by a new duty to collaborate with local partners and a shared duty to promote the Triple Aim (see above).

22. NHS providers are already playing a critical role in the changes underway in many systems, contributing to and/or leading work at ICS level to plan and transform services and improve system performance, and collaborating with other local providers (including those from outside the NHS) at place and neighbourhood levels to redesign care pathways and deliver more integrated services for local people.

23. The policy intention is that NHS commissioners and providers should increasingly be working hand-in-hand to plan care for their populations. While distinct commissioning and provision responsibilities, and the functions that go with them, still formally sit in separate organisations, in practice the division is becoming increasingly blurred (for example, as providers are represented on the ICB). Fundamentally, a key principle in the reforms is that providers are part of the ICS – just as much as the ICB and ICP are – and as such they are being asked to take on wider responsibilities for the performance of the whole system.

24. Provider collaboratives lie largely outside these legislative changes, with the formal duties and accountabilities of Trusts unaffected by them. However, provider collaboratives, along with place-based partnerships, are badged as ‘a key component of ICSs’ enabling them to deliver their core purpose and meet the Triple Aim of improving health and wellbeing of the population, improving quality of care and efficient use of resources – which is now also underpinned by a need to take action on health inequalities.

25. NHS Providers play a key role in ICSs, being asked to contribute not just as individual organisations but also to participate in their collaborative form, as the traditional commissioner/provider split is intentionally blurred. This participation could take the form of a provider collaborative taking on some of the functions that were formerly those of the commissioner, such as changing a model of care. This is intended to

support the desired shift from a transactional approach to planning services towards organisations working together to do this. Provider collaboratives are intended to work with the ICB to determine how best the collaborative can contribute to the delivery of shared priorities.

26. Provider collaboratives will also interact with more than one ICS in many cases. Collaboratives are being encouraged to think about how they can be part of partnerships at a multi-ICS level where this scale is necessary to work effectively. They will also interact and interface with other bodies, including those focused on single specialties or clinical support services (such as cancer alliances and clinical support networks) which can work with one or more ICS, although how this will work in practice is currently unclear.

27. NHS Providers will need to identify how they will work at place, a smaller geography within an ICS and the level at which ICS policy states that much of the activity to integrate care and improve population health will happen. The integration White Paper[1] strengthened the role of place, with ICSs expected to delegate significant responsibilities and budgets to this level, and provider collaboratives will need to engage at this level. This will take place through individual members of the provider collaborative working as part of place-based partnerships, but also with the provider collaborative, in its collective form, working together with these partnerships at place.

## What does this mean for Local Government?

28. For ICSs to succeed, they will need to function as equal partnerships with local government not just involved but jointly driving the agenda alongside the NHS and other key partners. Importantly, partnerships between local government and NHS organisations are also developing at the level of 'place', which is usually coterminous with upper tier local authority and Health and Wellbeing Board boundaries.

29. The involvement of local government in ICSs and place-based partnerships can bring three key benefits. The first is the opportunity to join up health and social care at all levels in the system, creating better outcomes and a less fragmented experience for patients and users. The second is the potential to improve population health and wellbeing and tackle inequalities through the leadership of public health teams as well as NHS and local government acting together to address wider determinants of health such as housing, local planning and education. Finally, the involvement of local

[1] https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations

government can enhance transparency and accountability through supporting engagement with local communities and providing local democratic oversight.

30. Within the new statutory ICS structures, the involvement of local government has been formalised through the ICP and through the direct representation of local authorities on the ICB. In addition, ICSs must draw on the joint health and wellbeing strategies of their local health and wellbeing boards in producing their integrated care strategies and five-year system plans.

## What does this mean for VCSE organisations?

31. Voluntary, Community and Social Enterprise (VCSE) organisations play a critical role within local health and care systems, both as service providers and as vehicles for community engagement and voice. They are therefore important strategic partners for ICSs in terms of delivering improvements in health and wellbeing, as well as reducing inequalities, which often involves working more closely with communities.

32. The involvement of VCSE organisations within formal ICS structures is open to local determination, but national guidance has set clear expectations that they should be involved both within the governance structures (for example, through membership of the ICP) and in delivering key workstreams.

33. Resource constraints and the diversity of the sector can both act as barriers to the participation of VCSE organisations, and their involvement in shaping priorities, plans and decisions at a system level remains limited in many cases. In some systems, VCSE alliances or infrastructure organisations are playing an important role in bridging this gap. Importantly, VCSE organisations also have a fundamental role in planning at place and active delivery at neighbourhood levels.

## Our system in Sussex

34. Our Sussex Integrated Care Strategy – Improving Lives Together – sets out our ambition for health and care across Sussex over the next five years. We want to improve the lives of local people by supporting them to live healthier for longer and making sure they have access to the best possible services when they need them.

35. To make our ambition a reality, we have developed a Shared Delivery Plan (Figure 1) across system partners. It aims to bring all the work together into one plan so all organisations can collectively focus on bringing the greatest benefit to local people.

36. The improvement plan sets out the:

- **Long-term Improvement Priorities** that will bring about the greatest long-term benefits for local people, services and our workforce. These are:
    - Creating integrated community teams
    - Growing and developing our workforce
    - Making better use of digital technology and information

- **Immediate Improvement Priorities** to services that need the greatest improvement. These are:
    - Increasing access and reducing variability in primary care
    - Improving response times to 999 calls and reducing A&E waiting times
    - Reducing diagnostic and planned care waiting lists
    - Accelerating patient flow and discharge in hospitals

- **Continuous Improvement Priorities** that need to be part of all improvements that are made. These are:
    - Addressing health inequalities that exist across our population by improving access to services, experience and outcomes for those who are most disadvantaged.
    - Addressing the mental health, learning disabilities and autism service improvements that we need to make.
    - Strengthening clinical leadership to allow us to make improvements to both health and care services and the health outcomes of local people.
    - Getting the best use of the finances available so we can invest in services and make sure we are working in the most effective and efficient way.

- **Place-based Priorities** and the implementation of our Health and Wellbeing Strategies in Brighton & Hove, East Sussex and West Sussex.

**Figure 1 – Summary of Shared Delivery Plan.**


37. For 2023/24, the leadership model that has been employed to deliver this is where a lead NHS Chief Executive or Local Authority Chief Officer will work with an ICB Chief Officer to co-deliver the SDP, but as we start to consider the appropriate way to respond the challenges that the Sussex Health and Care System faces it is important that the system develops its system architecture.

## Our financial outlook

38. Like all ICBs across the country, there is a challenging financial outlook for the next 5 years. This is a challenge that NHS and local government will need to rise to together.

**Medium Term Financial Plan requirements and approach**

39. NHSE requested that ICBs put together a joint system-wide Medium Term Financial Plan (MTFP) that demonstrates a route to a recurrent breakeven position by 2025/26.

40. For Sussex's MTFP, a 5-year financial outlook has been modelled and the development of this was a predominantly finance-led process, led by the Finance Leadership Group (FLG) with engagement of CEOs and key programme leads to provide direction and input. The principles, assumptions and input data have been

agreed through the FPDG (Financial Planning and Delivery Group) and a MTFP working group. Many of the assumptions have been informed by NHS England.

41. It is important to note that there are other public sector organisations, particularly local government, who are also experiencing significant financial challenges and we need to ensure we are working with them in partnership.

42. A single and consistent approach to modelling has been agreed in response to uncertainty around key assumptions (normalising adjustments, pay and non-pay inflationary cost pressures and demand growth).

43. Like all systems across the country the NHS in Sussex faces significant financial challenges. The partners across the system have currently agreed a 3% recurrent business as usual efficiency target which reduces the challenge in reaching recurrent balance, but the system will still need further transformational savings to be achieved to deliver the required recurrent breakeven position by the end of 2025/26.

**Case for Change – options to bridge the gap and next steps**

44. The 'Do Nothing' option presents a scenario where the system is no longer financially sustainable.

45. Recognising the magnitude of the challenge and pace required to demonstrate a route to breakeven, our system leaders have collectively agreed to a collaborative system approach to drive transformational change. Developing a pipeline of transformational initiatives, using a programmatic approach to quantify saving opportunities and establishing the infrastructure required is a key next step in establishing a route to achieving financial sustainability by 2025/26.

46. In summary, we will not be able to resolve the size of the financial challenges without our organisations working together in a fundamentally different way. All NHS organisations have also agreed that the current model of care delivery is not affordable or sustainable in its current form.

47. As a result, a revised Financial Sustainability and Productivity Programme will be established and overseen through a Financial Sustainability and Productivity Programme Committee. This committee will work in a committee-in-common approach across all our NHS Trusts and the ICB. Consideration will be given to ensure that the committee will have the appropriate membership of primary care colleagues.

48. A committee-in-common is a committee where members join together to make shared decisions. It does not affect statutory independence of members of the committee and will help to direct the work of all partners across the system.

49. A Joint Senior Responsible Officer approach will be taken with the Chief Executive Officer of the ICB working with one of the NHS Trust Chief Executives.

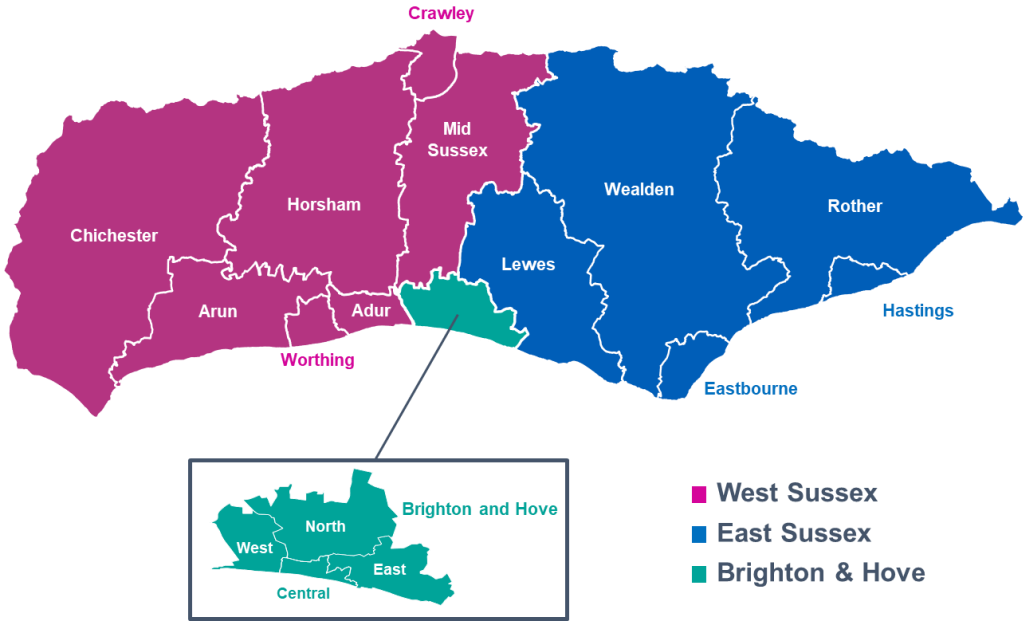
50. Once the programme is established, the ICB will transfer resources to the provider sector in their collaborative form (see below) and consider whether there are areas of the SDP that need to be reprofiled/reconsidered.

## Our system architecture

### Delivering Integrated Community Teams

51. Across the Sussex Health and Care System, it has been agreed that the system will orientate itself around neighbourhoods grouped together within 16 'Integrated Community Team' footprints (Figure 2). This is modelled around borough and district population footprints in East Sussex and West Sussex and four discrete neighbourhood areas in Brighton & Hove. In collaboration with our communities and our local authorities at a two-tier level, we have agreed to integrate services around the district and borough footprints within Sussex. This is a significant change for the system and indicates that the NHS and local government organisations have committed to work in a fundamentally different way to integrate care and improve population health. We aim to build on existing community networks with the local statutory and non-statutory organisations that exist in our communities. We have agreed that the Integrated Community Teams will require a fundamental shift to a model of care that is asset-based and works with communities to co-develop tailored local solutions.

**Figure 2 – Map of Integrated Community Teams**




## Developing Places

52. Sussex is well known for its three places. Each place is the same as the local government footprints with the two County Councils of East Sussex and West Sussex, plus the unitary authority of Brighton & Hove. We have three locally determined Health & Wellbeing strategies and we have agreed that the development of integrated community teams in their area will be overseen by each place-based partnership, to ensure the collective resources available across the NHS and local government are deployed strategically and to best effect.

53. The ICB will also redesign its commissioning and planning approach to be clear about the master plan for the arrangement of health services at each place and how it ties into the relevant neighbourhoods. There is a need to restate the joint commissioning arrangements with each of the local authorities to create a stronger strategic framework for commissioning at place that supports system wide strategic commissioning and the development of integrated community teams.

54. There will also be a refresh of the partnership executives at each place to ensure a more standard and consistent approach across the three places.

55. As part of this approach NHS Sussex has recently commissioned a Voluntary Community and Social Enterprise Alliance to work across the system and to work with the sector.

**Figure 3 – Map of three places**


**Developing provider collaboratives**

56. To ensure that there is a robust and equitable model of care within the community, the providers of NHS services have come together and agreed that they will form a community collaborative across Sussex. One of the key responsibilities for this collaborative will be to design a core NHS community model of care that is standardised in each of the Integrated Community Teams. As part of this discussion, consideration will be given to working with public health and social care colleagues and comparing to best practice models at a national and international level. Consideration will also need to be given to what percentage of the model across Sussex is standard and what will need to be determined locally due to differential population demographics and health need. Consideration will also be given to how to work with place-based partnerships on the model of care. It is expected that this community collaborative model will be in place no later than 1st April 2024.

57. The organisations committed to working into this community collaborative are:
    - East Sussex Healthcare NHS Trust
    - Sussex Community NHS Foundation Trust
    - Sussex Partnership NHS Foundation Trust
    - Queen Victoria NHS Foundation Trust

58. It is currently proposed that primary care across Sussex will also form part of the community collaborative and conversations among Primary Care Leaders are ongoing. The intention is for all primary care providers (general practice, pharmacy, optometry and dentistry) to be part of this over time, but in the initial phases the two key elements will be general practice and pharmacy. Further work needs to be undertaken over the coming months to set out a framework of how this network of networks will be established and to ensure all organisations are well engaged in this process.

59. Our hospital services are also in need of change and as we develop a community model of care, it is expected that a complementary acute model of care is designed to ensure that we have evidence-based acute pathways as we transfer services and appropriate funding to the new community model. It is expected that this acute collaborative model will be in place no later than 1st April 2024.

60. The organisations that have committed to working into this acute collaborative are:
    - East Sussex Healthcare NHS Trust
    - Surrey and Sussex Healthcare NHS Trust
    - Sussex Partnership NHS Foundation Trust
    - Queen Victoria NHS Foundation Trust
    - University Hospitals Sussex NHS Foundation Trust

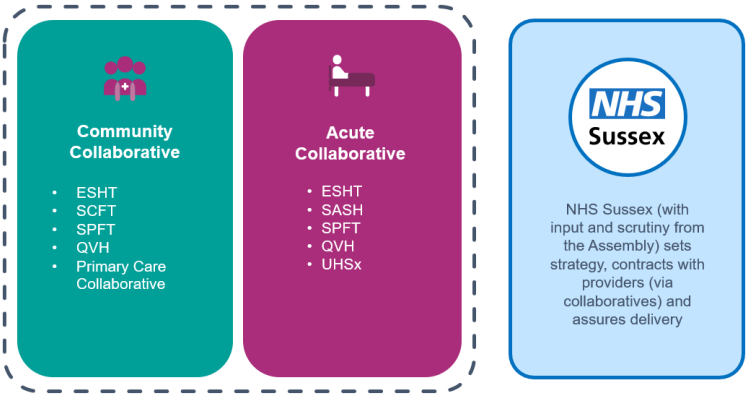
61. It is also essential that both community and acute collaboratives work together to ensure that their new models of care are complementary.

62. It is also expected that other service transformation responsibilities that currently sit within NHS Sussex are transferred to the provider collaboratives to work on through a new strategic commissioning framework.

63. Other discussions have been held with other partners about their collaborative model and there have been emerging discussion with the hospice sector about how the system can work with that sector in a more collaborative manner.

64. Each of the provider collaboratives will be led by a Senior Responsible Officer, who will be a Chief Executive working within the NHS, and this work will directly respond to the immediate financial challenges that the system is facing.

**Figure 4 – Provider collaborative model**



**Developing NHS strategic commissioning**

65. The key element of commissioning is still relevant to the arrangement of health services. However, the way that this needs to be enacted needs to change in Sussex. With the advent of the provider selection regime, NHS Sussex now needs to develop a new organisation that can work with partners in a fundamentally different way.

66. Figure 5 summarises the commissioning cycle and as part of assessing the new Target Operating Model for NHS Sussex, it is important to ensure that we can continue to fulfil our commissioning obligations.

**Figure 5 – The commissioning cycle**


- **Assessing needs**: NHS Sussex has a lot of data and information that it can use, however this needs to be centralised into one insights observatory that can triangulate numerous data and information sources. This will need to incorporate insights from public health and wider public sector information.
- **Reviewing service provisions:** The historical commissioning of the seven legacy CCGs has left levels of inequity across the health and care system and there will need to be changes over the next 2 years to address this. This will also include using the new provider selection regime as a tool to identify priorities.
- **Deciding priorities:** Due to the current financial constraints that the NHS is facing alongside other public sector organisations, strategic choices will need to be made about where to invest and disinvest in services. Using strong insight information

should facilitate this discussion with a focus on population need (e.g. Core 20+5 and other health inequalities initiatives).

- **Designing services:** Our aim is that those closest to seeing our patients and the wider population every day are best placed to design the services within a commissioning framework. As such, NHS Sussex will need to develop capabilities that can be placed within the provider collaboratives and place-based partnerships.
- **Shaping structure of supply:** It is important that NHS Sussex works with the public and private sector to ensure that there is a market that can respond to the commissioning plans in future years. Particular attention needs to be given to the role of digital transformation, research and development and artificial intelligence.
- **Planning capacity and managing demand:** One key role of NHS Sussex is to work with providers to manage demand over a multi-year horizon. This will become increasingly important as the two new models of care in the community and acute services begin to change where patients are seen and how teams are organised to respond to this.
- **Supporting patient choice:** Under the NHS Constitution, it is important that NHS Sussex is more facilitative about choice, and this is particularly relevant where we have people waiting too long for care.
- **Managing performance:** It is a key role to oversee the service of commissioned services, and this will require a revised oversight mechanism in Sussex in line with the changes to the NHS Oversight Framework at a national level.
- **Seeking public and patient views:** As we develop our new models of care and the new insights observatory, we will want to hear public and patient views at all levels throughout the system and then communicate pre-actively with the public on how we redesigning our integrated services. We will need to spend time working with new teams on how they take this forward.

67. NHS Sussex and individual NHS providers cannot create this change on their own and it is important that wider public sector organisations are part of the changes needed to focus on the wider determinants of health. Since its inception, NHS Sussex has been chairing the Sussex Health and Care Assembly (the name for our ICP in Sussex), but in collaboration with the three local authorities we have agreed that it is now time to broaden the membership to respond to our shared challenge and appoint an Independent Chair to the Assembly. It is expected that this will be in place by early 2024/25.

## Risks to delivering the changes

68. There are a number of risks to delivering fundamental change of this scale that will need to be mitigated and it is expected that the Board will want to focus on these risks and how we aim to mitigate them across the system.

69. The need to deliver these changes within a finite financial envelope that enables the system to achieve a recurrent financial breakeven position by the end of 2025/26 is a critical requirement of this new approach.

70. The risks to the quality and safety of services, both now and during this change process, need to be fully articulated and effective mitigations put in place.

71. The impact on health inequalities, both now and during this change process, need to fully articulated and effective mitigations put in place.

72. In line with its new Target Operating Model, NHS Sussex will also need to transfer some existing ICB resources to the new parts of the system to provide capacity to deliver the new ways of working so that we can fulfil our joint commitments in Improving Lives Together.

## Recommendations

73. The NHS Sussex Board is asked to endorse the direction of travel for the changes outlined throughout the paper and in particular:

- To recognise the financial challenges and the financial sustainability issues facing the Sussex health and care system.
- To endorse the establishment of a revised Financial Sustainability and Productivity Programme, which will be overseen through a Financial Sustainability and Productivity Programme Committee-in-Common
- To confirm support for a new model of care in community and acute services.
- To confirm support for the acute and community provider collaboratives.
- To confirm support for moving at pace to change NHS Sussex into a strategic commissioning organisation.
- To agree the principle that NHS Sussex will provide resources to support the development and implementation of this new system architecture in line with the NHS Sussex Target Operating Model.

- To confirm support for working with our NHS and local authority partners to oversee the creation of the 16 Integrated Community Teams and aligning our place priorities with the local Health & Wellbeing Board strategies.
- To note that there needs to be robust engagement of primary care provider organisations in all sectors (i.e. dentistry, general practice, ophthalmology and pharmacy) as part of this change process.
- To note that other key partners (e.g. VCSE, hospice sector) will need further engagement at a neighbourhood, place and system level.
- To agree a formal timeline to produce the implementation and risk management plan to implement all these system changes for presentation at the next NHS Sussex Board Meeting held in Public on 31 January 2024.

**Adam Doyle and Stephen Lightfoot**
**November 2023**

East Sussex Healthcare NHS Trust

# Audit Committee
# 23 November 2023

## 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) |
|---|---|---|---|
| 084/23 | Fire Annual Report | • In 2022-23, 6,767 of 6,992 fire-related Planned and Preventative Maintenance jobs were completed (97%).<br>• Compartmentation repairs to prevent potential fires from spreading had taken place in several areas at EDGH. Further upgrades of this nature were incorporated during refurbishment projects across the Trust's estate.<br>• During 2023-24, the respective Fire Strategies for Bexhill and Conquest Hospitals would be reviewed. Fire alarms would also be replaced at EDGH and improvements to fire doors at Conquest would continue. | |
| 085/23 | Security Assurance Report – 6 Month Update | • Incidences of violence and aggression (V & A) within the Trust continued to increase. This sadly was a trend seen nationally within healthcare contexts.<br>• The V & A Reduction Group continued to meet on a regular basis, with a focus on the Prevention and Management of Violence and Aggression.<br>• Theft and criminal damage remained low. The acute sites retained their safety accreditation through the British Parking Association, following inspection by Sussex Police.<br>• Counter-terror training was also delivered to staff, with further sessions planned for early 2024. | |
| 086/23 | Corporate Risk Register | • As at the 6th November 2023, the ESHT Risk Register contained 265 risks, of which 67 risks qualified as Corporate Risks.<br>• Of these 67 risks, 15 of these were due for review, as per the Risk Management Policy and Procedure. | |

| Agenda item number | Title and function of the paper | Key points made in the paper | Associated actions (as necessary) |
|---|---|---|---|
| 087/23 | Information Governance Toolkit Update | • 78 pieces of evidence in support of the Data Security and Protection Toolkit (DSPT) had already been gathered since the new reporting year began in July 2023.<br>• The Trust expected to be fully compliant with DSPT standards by June 2024, when the reporting year would end. | |
| 088/23 | Tenders and Waivers | • 10 single tender waivers with a cumulative value of £1.8m were approved between 1st July and 31st October 2023. This was a decrease in value and quantity of waivers compared to the previous quarter.<br>• Procurement continued to challenge all waivers that were presented, ensuring that all compliant routes to purchase were considered and that value for money was achieved. | |
| 089/23 | External Audit Report | • The full external 2023/24 external audit plan would be presented to the Committee for approval in January 2024. | |
| 090/23 | Internal Audit Report | • The following Final Reports had been issued:<br>- Financial Management and CIPs (5.23/24) - Reasonable Assurance<br>- Job Planning Productivity (6.23/24) – Reasonable Assurance | • Committee Chair to liaise with Finance about how recommendations from the 5.23/24 audit would be implemented.<br>• Recommendations from 2021/22 audit work would be reviewed to check their relevance. |
| 091/23 | Counter-Fraud Service Progress Report | • 8 counter-fraud referrals had been received since September, indicating staff were aware of how to escalate concerns.<br>• An integrative counter-fraud awareness stand had been operated on each acute site, with lots of staff engagement.<br>• Bespoke sessions for Finance and Board staff were planned. | |

East Sussex Healthcare NHS Trust

# Finance and Productivity Committee 23 November 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) |
|---|---|---|---|
| 176/23 | **M7 Financial Performance**: Presentation of Trust's financial position both with key issues highlighted | • In month deficit of £1.4m, YTD £5.0m<br>• Key drivers being industrial action, non-pay inflation, pay award funding and mental health costs.<br>• Forecast is £11.9m deficit | • Tracking mechanism to be implemented to provide assurance against delivery of revised financial plan<br>• Pack to be re-cut with additional income and baseline change |
| 177/23 | **M7 System Financial Performance**: Presentation of System financial performance including analysis of all providers. | • In month system variance to plan YTD £40.1m.<br>• Of this £36.9m can be explained by "uncontrollable costs" (eg excess non-pay inflation)<br>• System has delivered £87.0m of efficiency YTD. | • System information to be revised for most recent national allocations |
| 178/23 | **Productivity Portfolio Update**: Presentation on productivity portfolio and efficiency position and programme risks noted | • Three main areas that required focus are: ERF Income. Length of Stay and 24/25 plan<br>• Theatre improvements noted<br>• Recent review of high value workstreams undertaken | • Outpatient deep dive to be undertaken<br>• More straightforward set of metrics over a longer timeframe to be provided<br>• Ongoing focus on length of stay and discharge |
| 179/23 | **M7 Capital Position**: Presentation update on Capital Position | • All schemes that form part of the 2023/24 programme have been approved.<br>• YTD material slippage of £6.6m and FOT shortfall of £2-3m, however mitigations are being developed and we remain confident of delivering the capital plan. | • Committee noted the position<br>• Ongoing monitoring of the capital position<br>• Business case for mitigating options to be brought to committee |
| 180/23 | **Items for escalation from CRG**: summarise schemes requiring F&P approval | • Additional funding had been received in relation to Bexhill Endoscopy, however the case has already been approved by F&P. | |

| Agenda item number | Title and function of the paper | Key points made in the paper | Associated actions (as necessary) |
|---|---|---|---|
| 181/23 | **BFF Enabling Works Fees MOU** | • The Committee noted the Memorandum of Understanding (MOU) dated 4 August 2023 for enabling works fees in 2023/24<br>• The need for project-specific governance was discussed | • Business case to be presented to the Private Board meeting in December for approval<br>• Proposed governance methodology to be agreed by Board |
| 183/23 | **Sussex Medium Term Financial Plan** | • The Committee received the latest version of the Sussex Wide Medium Term Financial Plan | |
| 184/23 | **Waiver for Community Paediatrics – Provider of Autism Assessments** | • Presentation of a paper seeking approval for spend relating to the provision of paediatric autism assessments; associated central funding agreed. Outsourcing of is required as a result of an increased waiting list. Waiver approved by the Audit Committee | |
| 185/23(b) | **OrderComms Business Case** | • Revised programme had been agreed with Clinisys to upgrade the current ordercomms, | • Business case to be circulated to the Committee for virtual agreement. |

**East Sussex Healthcare NHS Trust**

**Finance and Productivity Committee - Terms of Reference**

## 1. Constitution

The Trust Board has resolved to establish a committee of the Board to be known as the Finance and Productivity Committee (the Committee). The Committee is a 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 Board of directors.

## 2. Purpose

The Finance and Productivity Committee should provide recommendations and assurance to the Board relating to:

- ***Strategy and development***:
  - Development and oversight of the Trust's Financial and Capital Strategy
  - The process for business case assessments and scrutiny
  - including a review of future financial challenges and opportunities
  - Approve/recommend to Board business cases in line with Standing Financial Instructions (SFIs) and tracking of associated benefits.
  - Understanding the financial risk environment in which the Trust operates including reviewing relevant Board Assurance Framework (BAF) risks, providing assurance on mitigations (requesting plans where relevant) and helping the Board to set the financial risk appetite for the Trust
  - The effectiveness and robustness of financial planning
  - Understanding the capital and market environment in which the Trust operates

- ***Monitoring and assurance***
  - Tracking monthly financial and capital performance against budget, and reviewing and approving changes to forecast if required
  - Monitoring balance sheet risks and the cash position
  - Reviewing productivity and efficiency delivery
  - Undertaking substantial reviews of issues and areas of concern.

## 3. Membership and attendance

The Committee and the Committee Chair shall be appointed by the Chair of the Board of directors. The membership of the Committee shall be as follows:

- At least three non-executive directors (one of whom shall be a member of the Audit Committee)
- Chief Financial Officer
- Deputy Chief Executive/Chief People Officer
- Chief Operating Officer
- Chief of Staff
- Director of Estates and Facilities
- Director of Transformation and Improvement
- Senior Medical/ Nursing input as required by agenda
- Associate Director of Digital as required by agenda
- Deputy Director of Finance
- Board Secretary/Nominee

## 4. Quorum

Quorum of the Committee shall be three members which must include a non-executive director and the Chief Financial Officer (or deputy). Nominated deputies will count towards the quorum.

## 5. Frequency

Meetings shall be held monthly and at such other times as the Chairman of the Committee shall require.

## 6. Duties

The Committee shall review and monitor the longer-term financial health of the Trust. In particular its duties include:

- Reviewing the financial environment in which the Trust operates, and supporting the Board to ensure that its focus on financial and business issues continually improves
- Monitoring the productivity of the Trust, scrutinising the opportunities for improvement and challenging the organisation to increase efficiency as appropriate (with reference to the Trust's broader strategy and values)
- Supporting the Board to understand and secure the financial and fiscal performance data and reporting its needs in order to discharge its duties
- Understanding the market and business environment in which the Trust operates and keeping the capacity and capability of the Trust to respond to the demands of the market under review
- Understanding the business risk environment within which the organisation operates, providing assurance on mitigations (requesting

plans where relevant) and helping the Board to agree an appropriate risk appetite for the Trust
- Supporting the Board to agree an annual capital and financial strategy and process
- Supporting the Board to agree an integrated business plan
- Approving or recommending to the Board business cases according to the SFIs
- Ensuring that business cases submitted for approval are in line with the priorities identified in the Trust's strategy
- Receiving assurance and scrutinise the effectiveness of demand and capacity planning.
- Ensuring that the overall financial strategy of the ICS, and any decisions relating to finance made by the ICB, are considered

The Board may from time to time delegate to the Committee the authority to agree specific investment decisions over and above the annual financial plan provided that the amended plans:

- Do not compromise the Standing Orders and Standing Financial Instructions
- Do not adversely affect the strategic risk facing the Trust
- Do not adversely affect the organisation's ability to deliver its operational plans

The Committee may as appropriate review the work of other Committees within the organisation whose work can provide relevant assurance to the Finance and Productivity Committee's own scope of work.

## 7. Decision making

Every decision put to a vote at a Committee meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding, (i.e. Chairman of the Committee) shall have a second and casting vote.

## 8. Reporting arrangements

The minutes of the Committee meetings shall be formally recorded by the Executive Assistant to the Chief Financial Officer and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive actions.

The Committee shall undertake a self-assessment of its effectiveness on at least an annual basis. The Chief of Staff will support the Committee to develop and implement an annual work programme

These terms of reference shall be reviewed by the Board of directors at least annually.

January 2023

East Sussex Healthcare NHS Trust

# People & Organisational Development (POD) Committee
# 16 November 2023

## Summary of meeting for Trust Board

**Carys Williams – Chair of POD Committee**

| Agenda item number | Title and function of the paper | Key points made in the paper | Actions |
|---|---|---|---|
| 3.1 | POD Workforce Insight Report | • Turnover continued decrease for the eighth consecutive month<br>• Vacancies reduced by 0.8% to 7.4% (596.2 fte vacancies)<br>• Mandatory Training monthly rate increased by 0.6% to 89.4%<br>• Sickness monthly rate increased by 0.3% to 5.5%; predominantly due to COVID and respiratory illness<br>• Appraisals rate showed a slight increase of 0.2% to 82.6%<br>• SAS Doctors vote to take industrial action<br>• Staff Survey completion rate 43%. | |
| 3.2 | Workforce Planning | • Report provided on initial stages for business planning<br>• Triangulated baseline for month 6, forecast maintaining current position<br>• Drop-in sessions for training on business and annual planning arranged for senior managers. | |
| 4 | Staff Survey Feedback | • Positive feedback from Core Services and Estates & Facilities divisions<br>• Informal engagement sessions in place within the Corporate Nursing Team<br>• Restorative Supervision and practice educators highlighted as an area of importance<br>• April POD Committee to focus on Staff Survey. | |

| Agenda item number | Title and function of the paper | Key points made in the paper | Actions |
|---|---|---|---|
| 5.1 | Freedom to Speak Up | • Report provided on activity of Speak Up Guardians<br>• Reduction of bullying and harassment cases raised but attitudes and behaviour are the highest reporting concerns<br>• The new category for worker safety and wellbeing has increased with the number of staff concerns<br>• Patient safety concerns were 7 for quarter 1 2023 (18 in 2022) and 8 for Quarter 2 2023 (9 in 2022)<br>• The theme of National Speak Up month in October was Breaking down Barriers<br>• Greater awareness of the voice of the Speak Up Guardians - National Guardian Doctor in post enabling lots of healthy and constructive conversations about difficulties and learning<br>• ESHT Resolution Procedure (former Grievance Procedure) now included a resolution form for informal processes to be conducted.<br>• A discussion took place regarding concerns around increased violence towards staff and the impact on both patients and staff with more mental health patients being cared for in the acute hospitals rather than where staff were best qualified to support them. | A collective escalation from both POD Committee and Quality and Safety Committee to the Trust Board on concerns of increased violence towards staff. |
| 7. | Items for Information | • Appraisal Compliance (monthly)<br>• People Strategy update | |

East Sussex Healthcare NHS Trust

# Quality & Safety Committee
# 16 November 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) |
|---|---|---|---|
| 186/2023 | Action Log Update | • In the context of an open action related to monitoring of health inequalities and identification of areas of deprivation it was noted that a Health Inequalities Sub Committee was in the process of being set up. | • Richard Milner to confirm to the Committee what mechanism/group will be in place for the management of, and reporting on, health inequalities and how the Quality & Safety Committee will have sight of that. |
| 188/2023 | Patient Safety & Quality Group | • Continued focus on violence & aggression.<br>• Low data submission for Rheumatology Audit. Trust currently an outlier. | • Violence & aggression Reduction Group working through action plan.<br>• Joint escalation with POD to board for further discussion and action<br>• Reason for low data submission being investigated by Assistant Director of Clinical Governance. |
| 189/2023 | Mortality Deep Dive | • Mortality overall for the trust and at individual site-based level within expected limits.<br>• 4 individual areas identified for deep dive review due to higher rates of mortality. Some coding issues identified and rectified. Next area of focus to be fractured neck of femur.<br>• Discussion regarding links to end of life care and ReSPECT - data showing improvement. | • Simon Merritt to ensure graphs relating to End of Life Care and ReSPECT to be available for December Trust Board meeting. |
| 190/2023 | Division Escalation Report - Sussex Premier Health | • WiFi issues – escalated through the IPR meeting.<br>• Drop in Friends and Family Test response rate | • SPH IPR for November would be face to face with the aim of addressing WiFi and other issues.<br>• Meeting planned with Patient Experience Lead to discuss improvement. |

| Agenda item number | Title and function of the paper | Key points made in the paper | Associated actions (as necessary) |
|---|---|---|---|
| 192/2023 | Governance Quality Report (Oct 23 data) | • Unusually – Delivery Suite and office/administration in the top 5 locations for incidents. Top subcategory for Delivery Suite was Caesarean section (8). Brief review of office/administration areas revealed this related to adoption – clinic letters not being signed in an acceptable timescale.<br>• 1 Never Event reported.<br>• Gradual improvement in overdue Amber reports. | • To be monitored.<br>• Under investigation. |
| 194/2023 | Maternity Clinical Quality Surveillance Report (Aug 23 data) | • No concerns. | |
| 195/2023 | Quality & Safety Dashboard | • 2nd iteration of the dashboard shared. This now included safety and patient experience metrics. | • Mental health and community metrics being worked on along with narrative relating to violence and aggression. |
| 196/2023 | External Visits and Reviews | • Significant number of visits – an increase post-pandemic. | • |
| 197/2023 | Quality Impact Assessments | • Changed approach to efficiencies this year from a divisional to a progamme approach.<br>• 8 projects reviewed with no negative impacts. | |
| 198/2023 | Maternity Services Overview Report – Q2 2023/2024 and CNST sign off – Year 5 | • Good progress and achievement of compliance across the 10 safety actions. | |
| 199/2023 | Patient Experience Annual Report – 2022/2023 | • Positive report and recognition of some changes needed going into 2023/2024.<br>• Relatively high level of re-opened complaints for Medicine and Urgent Care noted. Noted that these were mainly due to Datix processes relating to obtaining of consent or further questions driven by bereavement responses. | • Datix processes to be reviewed as part of the modelling on Datix Icloud. |

# Quality and Safety Committee

## Terms of Reference

1. Purpose

The Trust Board has resolved to establish a committee of the Board to be known as the Quality and Safety Committee (the Committee). The main duties of the Committee, on behalf of the Board, taking account of best practice are to:

- Ensure that the organisation's culture and values support innovation, learning, scrutiny and challenge
- Ensure that systems and processes are in place to support effective decision making, based on sound evidence and patient, public, staff and professional experience
- Ensure that structures and systems are in place to support continuous improvement of services and that services are of a high quality, are safe, efficient, effective and deliver a positive staff and patient experience
- Ensure that risks to quality and safety are reviewed regularly and that systems and controls are in place to ensure mitigation, that risks are current and reflect the context and feel of the organisation and the system

2. Responsibilities

**Assurance**

- Seek assurance that patients, staff and other key stakeholders are actively and effectively engaged in quality and safety issues and that the mechanisms for seeking and responding to feedback from staff and patients are robust and effective
- Seek assurance that recommendations emerging from national NHS quality and safety reports are considered and implemented as appropriate
- Review the Trust risk register and Board Assurance Framework (BAF) to identify relevant quality and safety risks and seek assurance that appropriate management action has been taken to manage and mitigate these risks, reporting any gaps in control or assurance to the Board
- Review the Trust's key quality metrics to seek assurance that areas of underperformance are identified and that appropriate quality improvement actions are taken to deliver the measurable improvements required
- Monitor and review the systems and processes in place in the Trust in relation to Infection Prevention and Control and to review progress against identified risks to reduce healthcare acquired infections.
- Receive reports and assurances (including those from internal and external audit) that the Trust's Quality Governance Structure is being effectively operated and agree any amendments to the strategy prior to recommending these to the Board for approval.

**Improvement**

- Seek assurance that the Trust's Quality Improvement Programme addresses key areas of concern & risk, is being delivered in a timely way and that there is an evidence base for the effectiveness of the plan & the delivery of the required quality improvements
- Seek assurance that effective management processes are in place that ensure the Trust has taken appropriate action and shared learning in response to relevant national and local reports, guidance and reviews to improve the safety and quality of care.
- Review themes and trends that occur in patient and staff feedback, patient safety & quality data, clinical audit, complaints, Claims and Inquests, patient safety and serious incidents. Seek assurance that actions are in place and that learning is being embedded.
- Monitor the programme of external visits and reviews and have oversight of the progress in implementing actions and shared learning. To receive a highlight report and minutes from the Patient Safety and Quality Group and from all other groups that report into the Committee

**Other Activities**

- To receive exception reports for Health and Safety and seek assurance on the actions to be taken and identified learning shared across the organisation.
- Monitor the Trust's Quality Accounts and ensure effective consultation with stakeholders takes place and to monitor the delivery of the quality targets.
- Receive a six monthly review of Quality Impact Assessments in relation to cost improvement programmes, for assurance that a robust process is in place and that unintended consequences are identified, mitigated and monitored.
- The Committee will work with other Committees within the organisation whose work can provide relevant assurance to the Quality and Safety Committee's own scope of work; in particular this will include the Finance and Investment Committee and the Audit Committee.

## 3. Membership and Attendance

The Committee and the Committee Chair will be appointed by the Chair of the Trust Board. Members of the Committee shall be:

**Core Membership**

- Three Non-Executive Directors one of whom will be the Committee Chair
- Chief Medical Officer
- Chief Nurse
- Deputy Chief Operating Officer
- Chief of Staff
- Chief Pharmacist
- Director of Midwifery
- Assistant Director of Clinical Governance

- Assistant Medical Director (also deputises for Chief Medical Officer)`
- Deputy Chief Nurse (Quality & Policy) (also deputises for Chief Nurse)
- Assistant Director of Nursing and Quality for each Division
- Head of Midwifery
- Assistant Director of Allied Health Professionals
- Senior Representative – Sussex Premier Health
- Assistant Director HR - Education
- Head of Quality & Governance, Core Services Division

Chiefs of Division, while not core members, will be invited to all meetings on a non-mandatory basis except when required to address specific agenda items.

**4. Quorum**
Quorum of the Committee shall be four members, at least one of which must be a non-executive director. Core members are expected to attend all meetings. In their absence a fully briefed deputy must attend and will count towards the quorum.

**5. Frequency**
Meetings shall be held every month and at such other times as the Chair of the Committee shall require. Work plans will detail the reports to be taken at each meeting.

**6. Authority**
The Committee is authorised by the Trust Board to review any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee, and all employers are directed to cooperate with any requests made by the Committee.

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

The Committee may establish sub-committees or working groups if this would support it in achieving its objectives.

**7. Reporting arrangements and subcommittees**
Minutes of the Committee meetings shall be formally recorded by the Secretary to the Committee and submitted to the Trust Board. The Chair of the Committee shall present a short, written summary of each Committee meeting 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 statement on internal control and by exception as and when necessary.

The Committee shall undertake a self-assessment of its effectiveness annually.

The committee has the following subcommittee reporting into it:
Patient Safety and Quality Group

These Terms of Reference shall be reviewed by the Committee and proposed revisions considered by the Trust Board on at least an annual basis.

East Sussex Healthcare NHS Trust

# Strategy & Transformation Committee 26 October 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) |
|---|---|---|---|
| 034/2023 | Integrated Community Teams | • A full discussion took place on the difference between community teams and specialist teams and how services would be prioritised according to local need as part of the governance and Integrated Care Services (ICS) processes for the community services. Workshops have been planned to determine scope and purpose.<br>• Footprint may mirror LA boundaries | • Recommendation for a summary of the recommendations be established for presentation at the November Board Seminar. |
| 035/2023 | Board Assurance Framework (BAF) 23/24: risks for this Committee | • All BAF risks were refreshed for 23/24 at the May Seminar, 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. The risks were presented through the Strategy & Transformation Committee and have been reviewed and agreed around the amended wording of the risks and descriptions.<br>• BAF 1: a watch would be kept on the time taken required for ICB work.<br>• BAF10: resource to deliver to the current timeline is being reviewed and could elongate the programme by 6 months.<br>• BAF 12: Better data is being produced for the BI team. | • Mitigating actions remain ongoing and will be reported in the Q3 update. |
| | | | |

| Agenda item number | Title and function of the paper | Key points made in the paper | Associated actions (as necessary) |
|---|---|---|---|
| 036/2023 | Transformation updates (next steps) | • The workstream summaries and deep dives was shared with Committee members to escalate updates and gain assurance as part of the Transformation Board and Strategy and Transformation Committee.<br>• Dashboards gave good assurance to committee members on progress. | • Agreement to include a flowchart in the summary to detail each programme that was on track in the current workstreams.<br><br>• EPR deep dive - A key risk was escalated, i.e. NHSE's requirement that the ICS as a whole would look at EPR convergence and single procurements. The Committee was assured that appropriate mitigating actions were being taken by the Trust with the support of the ICS, and that it would continue to receive updates on this risk. |
| 036/2023 | New Hospital Programme (NHP) | • The Trust was awaiting formal feedback on the Outline Business Case (OBC). The Strategic Outline Case (SOC) had been reviewed and noted that some central guidance had been changed. This necessitated re-modelling to refresh demand, capacity and include the Target Operating Model to reach stage two for the design at Eastbourne. | • To progress programme, which for enabling works such as MC}SCP and Education centre will go to F&P committees prior to Board for agreement. |

| Agenda item number | Title and function of the paper | Key points made in the paper | Associated actions (as necessary) |
|---|---|---|---|
| 037/2023 | EPR OBC | A summary on the clinical systems /EPR was provided on the following:<br><br>• Investment Objectives.<br>• Scope of any system convergence<br>• EPR Programme Board Structure / Governance.<br>• Benefits Modelling.<br>• Timelines.<br>• Full Business Case Process.<br>• Procurement Challenge.<br>• Getting Ready for EPR. | • An updated report to follow at the February meeting, this will include an implementation and embedding plan. A future FBC will go to the trust board in May 2024. |
| 038/2023 | Strategy & Transformation Committee – Annual Review of Effectiveness | It was noted that four responses had been received and a discussion would be held offline to evaluate the responses. | |

**East Sussex Healthcare NHS Trust**

**Strategy and Transformation Committee - Terms of Reference**

## 1. Purpose

The Committee has been established to oversee and scrutinise the formulation, direction and delivery of strategy and related performance matters at the Trust, thus giving assurance to the board on the delivery of its strategy

This Committee is a sub-committee of the Trust Board with the appropriate delegated authority that will act as a co-ordination group providing a forum for review of strategic, policy and associated non-clinical governance issues

## 2. Duties

This Committee will:

Receive reports on key national policy initiatives/changes, System/Place-based planning/initiatives for alignment with ESHT direction

Review annual and long-term strategic plans and major business cases, and consider proposals for actions for discussion/agreement by Trust Board

Ensure the Trust has a strategic plan for clinical services, estates and facilities, digital/IT, OD/culture including annual presentation from Medical Director of Trust R&D priorities

Evaluate Trust-wide transformation programme progress against plan/target (noting that financial implications will be monitored through the (Finance & Productivity Committee)

## 3. Membership

The Committee comprises the following members:

| Executive | Non-Executive |
|---|---|
| Chief Executive*<br>Chief of Staff*<br>Director of Transformation and Improvement*<br>Director of Finance*<br>Chief People Officer*<br>Medical Director<br>Director of Estates & Facilities<br>BFF Programme Director<br>CIO | Jackie Churchward Cardiff (Chair)<br><br>An invitation to every Strategy and Transformation Committee will be extended to each Non-Executive.<br><br>Attendance is likely to reflect time commitments and membership of other Trust Committees |

*Core members

Additionally, other executive members and senior clinical leaders may be invited as required. Named deputies will be accepted for executive members only in exceptional circumstances.

## 4. Chair

The chair of the Committee is the Senior Independent Non-Executive Director/Deputy Chair.

## 5. Quorum

No fewer than two of the core members shown at section three (or designated deputies agreed in advance with the Chair) and three of the Non-Executives constitute the minimum number of members for this Committee to go ahead.

## 6. Frequency

This Committee meets bi-monthly for 1.5 hours

## 7. Authority

The Board has resolved to establish a Committee of the Board to be known as the Strategy and Transformation Committee. The Committee is a sub-committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference

## 8. Reporting arrangements

The Committee is accountable to the Trust Board. The Committee will report a summary of actions and recommendations to every Trust Board.

## 9. Notice of meetings

Papers will be sent out no later than five working days before the Committee.

At the discretion of the Chair papers may be sent later in exceptional circumstances only.

## 9. Conduct of meetings

Meetings of the Strategy and Transformation Committee shall be conducted in accordance with its Terms of Reference and the provisions of the Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions approved by the Board of East Sussex Healthcare NHS Trust.

## 10. Meetings behaviours

A Meeting Charter is available for members should they wish to consult it in advance of Committee meetings.

The Meeting Charter provides a reminder of appropriate behaviours and will be re-iterated by the Chair at the start of a meeting to ensure all participants understand the expectations throughout the meeting.

Meetings / groups will be conducted in line with Trust Values, with a mutual respectfulness for all participants.

It is the responsibility of all present to challenge behaviour deemed disrespectful, negative, inappropriate or aggressive

A successful meeting / group should be supportive, positive, timely and provide an outcome where there is progress made and actions allocated.

## 11. Notes of meetings

The Secretary shall take action-oriented notes of all meetings of the Group, including recording the names of those present and in attendance. Notes of the meeting will record actions arising from the meeting.

East Sussex Healthcare NHS Trust

# Infection Prevention and Control Annual Report

| | | | | | | |
|---|---|---|---|---|---|---|
| **Purpose of the paper** | This report outlines the infection prevention and control (IPC) activities of East Sussex Healthcare NHS Trust (ESHT) for the financial year 2022/23. Arrangements made by ESHT to comply with the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and allow the early identification of patients with infections, measures taken to reduce the spread of infections to others, audit, surveillance, achievements, and challenges are presented. | | | | | |
| | For Decision | | For Assurance | x | For Information | x |
| **Sponsor/Author** | Vikki Carruth/Lisa Redmond | | | | | |
| **Governance overview** | The report is approved by the Trust Infection Prevention and Control Group and the Quality and Safety Committee in October 2023. | | | | | |

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

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

| | |
|---|---|
| **Recommendation** | The Board is asked to note the report. |

**Executive Summary**

**Executive Summary**

A challenging year during which services were being re-established and COVID continued to circulate and cause outbreaks.

Four MRSA bacteraemia were reported which is an increase, all cases were assessed as unavoidable (the limit is zero avoidable infections).

The CDI limit was exceeded with 66% higher number of infections reported. The risk of CDI increases with age and antibiotic use. 77% of infections occurred in patients over 75years who had received antibiotics. The national rate of CDI is also increasing. A national collaborative working group to understand and address why this is happening. There was on case of cross infection of CDI that occurred in a patient when the deep cleaning which is normally undertaken was not carried out at a time of operational challenge. Duty of candour was undertaken. There also continues to be delays isolating patients with diarrhoea because of high bed occupancy and low percentage of single rooms. A recovery action plan has been agreed and will require support with antimicrobial stewardship.

COVID and flu were both prevalent in high numbers, with over 750 patients diagnosed with flu and over 3,000 cases of COVID. The plans for patient pathways put in place and there was only one outbreak of flu affecting 9 patients.

Monkeypox infection required a new focus and preparedness as an international outbreak was declared. There were no healthcare associated infections at ESHT.

The surgical site surveillance revealed a high number of hip replacement infection rate higher than the national average, this was considered at the SSISS meetings and it was felt that patient deconditioning during delay in access to surgery was a contributory factor. The trend has not continued into 2023/24.

A ventilation steering group has been established following learning from the pandemic regarding the importance of air quality in reducing transmission of airborne infections.

Further support is required with auditing of compliance with IPC standards. The IPC service is fully established and responsive to infection challenges.

| | |
|---|---|
| | Further work was undertaken with Nervecentre to reflect changes to assist managing common respiratory pathogens in addition to COVID and this really helped with patient pathways during winter.<br><br>The requirement for mandatory surveillance of healthcare associated infections has been met.<br><br>The national specification for cleanliness was maintained throughout the year which reduced risk of acquisition of infection from the environment or equipment.<br><br>Work has commenced on embedding the new National IPC manual in clinical practice.<br><br>Please note that the full IPC Annual Report is available in the appendix to the Board papers. |
| **Next steps** | We will work with ICS and regional colleagues to identify where improvements may be made. We have started to collect frailty data alongside CDI infection to understand if there is a link and whether we can find Improvements here. The new patient safety framework will be adopted by IPC focusing on lessons learnt and quality improvement.<br><br>Within ESHT increased focus on antimicrobial stewardship is required to minimise the risk of C. difficile and infections caused by resistant gram-negative organisms.<br><br>We will continue to plan for surges in COVID prevalence alongside the risk of other respiratory infections. We will focus on the fundamentals of IPC using the national IPC manual to ensure staff have up to date knowledge of IPC precautions and are prepared for potential challenges from emerging pathogens. |

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 five documents between 4th October 2023 and 4th December 2023:<br><br>**Sealing 98 – Essity UK Ltd, 30th October 2023**<br>Agreement for provision of continence products and delivery service for three years.<br><br>**Sealing 99 – GE Medical Systems Ltd, 8th November 2023**<br>Mutual termination and deed of transfer agreement.<br><br>**Sealing 100 – Aecom Ltd, 8th November 2023**<br>Agreement for provision of civic and structural engineering services<br><br>**Sealing 101 – Willmott Dixon Construction Ltd, 29th November 2023**<br>Deed agreement for design and professional services relating to development of a business case for proposed new car park at Conquest Hospital<br><br>**Sealing 102 – Bauvill Ltd, 4th December 2023**<br>Tender award for Bexhill Ophthalmology construction |

| | |
|---|---|
| **Next steps** | Not applicable |

East Sussex Healthcare NHS Trust

# Infection Prevention & Control

# Annual Report

# 2022 - 2023

ESHT Infection Prevention and Control

**Contents**

## 1. Executive Summary

This report outlines the infection prevention and control (IPC) activities of East Sussex Healthcare NHS Trust (ESHT) for the financial year 2022/23. Arrangements made by ESHT to allow the early identification of patients with infections, measures taken to reduce the spread of infections to others, audit, surveillance, achievements, and challenges are presented.

The prevention of avoidable infections is fundamental to safe patient care. ESHT employs a team of specialist nurses and support staff to advise and co-ordinate activities to prevent and control infection, but it is the responsibility of all staff in the organisation to comply with Trust policies and implement these.

**Key points during 2022/23:**

A challenging year during which services were being re-established and COVID continued to circulate and cause outbreaks.

Four MRSA bacteraemia were reported which is an increase, all cases were assessed as unavoidable (the limit is zero avoidable infections).

The CDI limit was exceeded with 66% higher number of infections reported. The risk of CDI increases with age and antibiotic use. 77% of infections occurred in patients over 75years who had received antibiotics. The national rate of CDI is also increasing. A national collaborative working group has been established to understand and address why this is happening. There was one case of cross infection of CDI that occurred in a patient, when the deep cleaning that is normally undertaken was not carried out at a time of operational challenge. Duty of candour was undertaken. There continues to be delays isolating patients with diarrhoea because of high bed occupancy and low percentage of single rooms. A recovery action plan has been agreed and will require support with antimicrobial stewardship.

COVID and flu were both prevalent in high numbers, with over 750 patients diagnosed with flu and over 3,000 cases of COVID. The plans for patient pathways put in place worked well and there was only one outbreak of flu affecting 9 patients.

Monkeypox infection required a new focus and preparedness as an international outbreak was declared. There were no healthcare associated infections at ESHT.

The surgical site surveillance revealed a high number of hip replacement infection rate higher than the national average, this was considered at the SSISS meetings and it was felt that patient deconditioning during delay in access to surgery was a contributory factor, the infections were not common to a particular surgeon or theatre and not shown to be related to an outbreak. The trend has not continued into 2023/24.

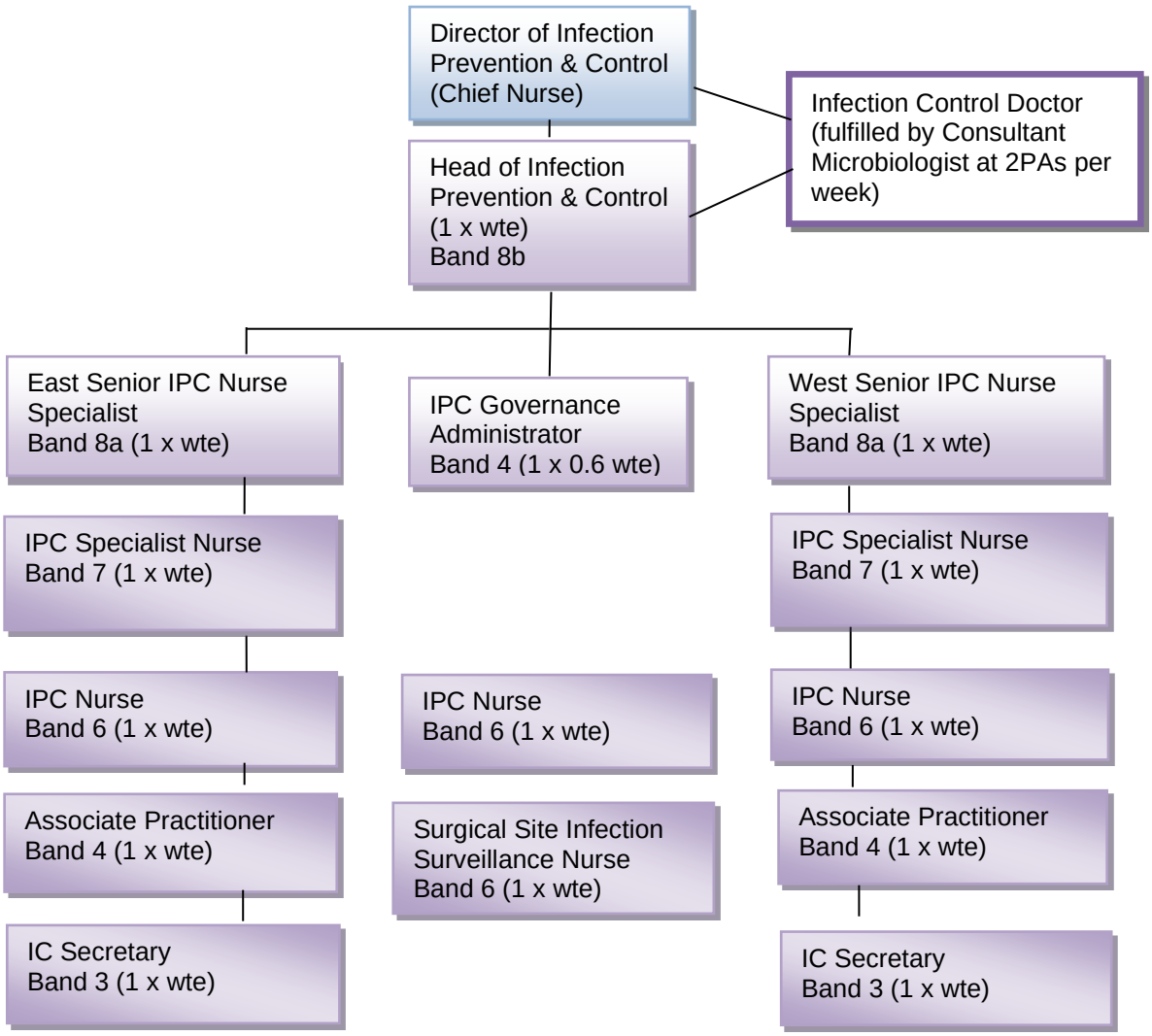
A ventilation steering group has been established following learning from the pandemic regarding the importance of air quality in reducing transmission of airborne infections. Further support is required with auditing of compliance with IPC standards. The IPC service is fully established and responsive to infection challenges.

Lisa Redmond, Head of Infection Prevention and Control

## 2. Structure

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

### 2.1 Infection Prevention & Control Team Structure

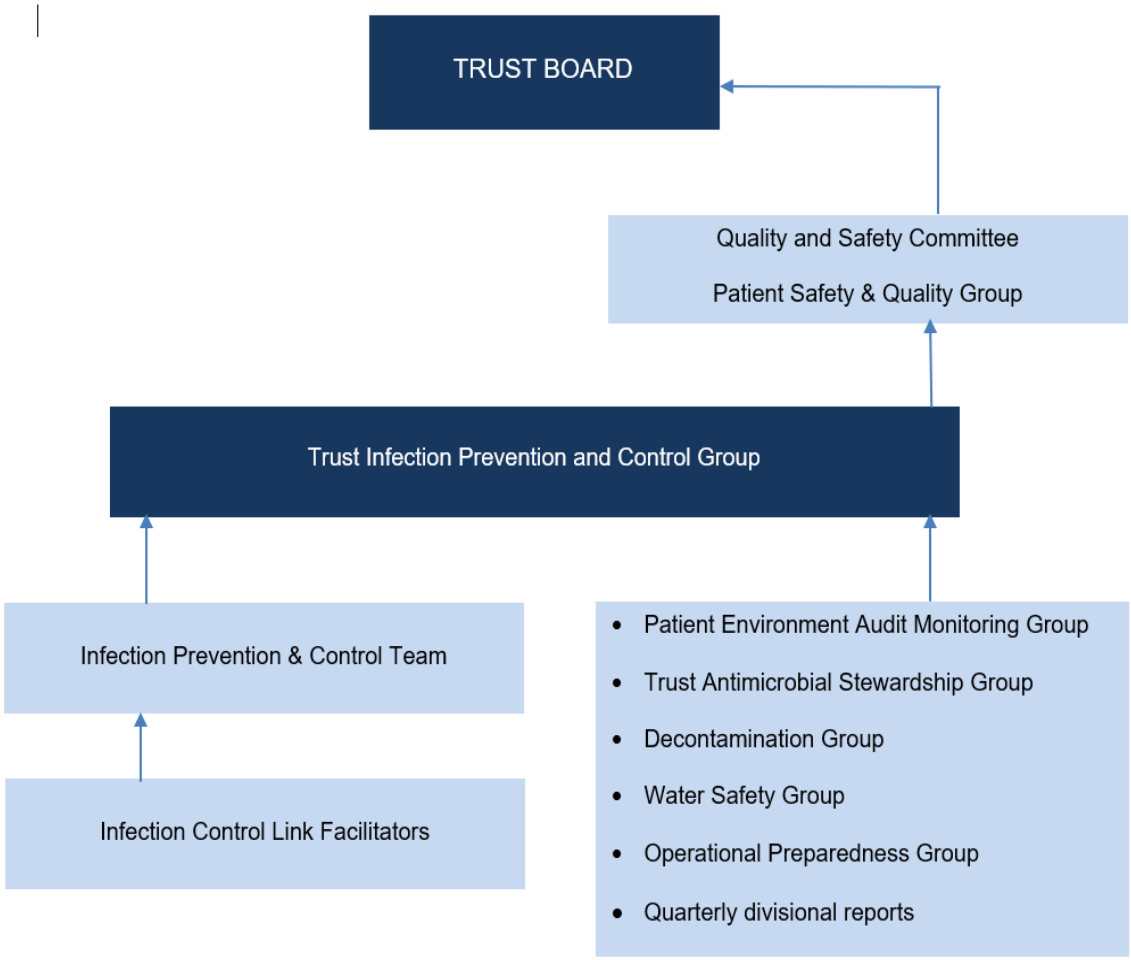



The IPCT comprises of specialist Infection Prevention and Control nurses and administrative staff. Two area teams (East and West) based in each of the acute hospital sites provide Infection Prevention and Control support to all ESHT services in their local area (acute, community, inpatient and domiciliary).

In addition to the IPCT, the Trust also funds 4 x wte Consultant Microbiologist posts (2 on each acute site) based within the Core Services Division who work with the IPCT, one of whom undertakes the role of Infection Prevention and Control Doctor.

An Orthopaedic Surgical Site Infection Surveillance Nurse post has now been moved from the Diagnostics Anaesthetics and Surgery Division to the IPC service and an Antimicrobial Prescribing Lead post is appointed within the Core Services Division.

## 2.2 Infection Prevention & Control Internal Reporting Arrangements




The Trust Infection Prevention and Control Group (TIPCG) is chaired by the DIPC/ Chief Nurse. The Group meets monthly and has wide representation from throughout the Trust including from Divisions, Occupational Health, Pharmacy, Integrated Care Board, and external membership from the local department of UK Health and Security Agency (UKHSA). The TIPCG reports monthly by exception, to Patient Safety and Quality Group regarding performance and operational issues and compliance against the Infection Prevention and Control Board Assurance Framework (BAF). There has been no reporting to the senior leader's forum, instead IPC contributes to the Clinical Advisory Group which was established to support the COVID pandemic response and has been agreed as useful group to continue.

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

## 2.3 Infection Prevention & Control External Reporting Arrangements

External reporting arrangements have been subject to change due to development of the Integrated Care Board (ICB). The DIPC and Head of IPC discuss any significant IPC issues with the ICB Head of Quality and Nursing and the Southeast Lead for NHSE/I. Daily external reporting relating to COVID and additional outbreak reporting processes in relation to COVID outbreaks were streamlined during 2022/23. ESHT has been compliant with reporting requirements throughout the year.

## 2.4 Infection Control Link Facilitators

There are approximately 80 Link Facilitators across the Trust. Each new ICLF is provided with an induction programme provided by the IPCT. With the educational support and guidance from the IPCT, they are responsible for cascading and monitoring compliance with infection prevention and control practices at clinical level. The IPCT hold monthly ICLF meetings on each acute site. A new programme for link training via MS Teams is in place for 2022/23.

## 2.5 Joint Working across the Local System

The Trust IPCT continues to work with the Integrated Care Board (ICB), Public Health at East Sussex County Council, United Kingdom Health and Security Agency (UKHSA) and NHSE colleagues towards joint strategies for the reduction of healthcare associated infections which can lead to hospital admission.

The IPC specialist nurses are members of the Infection Prevention Society and the senior ICNs participate in the Sussex IPC cell which aims to share and discuss local initiatives, innovations, and work towards common goals across Sussex.

Surveillance of community acquired Clostridium difficile infections and Gram-negative bacteraemias has continued to be undertaken by the ESHT IPC team on behalf of the local ICB.

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

The Infection Control Board Assurance Framework is structured around the 10 criteria set out in the Code of Practice on the Prevention and Control of Infection linked to Regulation 12 of the Health and Social Care Act 2008. The framework was revised during the year to reflect learning and as part of the government move towards living with COVID.

The Trust performance against framework standards is discussed at the Trust Infection Prevention and Control Group (TICPG) which also receives reports from Divisions as evidence of local compliance and assurance.

It should be noted that the IPC BAF is iterative and has changed over time. This is the BAF summary presented at Quality & Safety April 2023

| Key Lines of Enquiry | Compliance Status | Continuous improvement / Actions | Progress with compliance |
|---|---|---|---|
| 1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users. | **Partial** | • There is a new requirement to have a seasonal respiratory winter plan and policy. | The Seasonal flu plan has been updated to take account of lessons learnt from COVID.<br>A new ESHT policy for respiratory viruses is out for ratification.<br>Ebola pathways have been agreed and training provided for staff. |
| 2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections | **Compliant** | | |
| 3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance | **Partial compliance** | *C. difficile* limit is being exceeded. More robust Antimicrobial Stewardship is required to pro-actively support prescribing practice. | Pharmacy and the AMS group seeking solutions. Consultant microbiologists trying to do AMS rounds. |
| 4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or | **Compliant** | | |

| | | | |
|---|---|---|---|
| nursing/medical care in a timely fashion | | | |
| 5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people | **Compliant** | | |
| 6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection | **Compliant** | | |
| 7. Provide or secure adequate isolation facilities | **Partial** | | It is challenging to isolate patients due to high bed occupancy. |
| 8. Secure adequate access to laboratory support as appropriate | **Complaint** | | |
| 9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent | **Partial** | | Several IPC policies are overdue for review. Solutions are being sought to support audit of compliance. |

| | | | |
|---|---|---|---|
| and control infections | | | |
| 10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection. | **Compliant** | | |

Compliance with the BAF is also reported to the Quality and Safety Committee who receive monthly updates on performance, agree actions and report/requirements escalate to the Trust Board as required.

## 4. Mandatory Surveillance

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

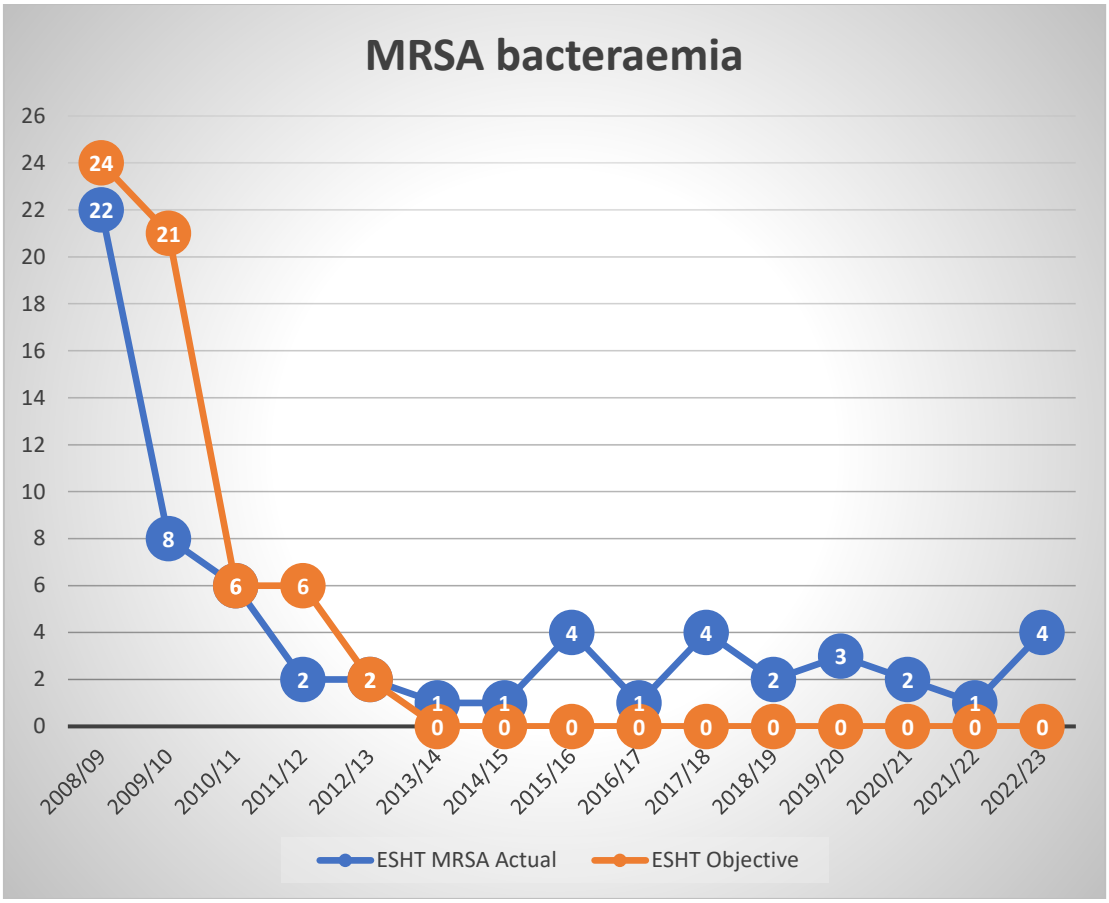
Each Trust is set an annual objective for numbers of MRSA bacteraemias and CDI. Not all cases of CDI or bacteraemias are avoidable or due to lapses and therefore the focus is on preventing avoidable harm. The number of MRSA bacteraemias has reduced significantly therefore the tolerance is now zero avoidable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

### 4.1 MRSA bacteraemia

ESHT continues to have a zero tolerance to cases of MRSA bacteraemia which could potentially be avoidable. ESHT reported 4 cases of healthcare associated MRSA bacteraemia in 2022/23 compared to 1 case in 2021/22.

| MRSA 2022/23 | | | |
|---|---|---|---|
| | ESHT | | CDI - CCG |
| Month | HOHA | COHA | Actual |
| April | 1 | 0 | 1 |
| May | 0 | 0 | 0 |
| June | 0 | 0 | 0 |
| Q1 | 1 | 0 | 1 |
| July | 0 | 0 | 1 |
| August | 1 | 0 | 0 |
| September | 0 | 1 | 1 |
| Q2 | 1 | 1 | 2 |
| October | 0 | 0 | 0 |
| November | 0 | 0 | 0 |
| December | 0 | 0 | 1 |

| | | | |
|---|---|---|---|
| Q3 | 0 | 0 | 1 |
| January | 1 | 0 | 1 |
| February | 0 | 0 | 0 |
| March | 0 | 0 | 0 |
| Q4 | 1 | 0 | 1 |
| **TOTAL** | **3** | **1** | **5** |




One MRSA bacteraemia reported for the month of April was associated with a Hickman line. The patient was known MRSA positive and know to the VAT team. Post infection review identified that the patient had pulled our their line and had very challenging behaviour that compromised the VAT team ability to monitor the line as usual. The patient has a complex medical history. The infection was assessed as unavoidable.

One MRSA bacteraemia reported for August was identified as being due to haemothorax post road traffic incident in a patient who was MRSA colonised prior to this admission so assessed as an unavoidable infection.

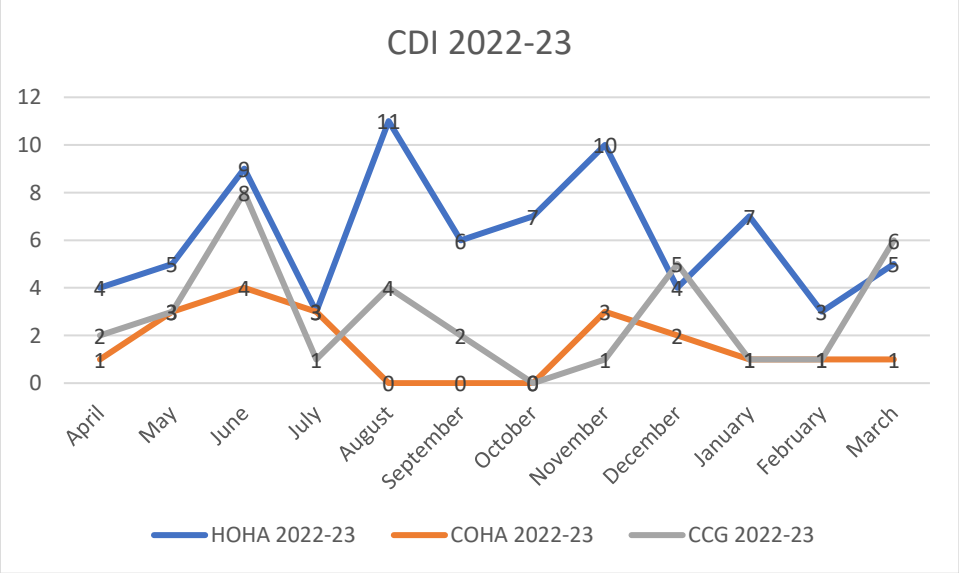
The case in September was community onset infection. The source was unknown, the blood culture was taken in the emergency department. the patient was treated with antibiotics and as the patient was from a nursing home the case was shared with public health colleagues at East Sussex County Council.

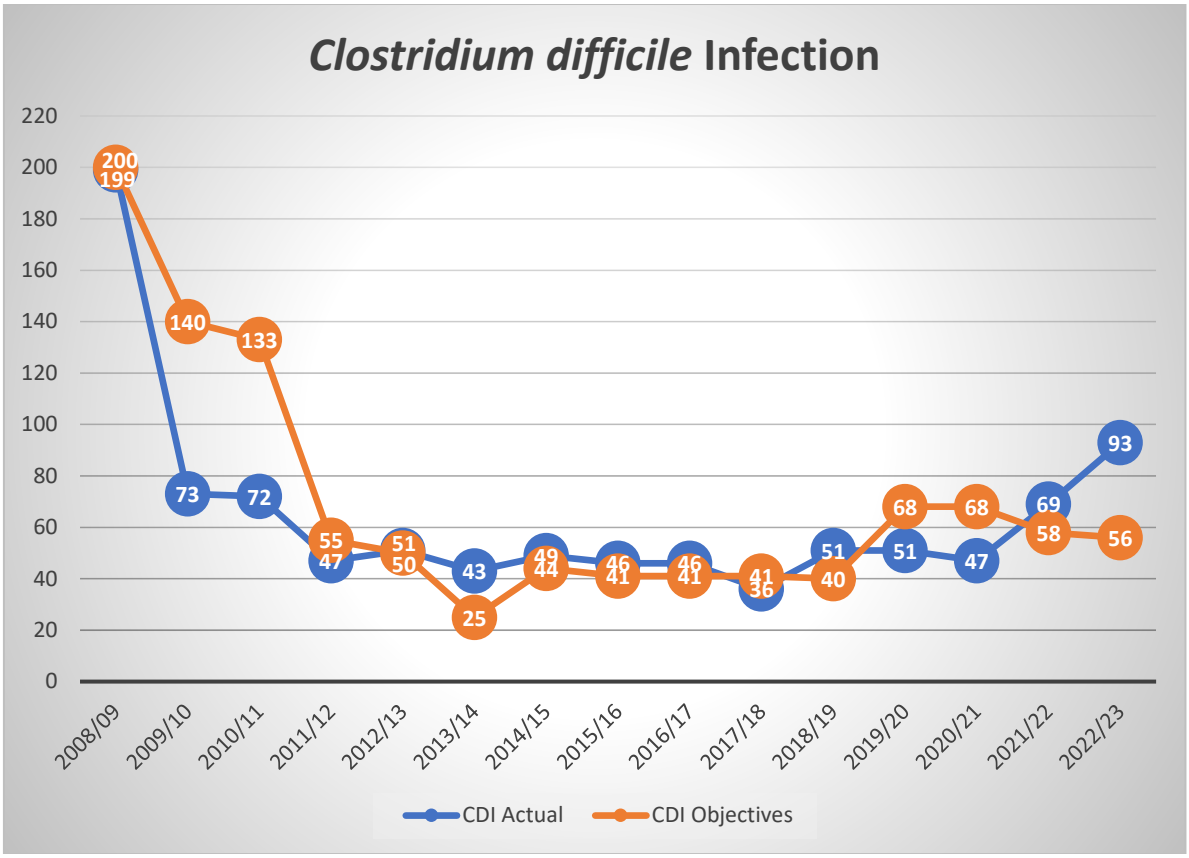
January bacteraemia related to a heel wound that was assessed as unavoidable because the patient had chronic pressure ulcers prior to admission.

## 4.2 *Clostridium difficile* infection (CDI)

The annual limit set for 2022/23 was 56 cases for ESHT to take account of prior healthcare exposure within 28 days. In total 93 cases were attributed to ESHT for 2022/23. 19 cases were Community Onset Healthcare Associated (COHA) because the CDI diagnosis was made within 28 days of a patient's previous treatment in hospital rather than related to a current admission. The number of *C. difficile* infections reported annually within ESHT is shown in the chart below.

| CDI 2022/23 – limit 56 | | | |
|---|---|---|---|
| | CDI – ESHT | | CDI - CCG |
| **Month** | **HOHA** | **COHA** | **Actual** |
| April | 4 | 1 | 2 |
| May | 5 | 3 | 3 |
| June | 9 | 4 | 8 |
| Q1 | 18 | 8 | 13 |
| July | 3 | 3 | 1 |
| August | 11 | 0 | 4 |
| September | 6 | 0 | 2 |
| Q2 | 20 | 3 | 7 |
| October | 7 | 0 | 0 |
| November | 10 | 3 | 1 |
| December | 4 | 2 | 5 |
| Q3 | 21 | 5 | 6 |
| January | 7 | 1 | 1 |
| February | 3 | 1 | 1 |
| March | 5 | 1 | 6 |
| Q4 | 15 | 3 | 8 |
| **TOTAL** | **74** | **19** | **34** |



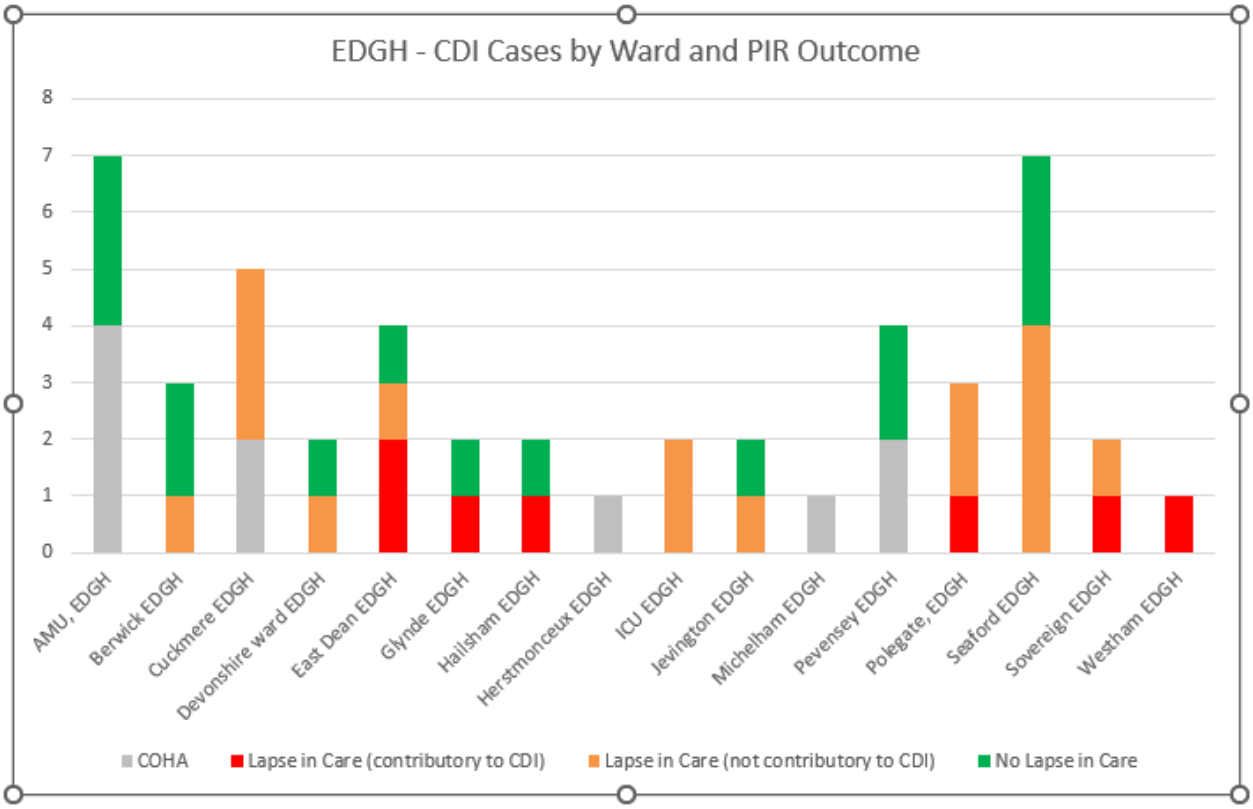


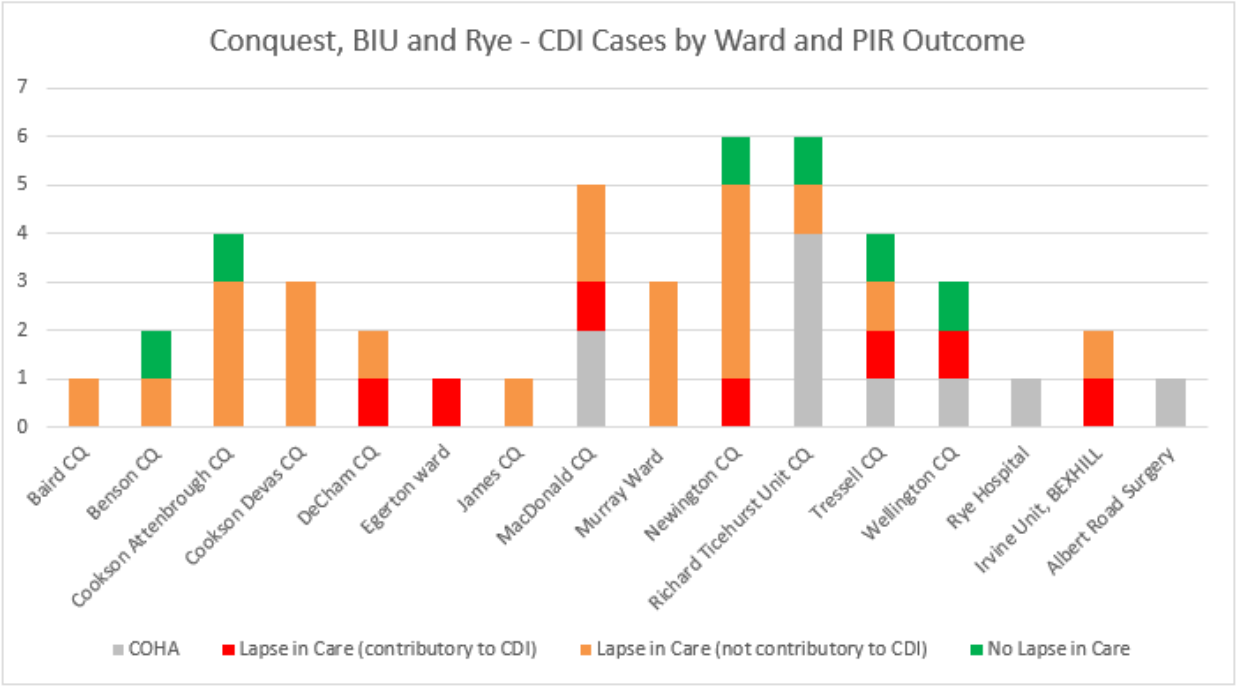

The reporting of CDI by acute Trusts changed further in 2018 with the addition of community onset cases with prior healthcare being attributed to ESHT. Patients who are coded as day admissions and then subsequently have community onset CDI are also included in the community onset healthcare associated (COHA) criteria. As Trusts do not code patients in the same way it can be difficult to directly compare Trusts in relation to COHA infections.

All Hospital onset healthcare associated (HOHA) CDI cases have had a multidisciplinary post infection review (PIR) where the patient risk factors, cleanliness, antimicrobial prescribing, and adherence to policy to assessed. The outcome is either No lapse in Care (Green), Lapse in Care that is unlikely to have contributed to the CDI (amber) and Lapse in Care that is likely to have contributed to the CDI (red). We have been unable to complete COHA investigation due to the numbers of HOHA and the difficulty in gaining information about the patient's health via GP records.

| >48hrs CDI | 2022/23 |
|---|---|
| No Lapse in Care | 22 |
| Lapse in Care likely to have contributed to outcome | 14 |
| Lapse in Care unlikely to have contributed to outcome | 38 |
| Community Onset Healthcare associated (PIR not undertaken) | 19 |
| TOTAL cases | 93 |

73 infections occurred in 68 patients; three patients had more than one reportable infection episode. 22 patients were assessed as having CDI despite adherence to the *C. difficile* and antimicrobial prescribing policies. Themes from the 38 non-contributory lapses are delays in isolation, delays in sending stool samples, lower scores for NSC audits and/or incomplete documentation that should be improved but which were unlikely to have negatively impacted on the patient and contributed to their CDI.



There is no significant difference in the number of infections diagnosed on each acute site. Cases have occurred on a broad range of wards, higher numbers associated with Seaford and Newington wards which care for frailty patients.

**Lapses in Care**

The year ended with 14 cases thought to have been lapses in care. 14 cases from 13 patients were assessed as having lapses in care which may have contributed to the development of CDI because there was non-compliance with either the CDI or antimicrobial policy. 11 of the 14 cases identified lapses in antimicrobial prescribing. Lapses related to incomplete prescription, inappropriate choice of antibiotic, lack of evidence of review. One case was a lapse due to probable cross infection. The remaining cases were assessed as lapses due to delays in starting or escalating treatment of patients with a known CDI history when symptoms returned.

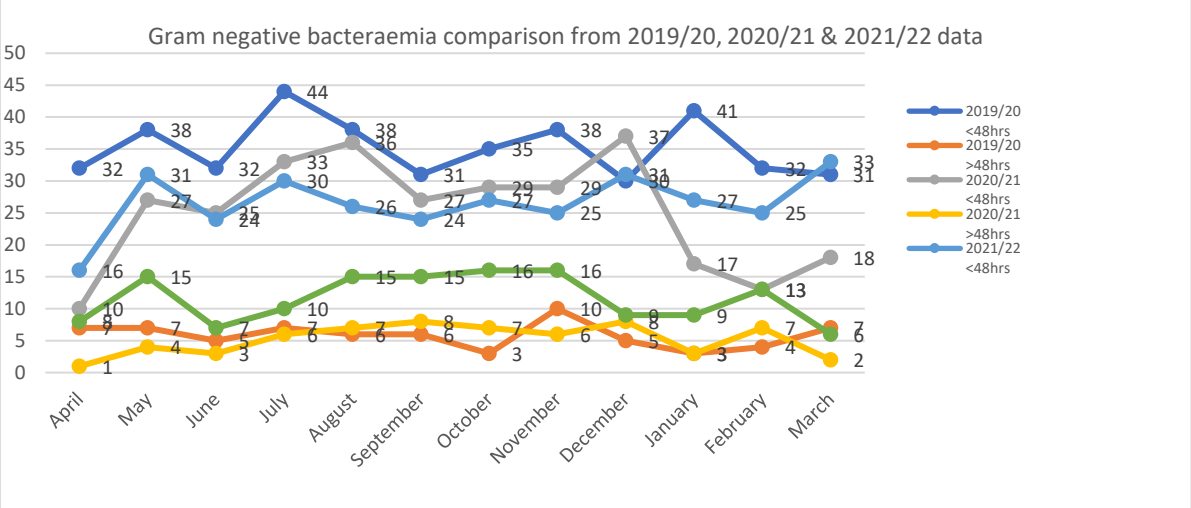
**Outbreaks and Periods of Increased Incidence (PIIs)**

The IPC team record the location of CDI cases and if two positive results are received from the same ward this is treated as a period of increased incidence and as per guidance, additional actions are taken such as additional training and audit on that ward. As a result of increases in overall CDI cases, all positive samples are treated in this way. In addition, all samples are sent to a reference laboratory to identify the ribotyping to detect if two samples are related because of cross infection. If there is an increase in incidence related to a ward, samples from *C. difficile* carriers are also sent to exclude this cohort as a source of cross infection.

There has been one case during 2022-23 that is due to probable cross infection. This occurred on Newington ward when a patient was isolated, but the bay was not deep cleaned or treated with HPV as there was extreme operational pressures requiring patients to be moved from the emergency department. Another patient in bay tested positive for CDI and the ribotype was found to be the same. The patient recovered and duty of candour was undertaken.

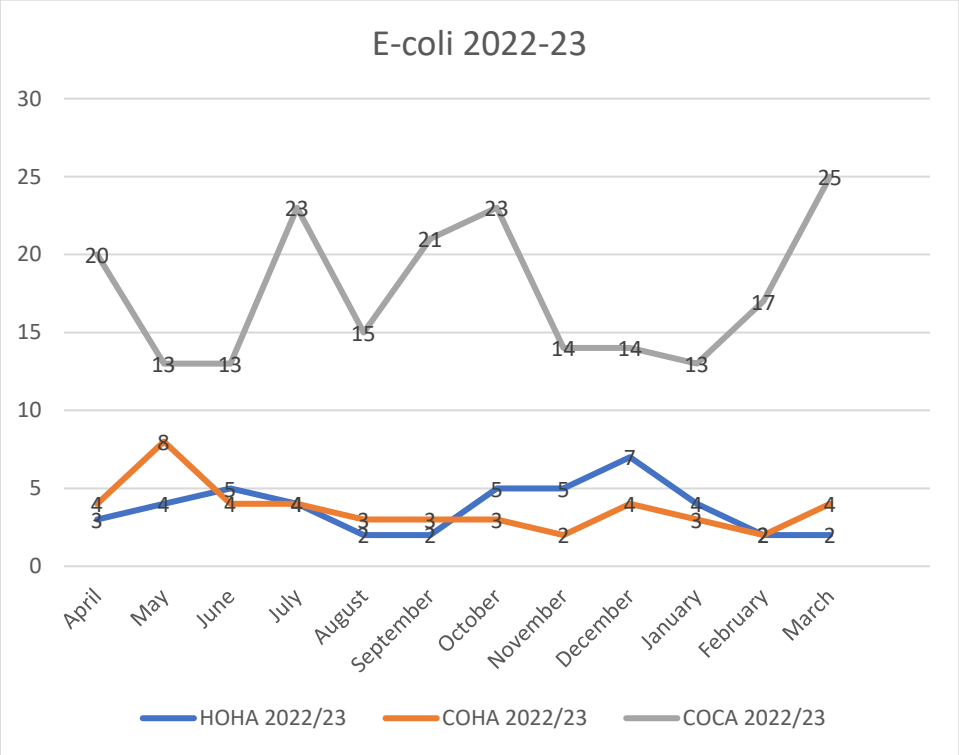
## 4.3 Gram-negative Bacteraemias

The reporting of Gram-negative bacteraemia is mandatory for all provider Trusts.



### 4.3.1 *E. Coli*

| *E. coli* 2022/23 – limit 81 | | | |
|---|---|---|---|
| | ESHT | | CCG |
| Month | HOHA | COHA | Actual |
| April | 3 | 4 | 20 |
| May | 4 | 8 | 13 |
| June | 5 | 4 | 13 |
| Q1 | 12 | 16 | 46 |
| July | 4 | 4 | 23 |
| August | 2 | 3 | 15 |
| September | 2 | 3 | 21 |
| Q2 | 8 | 10 | 59 |
| October | 5 | 3 | 23 |
| November | 5 | 2 | 14 |
| December | 7 | 4 | 14 |
| Q3 | 17 | 9 | 51 |
| January | 4 | 3 | 13 |
| February | 2 | 2 | 17 |
| March | 2 | 4 | 25 |
| Q4 | 8 | 9 | 55 |
| **TOTAL** | **45** | **44** | **211** |




*E. coli* remains the most common cause of GNB, and this is where we had been focusing improvement work in ESHT prior to the pandemic. This has not been sustained during COVID high prevalence.

We have reported 89 cases against a limit of 81. 45 cases of Hospital Onset Healthcare Associated (HOHA) *E. coli* bacteraemia and a further 44 cases of Community Onset

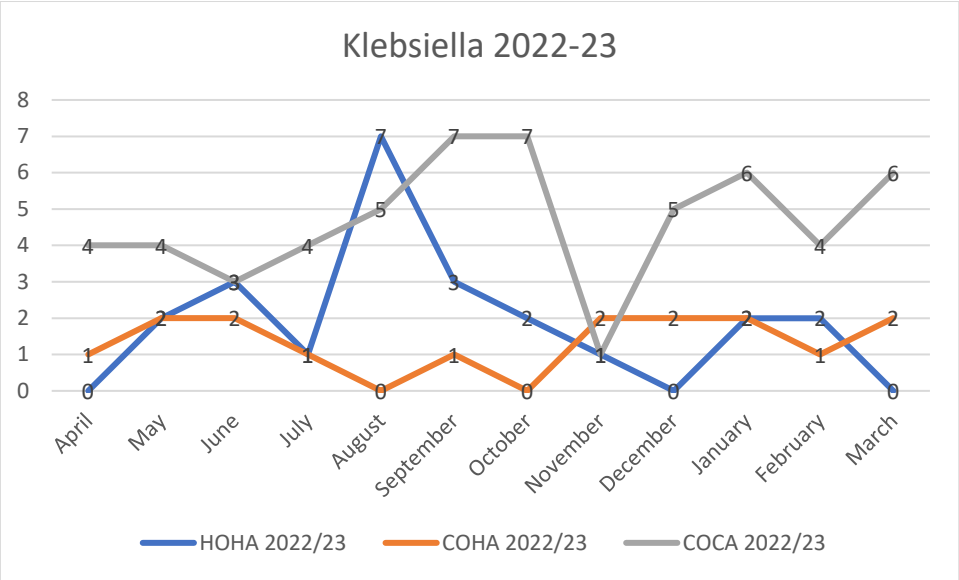
infection where the patient had prior healthcare within 28 days. It is very difficult to influence community onset cases with patients in their own homes. Deconditioning, dehydration, poor mobility and subsequent urinary tract infection can all increase the risk of *E.coli* bacteraemia.

The IPC team is also currently undertaking the *E.coli* bacteraemia primary care data collection on behalf of the ICB under a service level agreement (SLA). Further collaboration as and ICS is required to fully understand how we can positively impact on reducing these infections.

### 4.3.2 *Klebsiella sp.*

The trust was within the limit for *Klebsiella* bloodstream infection reporting 39 against a limit of 43.

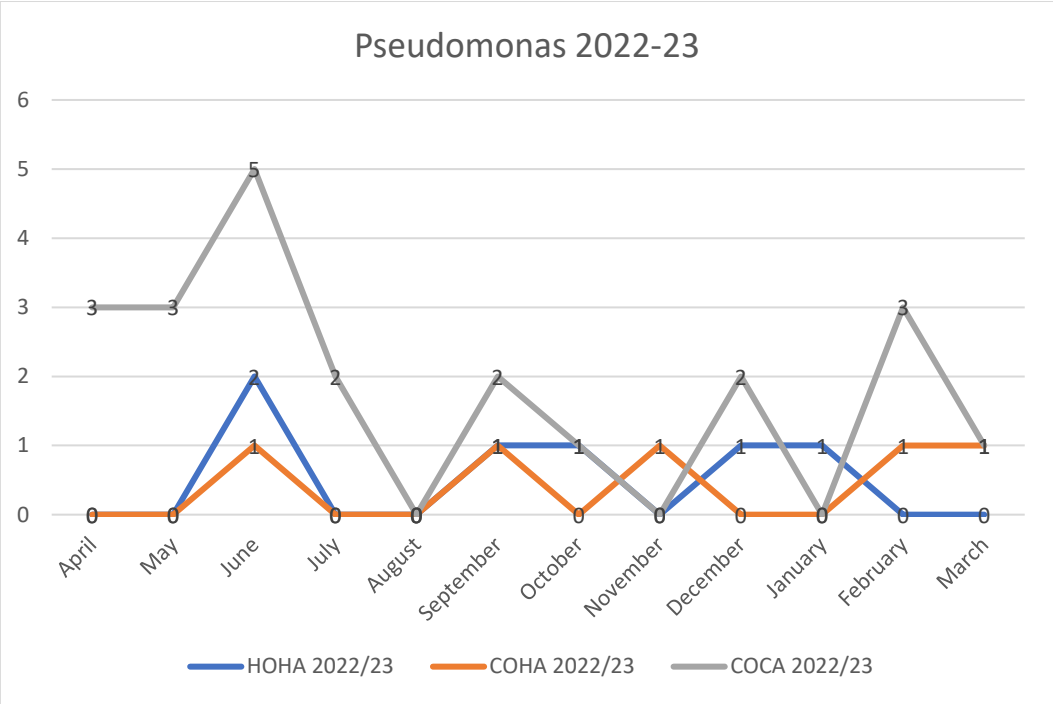
| ***Klebsiella sp.* 2022/23 – limit 43** | | | |
|---|---|---|---|
| | **ESHT** | | **CCG** |
| **Month** | **HOHA** | **COHA** | **Actual** |
| April | 0 | 1 | 4 |
| May | 2 | 2 | 4 |
| June | 3 | 2 | 3 |
| Q1 | 5 | 5 | 11 |
| July | 1 | 1 | 4 |
| August | 7 | 0 | 5 |
| September | 3 | 1 | 7 |
| Q2 | 11 | 2 | 16 |
| October | 2 | 0 | 7 |
| November | 1 | 2 | 1 |
| December | 0 | 2 | 5 |
| Q3 | 3 | 4 | 13 |
| January | 2 | 2 | 6 |
| February | 2 | 1 | 4 |
| March | 0 | 2 | 6 |
| Q4 | 4 | 5 | 16 |
| **TOTAL** | **23** | **16** | 56 |




### 4.3.3 *Pseudomonas*

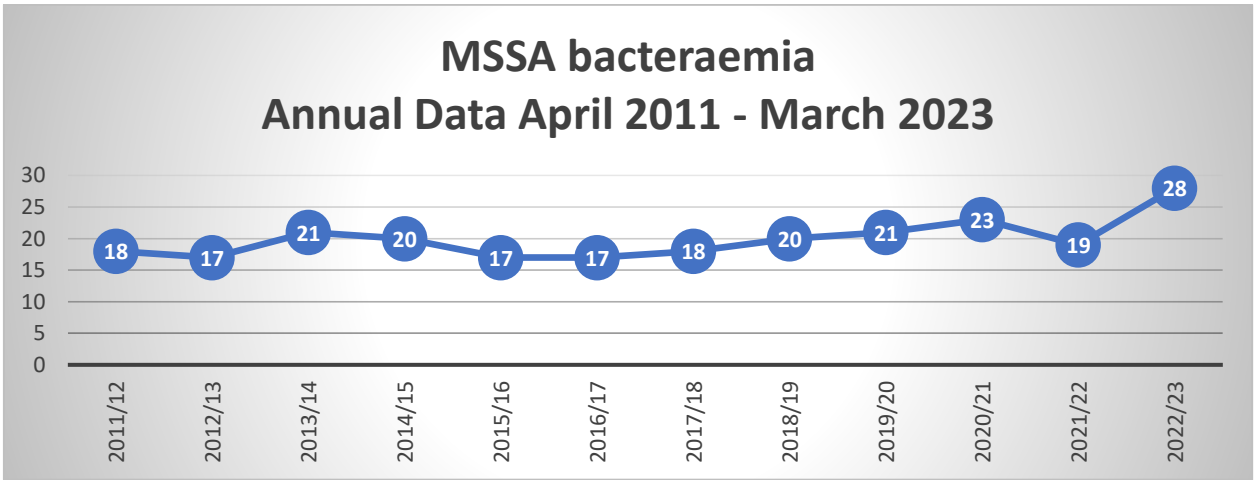
ESHT was within the limit set for *Pseudomonas* bloodstream infection reporting 13 cases against a limit of 18.

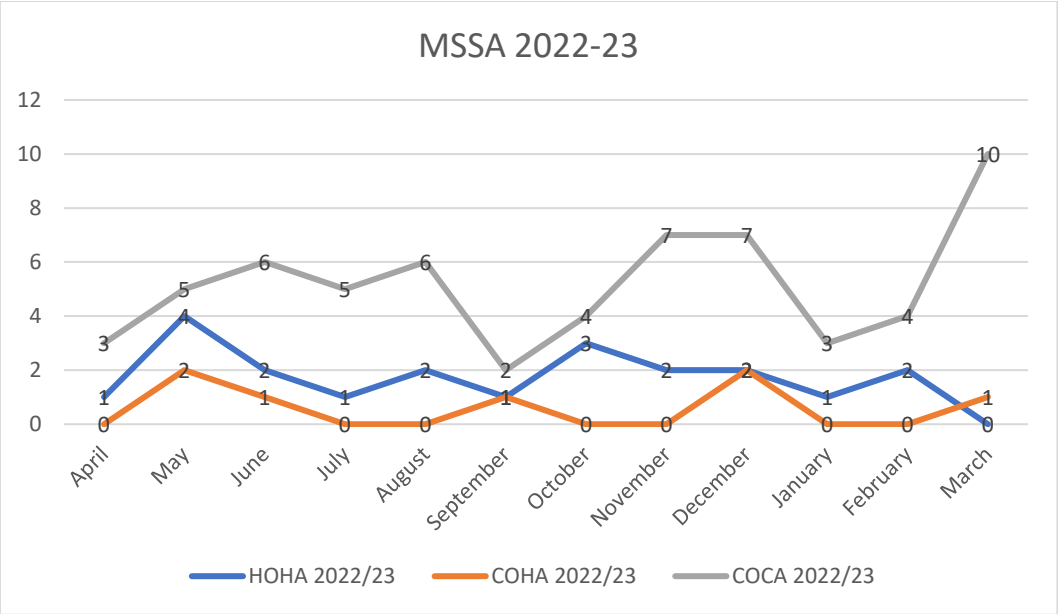
| ***Pseudomonas* 2022/23 – limit 18** | | | |
|---|---|---|---|
| | **ESHT** | | **CCG** |
| **Month** | **HOHA** | **COHA** | **Actual** |
| April | 0 | 0 | 3 |
| May | 0 | 0 | 3 |
| June | 2 | 1 | 5 |
| Q1 | 2 | 1 | 11 |
| July | 0 | 0 | 2 |
| August | 0 | 0 | 0 |
| September | 1 | 1 | 2 |
| Q2 | 1 | 1 | 4 |
| October | 1 | 0 | 1 |
| November | 0 | 1 | 0 |
| December | 1 | 0 | 2 |
| Q3 | 2 | 1 | 3 |
| January | 1 | 0 | 0 |
| February | 0 | 1 | 3 |
| March | 0 | 1 | 1 |
| Q4 | 1 | 2 | 4 |
| **TOTAL** | **6** | **5** | **22** |




## 4.4 Mandatory reporting of Methicillin Sensitive *Staphylococcus Aureus* (MSSA)

No limit has been set for MSSA blood stream infections for Trusts. As the bacteria is commonly found on the skin of 30% of the general population, the most common source of infection is skin and soft tissue.






28 MSSA bacteraemia were reported which is higher than usual, 7 cases were diagnosed in patients on admission who had previous healthcare at ESHT within 28days and we cannot ascertain if we could influence these infections. 7 of the infections were identified as relating to skin soft tissue infections and a further 4 infections were associated with intravenous catheters. One of these infections was assessed as potentially avoidable, the patient was receiving total parenteral nutrition, which is higher risk of infection, via PICC line but there was insufficient documentation of the PICC assessment prior to the bacteraemia. Lessons shared with VAT team and clinical team.

### 4.5 Mandatory Surgical Site Infection Surveillance Scheme

Since 2004, all NHS Trusts undertaking orthopaedic surgery have been required to complete the mandatory surveillance study program devised by the Surgical Site Infection Surveillance Service (SSISS) for a minimum of three consecutive months per year, for one of four orthopaedic categories. A standardised set of demographic and operation-related details are submitted for every patient undergoing Hip and Knee Prosthetic Replacement Surgery including re-surfacing and revision (excluding 1st stage revision where spacer implant is used) as well as the surgical procedure, inpatient stay, post discharge reports and complete relevant data of any case readmitted with a SSI during the first post-operative year.

The service:

- Provides hospitals with a protocol and tools to collect and analyse data on SSI using the minimum set of data required to take account of key risk factors.
- Provides national data for use in benchmarking rates of SSI.
- Ensures high standards of data quality.
- Maintain, as far as possible, comparability with data previously collected so staff can evaluate trends over time.
- Analyses data to improve our understanding of SSI epidemiology.

ESHT have completed surveillance for two of the four categories and practiced a continuous study to establish any patterns or trends over time.

Surgical site surveillance is conducted prospectively and submitted quarterly. However, as results are influenced by infections that develop 365 days after surgery results are published 12 months retrospectively. Finalised results are available up to 31st March 2022.

**Core data 1st April 2021 – 31st March 2022**

| Category of surgery | Number of procedures | Number of infections | Infection rate | Mean infection rate for all participating Trusts (data April 2015 -March 2021) |
|---|---|---|---|---|
| Total hip replacement | 293 | 5 | 1.7 | 0.5% |
| Total knee replacement | 243 | 1 | 0.4 | 0.4% |

The infections that have been identified have been caused by methicillin resistant Staphylococcus aureus (MRSA), methicillin sensitive Staphylococcus aureus (MSSA), *Staphylococcus epidermis*, *Pseudomonas aeruginosa*, *Enterococcus faecalis* and unspecified aerobic cocci. There is no evidence to suggest cross infection.

ESHT reported a higher-than-average rate of infections in hip replacements for this period and an average rate for knees. This was discussed at the multi-professional SSISS meetings, and it was felt that the reason for the high infection rate was due to patients having significant comorbidities and becoming deconditioned whilst waiting for surgery due to the length of the waiting list. Patients are supported with optimising health prior to surgery by being offered the opportunity to be referred for weight loss support and smoking cessation, they will also be contacted if they are anaemic, and a treatment plan put into place.

There has been good engagement with the surgical site surveillance nurse, the orthopaedic teams, pre-assessment and physiotherapy.

The joint schools have started to run again, and patients have been supported to sign up for digital access to their notes through patients know best. Patients can then access a library which includes information on how to use the decolonisation body wash, recommendations for iron rich food prior to surgery and the contact details for the surgical site surveillance nurse including the questionnaire to return at 30 days. Patients that do not chose to participate are given the same information on paper.
The physio assistants have been alerting any concerns with wounds and patients have been reviewed in theatres.

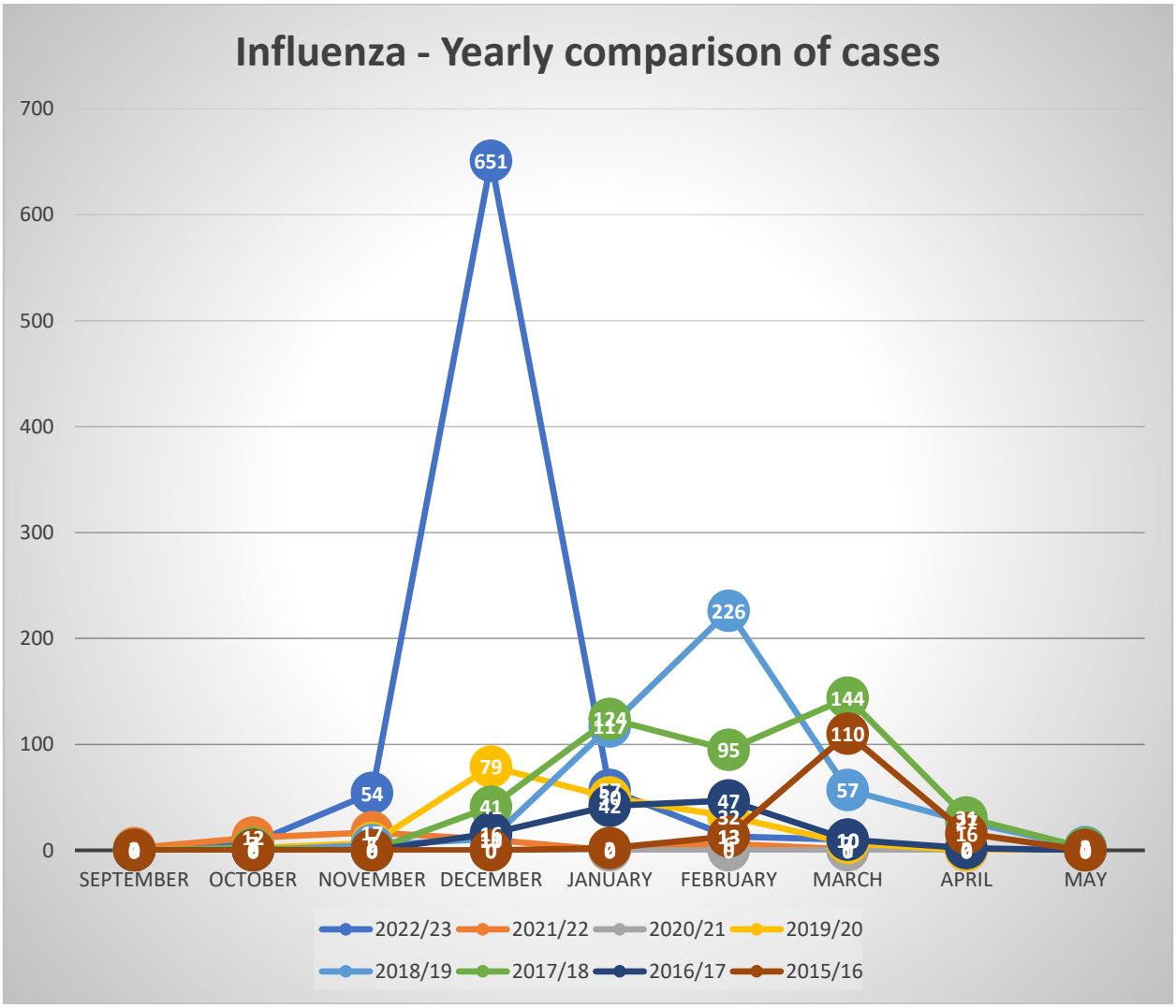
The pathway for using Pico dressings is being used for high-risk patients. This Pathway is supported by the NICE Guidance -Using PICO negative pressure wound dressing for closed incision management- MTG43.

The surgical site surveillance Nurse has been working alongside the preassessment team, orthopaedic consultants, theatres, ward staff and fracture clinic to complete the One Together audits. These audits ae looking at best practice and are supported by NICE guideline [NG125] Published date: April 2019. Surgical site infections: prevention and treatment. https://www.nice.org.uk/guidance/ng125 . The observations have been

completed and meetings are being scheduled to discuss the findings and agree action plans.

### 4.6 Influenza

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




A higher number of influenza infections were reported than ever before. This may be a consequence of increased testing as we now have a triplex test for COVID, flu and respiratory syncytial (RSV) virus and staff were well versed to undertake the test during winter season. Patient pathways were successfully developed with CAG to aim to keep patients with flu and COVID separate and avoid co-infection that could have greater consequence for patients

Once again, a successful campaign to vaccinate ESHT frontline clinical staff for flu and COVID booster was managed by Occupational Health and Wellbeing and successful utilisation of a peer vaccination scheme and COVID vaccination hubs.

## 4.7 Norovirus

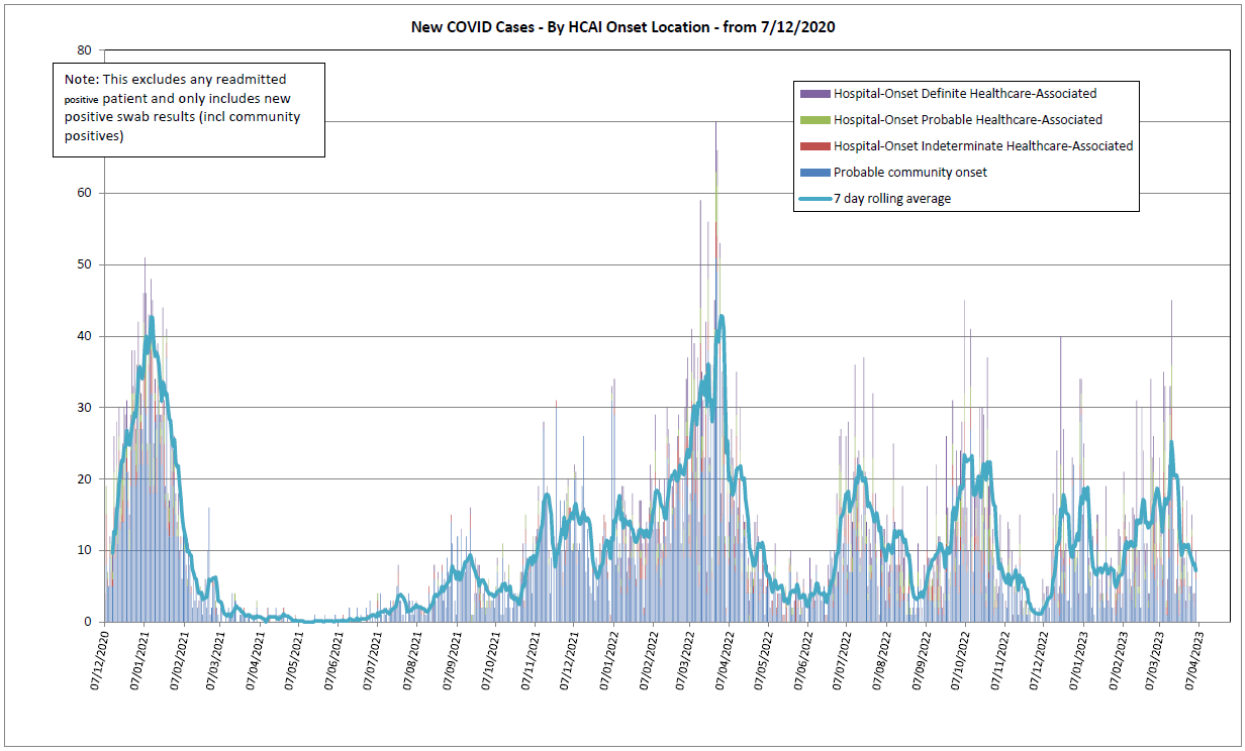
There was minimal Norovirus during the year, with six outbreaks (4 at EDGH and 2 at Conquest) small numbers of patients were involved and the outbreaks were of low operational and clinical impact.

## 5. Emerging Threats and Operational Preparedness

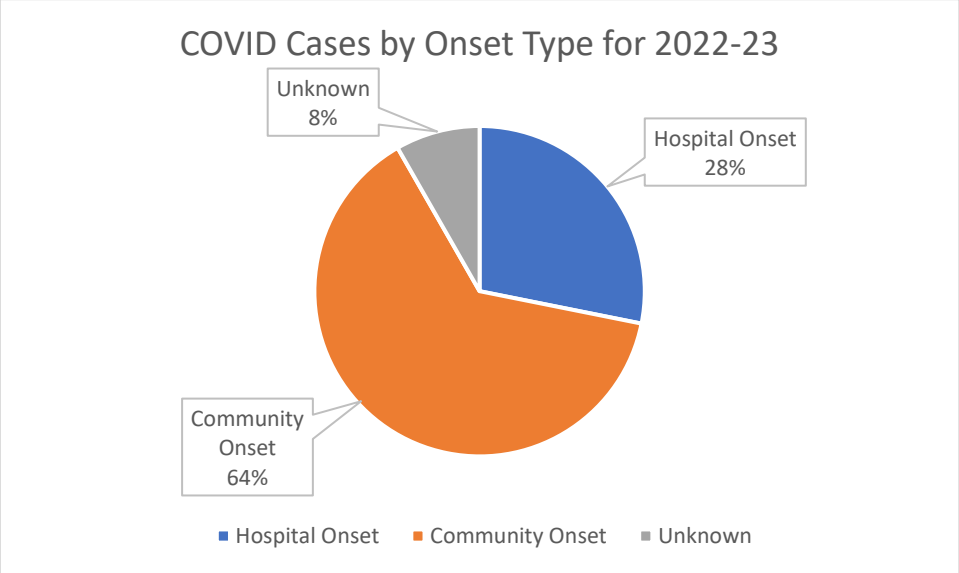
- The Trust 'Emergency Preparedness, Resilience & Response' (EPRR) Team is charged with ensuring that the Trust fulfils its roles under the Civil Contingencies Act 2004 and the NHS EPRR Framework, in ensuring the Trust is prepared to meet internal and external threats and can respond to a range of risk-assessed incidents as and when they occur.
- The EPRR Team remains fully linked to the Infection Prevention & Control Team, and as part of its remit, provides a horizon-scanning service, and is heavily engaged in risk-assessing identified threats and challenges.
- The EPRR Team will continue to work closely with the IPC Team to further develop the New Emerging Pandemics Plan which has been made a requirement under the EPRR Core Standards.
- There will be a focus over the next 18 months on working at service level to improve our overall resilience to such events via training and exercising.

## 5.1 SARS-CoV-2, COVID-19

The chart below shows the prevalence of COVID since December 2020. Over 3,000 patients were diagnosed during 2022/23 and this is largely a reflection of the local prevalence in East Sussex.



Testing and reporting in the community reduced therefore local prevalence was not readily known and only became evident when patient presented to hospital and were tested.




There were periods of high transmission within bays at at time multiple bays and wards were affected. Collaborative working between the operational site teams, clinical leads and IPC team managed to reduce the impact on services. Management COVID risk was regularly reviewed and discussed at CAG.

### 5.2 Respiratory Mask Fit testing

A dedicated team of four staff continued to provide fit testing for respiratory protection on fixed term contract basis. Of the 4694 staff eligible for fit testing; 93% have fit tested respiratory equipment. 44% are fitted to 2 or more current mask (up from 41%), 33% are fitted to 1 current mask and 7% staff have yet to attend or their mask fit has expired. 5.8% of staff are reliant solely on a respiratory hood for protection as have not passed on disposable masks.

## 6. Incidents related to Infection

### 6.1 Serious Incidents (SIs) and Risks Managed by the IPC Team

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

There were no IPC related incidents that required SI investigations. An amber investigation was undertaken in relation to a patient who had died of pneumonia and it

was felt that the hospital onset influenza infection had contributed to this as the patient was part of an outbreak on MacDonald ward when flu was circulating in the local population. The investigation concluded that the only way we could have prevented the spread of flu would have been if the patients were being cared for separately in single rooms. Given that the ward only four of the 28beds on the ward are in single rooms this was not possible at the time.

An investigation was undertaken to assess the relevance of four cases of MRSA colonisation throughout the year that appear to be the same and hospital onset in the Special Care Baby Unit. Outbreak control measures have been initiated. Environmental swabbing has not identified a source to date. In November 2022 we requested advice from UKHSA specialists who have advised that this was unlikely to be due to transmission between babies (as we thought) however they have advised that the results suggested that there is a common source of the MRSA which may be a shedding staff member or an environmental source. Staff screening was undertaken and did not isolate MRSA. It was suggested that we undertake enhanced testing of other MRSA positive samples to establish if this is unique to SCBU. Samples from other sources were not found to be the same as those on SCBU. There have been no further isolates of this type. The babies who were MRSA positive were considered to be colonised and there was no negative impact on health.

IPC also undertook an investigation of four cases of Pseudomonas related to Critical Care at Conquest. Environmental and equipment swabbing and review of practices did not identify a common source. We continue to monitor cases on the unit and map them by location to understand if there is a common risk factor.

In May an outbreak of Monkeypox was declared by UKHSA, that mainly related to London although many cases were reported in the Southeast. Monkeypox is usually a very rare infection with cases in the UK usually associated with travel and prior to May only 7 cases had been identified in the UK from 2018 to 2021. Mpox does not spread easily between people unless there is very close contact.

Spread of mpox may occur when a person comes into close contact with an infected animal (rodents are believed to be the primary animal reservoir for transmission to humans), human, or materials contaminated with the virus. Mpox has not been detected in animals in the UK.

The virus is transmitted through skin-to-skin contact, breathing in virus through the respiratory tract, or contact with mucous membranes (eyes, nose, mouth, genitals). Person-to-person spread may occur through:

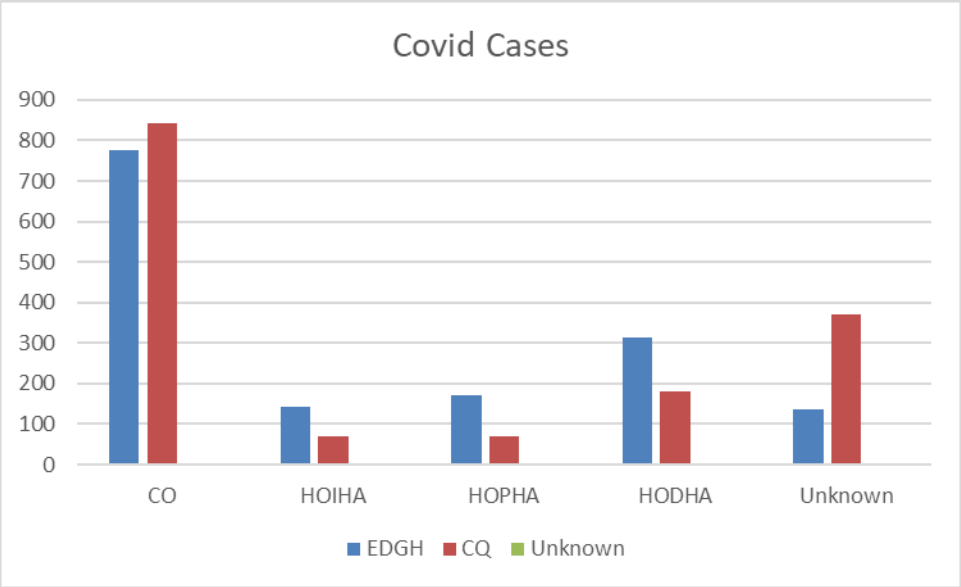
- direct contact with skin lesions or scabs (including during sexual contact, kissing, cuddling or other skin-to-skin contact)
- coughing or sneezing of someone who has mpox when they’re close to you
- contact with clothing or linens (such as bedding or towels) used by someone with mpox

The risk was managed collaboratively with by IPC agreeing guidelines and patient pathways with the CAG and sexual health services and supporting all services with interpretation of guidance. Several patients were confirmed with Monkeypox in our

region however there were no healthcare associated infections. Over 3700 cases have been reported in the UK, the outbreak is considered closed although ongoing vigilance is required.

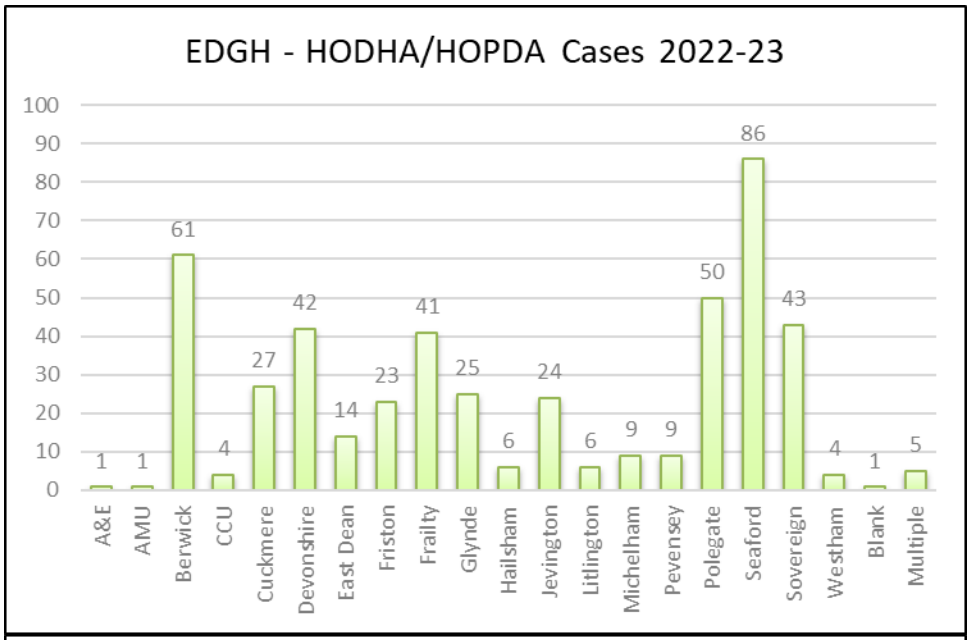
## 6.2 Outbreaks related to outbreaks of COVID

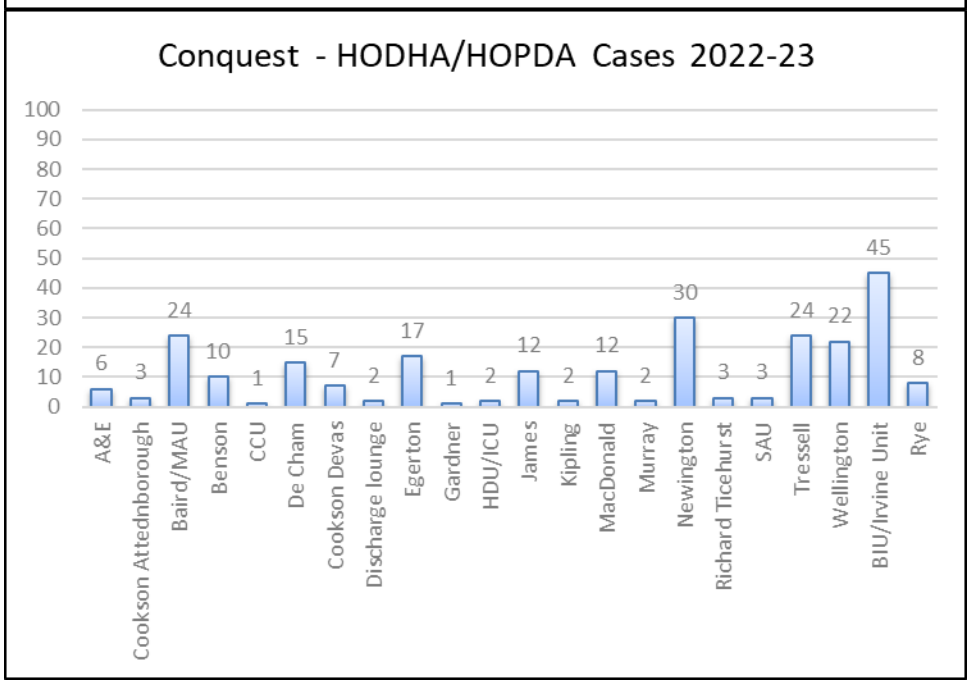
The table above shows the number of patients diagnosed on each acute site with COVID-19 at time admission or subsequently during their hospital stay. The requirement to report outbreaks externally changed in recognition that transmission within a bay is difficult to prevent. Only outbreaks that had significant impact were reportable.




Lessons learnt to date from early outbreaks both at local and national level are:

- There is increased evidence that airborne transmission occurs easily and therefore the percentage of people testing positive if sharing a common space will be high. As a result, ESHT staff have been advised to wear higher level respiratory protection when caring for COVID positive patients.
- The role of ventilation has been shown to be important in reducing transmission. The ventilation and air handling varies across the Trust, hepa filter units have been purchased to clean the air in a bay and thus improve air quality and try to reduce transmission.




There was higher transmission on Seaford ward and Berwick ward at EDGH. Patients could have been admitted to the ward incubating the infection but we noted that there was high transmission within bays on these wards. The bays on these wards do not have air exchange within the bays so additional hepafilters have been provided to improve air quality. The ventilation steering group has been established to aim to have greater understanding of air quality and how this can be improved.

## 7. Promoting Standard Infection Prevention Precautions

### 7.1 Hand Hygiene Promotion

The Trust IPCT continues to co-ordinate an annual programme to promote effective hand hygiene throughout the Trust including monitoring of compliance by clinical staff with monthly audits, training of ICLFs to undertake practical hand hygiene training of clinical staff. We continued to promote the importance of hand hygiene for staff, visitors

and patients including participation in the International World Hand Hygiene Month during May 2022.

## 7.2 Hand Hygiene Compliance

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

During this year, the decision to change the audit questionnaires was motivated by staff being able to perform their hand hygiene techniques correctly as advised by the UKHSA and WHO guidelines. The questionnaires also list the 5 moments of hand hygiene that improve the staff's awareness to be compliant in doing hand hygiene when performing various tasks in the point of care for both inpatients and non-inpatient areas. Previously, a "Fit to Care" hand hygiene compliance checklist was introduced for clinical teams working in environments such as clinical and community settings, which cannot be easily audited, to provide assurance that staff have undergone the correct IPC training and have the right equipment to be compliant with IPC policies. The audit questionnaire has been revised to provide greater assurance regarding competency as well as opportunity for hand hygiene.

The charts below provide details of the overall Trust compliance.

**Inpatient Areas 2022 – 2023**

| OVERALL INPATIENT AREAS COMPLIANCE SCORE FOR 2022 - 23 | EDGH Inpatients | CONQUEST Inpatients |
|---|---|---|
| **95%** | 96% | 95% |

| SITE | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|
| CONQUEST Inpatients | 99% | 98% | 82% | 99% |
| EDGH Inpatients | 99% | 98% | 90% | 98% |
| Total Average Score | 99% | 98% | 86% | 98% |

| Total Number of Audits Submitted for 2022 - 2023 | |
|---|---|
| CONQUEST Inpatients Areas | 9673 |
| EDGH Inpatients Areas | 8347 |
| Total Audits Submitted | 18020 |

| MONTHLY SCORES FOR INPATIENT AREAS | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SITE** | **April-2022** | **May-2022** | **Jun-2022** | **Jul-2022** | **Aug-2022** | **Sep-2022** | **Oct-2022** | **Nov-2022** | **Dec-2022** | **Jan-2023** | **Feb-2023** | **Mar-2023** |
| **CONQUEST INPATIENTS (INCLUDING SUSSEX PREMIER HEALTH, RYE AND IRVINE)** | | | | | | | | | | | | |
| Bare Below Elbows | 99% | 100% | 99% | 99% | 98% | 98% | 98% | 99% | 99% | 98% | 99% | 98% |
| Before patient Contact | 99% | 100% | 99% | 96% | 98% | 95% | 100% | 97% | 98% | 98% | 100% | 97% |
| After patient Contact | 99% | 100% | 100% | 98% | 98% | 99% | 100% | 97% | 98% | 98% | 98% | 99% |
| Hand Hygiene Technique | | | | | | | | | 98% | 99% | 100% | 99% |
| **EDGH INPATIENTS** | | | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BBE | 98% | 99% | 99% | 99% | 99% | 99% | 99% | 97% | 99% | 99% | 99% | 98% |
| Before patient Contact | 94% | 99% | 99% | 98% | 98% | 96% | 97% | 95% | 99% | 98% | 98% | 97% |
| After patient Contact | 100% | 99% | 98% | 99% | 99% | 94% | 97% | 100% | 99% | 98% | 99% | 95% |
| Hand Hygiene Technique | | | | | | | | | 98% | 99% | 97% | 94% |
| Total Score | 98% | 99% | 99% | 98% | 98% | 97% | 85% | 75% | 98% | 98% | 99% | 98% |
| Total Audits Done | 956 | 1200 | 1336 | 1351 | 1189 | 1291 | 1751 | 1793 | 1644 | 1788 | 1841 | 1880 |

## Non - Inpatient Areas 2022 – 2023

| OVERALL NON-INPATIENT AREAS COMPLIANCE SCORE FOR 2022 - 23 | OUTPATIENT AREAS | COMMUNITY AREAS |
|---|---|---|
| **84%** | 82% | 92% |

| SITE | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|
| Outpatient Areas | 86% | 87% | 79% | 80% |
| Community Areas | 100% | 84% | 91% | 99% |
| Total Average Score | 88% | 86% | 82% | 92% |

| Total Number of Audits Submitted for 2022 - 2023 | |
|---|---|
| Outpatient Areas | 2873 |
| Community Areas | 741 |
| Total Audits Submitted | 3614 |

**MONTHLY SCORES FOR NON-INPATIENT AREAS**

| SITE | Apr-2022 | May-2022 | Jun-2022 | Jul-2022 | Aug-2022 | Sep-2022 | Oct-2022 | Nov-2022 | Dec-2022 | Jan-2023 | Feb-2023 | Mar-2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Outpatient Areas | | | | | | | | | | | | |
| Bare Below Elbows | 100% | 100% | 100% | 99% | 100% | 98% | 99% | 99% | 99% | 99% | 100% | 99% |
| 5 Moments of Hand Hygiene | | | | | | | | | | 100% | 100% | 98% |
| Glow Box Training | 82% | 68% | 72% | 76% | 68% | 77% | 63% | 52% | 61% | 63% | 55% | 46% |
| Hand Hygiene Technique | | | | | | | | | | 100% | 100% | 99% |
| Community Areas | | | | | | | | | | | | |
| Bare Below Elbows | 0% | 100% | 100% | 96% | 100% | 56% | 97% | 92% | 100 | 100% | 100% | 100% |
| 5 Moments of Hand Hygiene | | | | | | | | | | 100% | 100% | 98% |
| Glow Box Training | 0% | 100% | 100% | 42% | 100% | 22% | 79% | 62% | 50% | 100% | 100% | 100% |
| Hand Hygiene Technique | | | | | | | | | | 0% | 0% | 100% |
| HH Kit available | 0% | 100% | 100% | 87% | 100% | 100% | 95% | 100% | 100% | 100% | 100% | 100% |
| Aware of replenishment process | 0% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Gel/Foam attached on the uniform | 0% | 100% | 100% | 100% | 100% | 67% | 92% | 96% | 50% | 100% | 100% | 87% |
| Total Score | 91% | 84% | 90% | 86% | 86% | 85% | 86% | 79% | 80% | 83% | 81% | 83% |
| Total Audits Done | 112 | 205 | 258 | 326 | 293 | 289 | 466 | 434 | 295 | 247 | 232 | 457 |

A total of 18020 audits were submitted for Inpatient areas with an overall score of 95% for the year 2022 – 2023. The quarterly score indicates that the staff in inpatient areas had been consistently adhered to the Hand Hygiene standards. However, the scores for Quarter 3 showed a significant drop in compliance levels, with EDGH scoring 90% and Conquest scoring 82%. It is essential to note that the drop in scores was likely due to the change in questionnaire in the audit, which could have caused confusion for staff on whether to use the new or old questionnaires. The IPCT has discussed this issue during the link meetings and provided support to ensure that the IPC link nurses is accurately answering the new questionnaires.

The Hand Hygiene compliance scores for the non-inpatient areas for 2022 – 2023 indicate poor compliance with an overall compliance score of 84%. The compliance score for outpatient areas is even lower at 82%, while the community areas show better compliance with an overall score of 92%. Quarterly audit scores show a fluctuation in compliance throughout the year, with Quarter 3 having the lowest compliance score with an average of 82% (outpatient areas having a compliance score of 79%). This is due to the staff answering “unknown” which counts as non-compliant for the question if the staff had their Glow box training in the last 12 months. The total audits submitted for 2022-2023 were very low, with only 3614 audits submitted in total. Outpatient areas had a much higher number of audits submitted, with 2873 audits, compared to the community areas, which only had 741 audits submitted. The audit questionnaire for non-inpatient areas was updated in Quarter 4, showing higher compliance scores of 99-100% for staff performing hand hygiene technique correctly and being able to enumerate the 5 moments of hand hygiene.

The Hand Hygiene audit scores for the year 2022 – 2023 show that ESHT has maintained compliance with the standards for Hand Hygiene for the Inpatient areas. While the compliance score for the non-Inpatient areas were lower, this was due to staff answering “unknown” and therefore counted as non-compliant. Overall, the compliance for ESHT staff adhering to the WHO’s 5 moments of Hand Hygiene and performing hand hygiene technique correctly were very high.

### 7.3 Infection Prevention & Control Compliance Monitoring Programme

The Infection Control Associate Practitioners undertake compliance monitoring and with the ICNs they support those services where compliance is found to be reduced.

**Conquest**

| **Annual Summary for the Year 2022/23** | | |
|---|---|---|
| | | |
| **MRSA Compliance Monitoring** | | |
| | **Number** | **Percentage (%)** |
| No. of patients with MRSA or history of MRSA | 164 | |
| Compliant | 140 | 85 |
| Non-compliant | 24 | 15 |
| | | |
| **Hand Hygiene Audit** | | |
| | **Number** | **Percentage (%)** |

| | | |
|---|---|---|
| Total audits undertaken | 307 | |
| Compliant | 239 | 78 |
| | | |
| **Universal Precaution/PPE Audit** | | |
| | **Number** | **Percentage (%)** |
| Total audits undertaken | 248 | |
| Compliant | 194 | 78 |
| Non-compliant | 54 | 22 |
| | | |
| **Bare Below Elbow Audit** | | |
| | **Number** | **Percentage (%)** |
| Total audits undertaken | 709 | |
| Compliant | 698 | 98 |
| Non-compliant | 11 | 2 |
| | | |
| **Commode Audit** | | |
| | **Number** | **Percentage (%)** |
| Number of commodes audited | 200 | |
| Compliant | 169 | 85 |
| Non-compliant | 31 | 15 |
| Commode with bodily fluid | 31 | 100 |
| Commode damaged | 0 | 0 |
| Commode with lid missing | 0 | 0 |
| Other non-compliance | 0 | 0 |
| | | |
| **Sharps Bin Audit** | | |
| | **Number** | **Percentage (%)** |
| Number of sharps bins audited | 220 | |
| Compliant | 199 | 90 |
| Non-compliant | 21 | 10 |
| Sharps bin with blood | 10 | 48 |
| Lid open when not in use | 4 | 19 |
| Other non-compliance | 7 | 33 |

Feedback has been given to the nurse in charge/Matron following all the audit/compliance monitoring. The staff who were found to be non-compliant were spoken to and advice was given on the reason for non-compliance and what they should have done differently.

**EDGH**

The IPC Practitioner only started in role in January 2023, so only a limited number of audits were undertaken for this year.

| **Annual Summary for the Year 2022/23** | | |
|---|---|---|
| | | |
| **MRSA Compliance Monitoring** | | |

| | Number | Percentage (%) |
|---|---|---|
| No. of patients with MRSA or history of MRSA | 10 | |
| Compliant | 6 | 60 |
| Non-compliant | 4 | 40 |
| | | |
| **Commode Audit** | | |
| | **Number** | **Percentage (%)** |
| Number of commodes audited | 13 | |
| Compliant | 10 | 77 |
| Non-compliant | 3 | 23 |
| Commode with bodily fluid | 3 | 100 |
| Commode damaged | 0 | 0 |
| Commode with lid missing | 0 | 0 |
| Other non-compliance | 0 | 0 |

Compliance monitoring by the IPC associate practitioners provides a non-bias assessment of the clinical environment with real time feedback to clinical leads to promote best practice. The work is undertaken in addition to the national cleanliness audits and hand hygiene audits.

### 7.4 Training and Education

The IP&C specialist nurses provide a comprehensive training and education programme for all Trust staff and volunteers related to all aspects of infection prevention and control, both planned and as required. Infection Prevention and Control is part of mandatory induction and update. Compliance with mandatory IPC training remained above 85% overall for ESHT. Medicine and Urgent care divisions have struggled to achieve 85% at times due to staffing challenges and operational surge during the year.

The new national IPC manual for England has been launched and the team are focusing on ensuring clinical staff are aware and can benefit from this new resource.

### 7.5 Professional Development

Specialist nurses within the team maintain professional competence and attend relevant study and training. Networking with other clinical specialists is supported through attendance at regional meetings which have taken place online in the past year. The team have accessed online training and seminars to gain knowledge of emerging infections of concern.

Several members of the IPC team have successfully completed IPC and leadership training provided by NHS England in support of IPC following pandemic.

## 8. Maintaining a Clean Environment that Facilitates the Prevention and Control of Infection

The National Specification of Cleanliness (NSC) audits continue to be monitored via the Patient Environmental Action Meeting (PEAM) and the Trust Infection Prevention control group (TIPCG) and the Divisional Integrated Performance Reviews.

We have restructured the department changing the reporting lines and introducing a completely new team of auditors at Eastbourne. The Trust NSC target score for Clinical equipment and Housekeeping was assessed as >92%, overall, this was achieved although there were some low scoring areas. Where an area has consistently scored low, they are asked to attend the Patient Environmental Audit Meeting (PEAM) to provide assurance of the actions being taken to address the low compliance and this is discussed at the TIPCG which is chaired by the DIPC.

| | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| House Keeping | 94.87% | 94.19% | 96.08% | 95.39% | 94.90% | 94.01% | 94.39% | 94.91% | 95.17% | 95.43% | 94.72% | 95.23% |
| Clinical Staffing | 88.26% | 83.89% | 87.52% | 85.88% | 86.79% | 91.57% | 87.10% | 86.43% | 88.65% | 89.86% | 88.02% | 93.93% |
| Estates | 92.10% | 86.69% | 87.75% | 87.02% | 91.51% | 92.66% | 95.16% | 95.43% | 95.39% | 95.40% | 95.12% | 93.50% |

The Clinical Orderly role continues to support cleaning of clinical equipment, where there are some vacancies, some areas have struggled to maintain the high scores, particularly in the community sites. Estates scores are considered as either a cleanliness or a maintenance concern. Cleanliness is reported and discussed at PEAM. Maintenance issues are directed straight to Estates department. Most estates failures are around maintenance issues relating to aging infrastructure which requires investment, works are prioritised by risk; the average annual cleanliness score for estates (90%) is compliant with NSC. It is anticipated that forthcoming “Building for Our Future” project work being led by our Estates and Facilities team, will significantly improve the standards of the estate.

**New National Standards of Cleanliness**

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

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

In addition, the audit scoring reporting methodology has now changed to show as a star rated system rather than a % score. The new standards were implemented from May 2022.

## 8.1 Housekeeping

The Housekeeping services for ESHT continue to be provided by the in-house team within Facilities. Housekeeping resources are matched to each area in line with the National Specification for Cleanliness (NSC 2021). We continue to clean with bleach based products as we recover from the pandemic.

## 8.2 Deep Clean Programme

The Rapid Response team continue to provide cover 24/7 and are an integral part of the housekeeping team. We have seen a rise in deep clean requests peeking at an average of 1000 per month. Although the numbers have dropped slightly since Feb 2022, they remain significantly higher than pre-pandemic.

| Years | 20/21 | 21/22 | 22/23 |
|---|---|---|---|
| Av. No. of Deep cleans carried out on the Acute Sites | 1103 | 855 | 977 |

22/23 – Highest month in this year was January 2023 with 1645 cleans and the lowest month was September 2022 with 635 cleans.

It has been challenging to undertake hydrogen peroxide vaporisation treatment of clinical environments due to the lack of decant facilities while there is increased bed occupancy. This has been mitigated by ensuring that deep cleaning is undertaken by the rapid response team of housekeepers who have dedicated resource for this environmental decontamination.

## 9. Antimicrobial Stewardship Activities and Innovation

The Trust Antimicrobial Stewardship Group (ASG) core membership consists of a consultant medical microbiologist, antimicrobial pharmacist, and a ICB representative.

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

This is achieved by:

- Developing and maintaining evidence based antimicrobial policies and guidelines for use in secondary and primary care
- Developing a strategic plan with the aim to continuously improve antimicrobial prescribing practice
- Ensuring safe and cost-effective antimicrobial use.
- Monitoring antimicrobial expenditure data and addressing identified issues
- Undertaking audit on antimicrobial prescribing practice and providing feedback to TIPCG, ASG and MOG
- Providing advice to other specialist groups/committees on antimicrobial use
- Providing education to staff on all matters relating to antimicrobials.
- Educating patients and members of the public on antimicrobial stewardship
- The lead antimicrobial pharmacist providing feedback from lesson learnt, following a Post Infection Reviews to the pharmacy team.

The Adult and Paediatric antimicrobial guidelines are reviewed, on a regular basis, by the Antimicrobial Stewardship Group (ASG). The guidance is evidence based and Consultants and/or Allied Health professional (AHP) are consulted. Any major change to the Trust antimicrobial guidance must be submitted to the Medicines Optimisation Group (MOG) for consideration.

### 9.1 Multi-disciplinary team (MDT) Ward Rounds

The aim of MDT ward rounds provides specialist advice on antimicrobials.

The ward round should reduce the inappropriate prescribing of antibiotics, treatment failure rate and the development of antimicrobial resistance.

Regular AMS MDT ward rounds are undertaken in the following areas:

- Diabetic Foot Management
- Orthopaedics
- Acute medical units
- Wards highlighted by Infection control team e.g., CDI rate
- Endocarditis (TBC)
- Intensive Care Units

AMS wards rounds are targeted to a ward or area with a concern, for example a ward with an unexpected high use of broad-spectrum antibiotics. In addition, the ward round provides support to the prescribing team with specialist input into the highest risk and/ or most critical patients in the hospitals.

The review of antimicrobial prescribing follows standards outlined in the PHE “Start Smart then Focus” document (March 2015).

The AMS ward round has made several interventions that include.

- Stopping treatment.
- Escalating / de-escalating treatment.
- Switching administration route from an intravenous to oral treatment.
- Continuing current treatment and providing advice on duration/review date.
- Providing advice to the medical or surgical team on the prescribing of antibiotics for a CDI antigen or toxin positive patient.

### 9.2 Training

An in-house on-line module is used for induction and the 3 yearly assessment.

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

As part of the FY1/FY2 induction pharmacy provides an overview on antimicrobial prescribing and what support is available. Also, there may be a microbiologist training session on antimicrobial use.

### 9.3 Antibiotic Incident Reports

The lead antimicrobial pharmacist is involved in reviewing of incidents reported on Datix involving antimicrobials. An Antimicrobial and Ward Pharmacist should attend Post Infection Reviews (for example CDI) and provide feedback to the pharmacy team. In addition, the lead antimicrobial pharmacist may be asked to provide detail to a Freedom of Information request, and any investigations.

### 9.4 Audit of Antimicrobial Usage

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

To help provide assurance on AMS practice, pharmacy undertakes a monthly antimicrobial stewardship audit. The audit should identify AMS issues and highlight areas for improvement. If warranted, the concern will be escalated to the Antimicrobial Stewardship and Infection Prevention and Control Groups

The electronic prescribing and medication administration system (ePMA) is partially rolled out. The ePMA system helps pharmacy identify antimicrobial prescribing, and to prioritise patients to be reviewed for the AMS MDT ward round.

### 9.5 National Contract

ESHT must use all reasonable endeavours, consistent with good practice, to reduce its Broad-Spectrum Antibiotic Usage (measured in each case against the Broad-Spectrum Antibiotic Usage 2018 Baseline) by 4.5% by 31 March 2023.

For 2022/23, there was an increase of 26% for WHO categories Watch and Reserve, and an increase of 5% for total antimicrobial use.

Part of the increase in WHO Watch and Reserve antibiotics was driven by the expansion of the OPAT service – through the introduction of the virtual ward and crisis response team service.

The reasonable endeavours undertaken by the AMS team, included an increase in AMS ward rounds (to include broad spectrum antibiotic prescribing e.g., Meropenem), review of antimicrobial trend (use/supply) by ward, monitoring prescribing per policy and ongoing review of Trust antimicrobial guidance.

Pharmacy to challenge inappropriate antimicrobial prescribing. However, due to staffing level this was not always possible.

## 10. Water Safety

The Trust water safety Group reports to the TICPG quarterly. There is a robust programme of work to manage the risk from water related pathogens such as Legionella species and Pseudomonas species. The Trust water safety group agreed to installation of copper silver treatment at Conquest with the intention of reducing the need for remedial work to control the risk from waterborne pathogens. There have been no reported cased of healthcare related Legionella infection. Hospital onset pseudomonas infection is monitored and if two cases are associated with the same environment and the same time the IPC undertake investigation as per the outbreak policy. Additional IPC measures have been required in Critical Care in response to clusters of cases that have not been proven to be related but occurred at the same time, The Trust water systems have not been shown to be the source of infection although point of use filters and additional disinfection of water outlets is undertaken as part of our response to a period of increased incidence.

**Trust Policy**
The Trust has in place a Water Safety Policy to confirm responsibilities and arrangements for Water Safety Management. The Policy has been approved by TIPCG and Ratified by the Trust Policy Group in November 2020. The Policy has been updated and sent to the TIPCG members for approval.

**Water Safety Group (WSG)**
The Trust has a well-established Water Safety Group (WSG) which meets every 4 months to provide strategic management of the Trusts' water systems and practices. The most recent meeting was on 15th June 2023.

**Water Safety Risk Assessment**
The Trust is required to undertake Risk Assessments to identify the potential hazards which may be present from water systems and their use; and to identify the control measures to eliminate or reduce the risks of ill health.

Water Risk Assessments have been completed for all sites owned/leased by the Trust.

Schedules of the Remedial works, from the risk assessments, has been compiled and a number of the maintenance tasks have been completed in-house. More complicated and labour-intensive works are currently being contracted out with a view to completion, of at least the higher risk priorities, to be scheduled for the next 3 years.

*Pseudomonas* Risk assessments have been commissioned and are currently underway, to be completed in October 2023.

**Water System Schematics**
It is a legal requirement to have in place accurate schematics of Water Systems to demonstrate the organisation has a good understanding of its water systems.

Water Schematics for Eastbourne, Conquest and Bexhill have been prepared.

**Water Safety Plan (WSP) and Legionella Written Schemes of Control (WSoC)**
The Trust has in place a Written Water Safety Plan and Summary Compliance Report is reviewed and updated for the Water Safety Group (WSG) each quarter.

**Written Schemes of Control (WSoC)** are in place for each site and are currently being reviewed and updated.

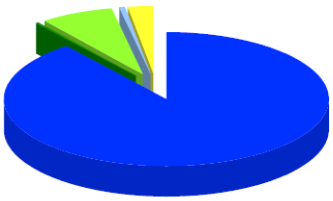
**Maintenance**
The Estates Department has in place a comprehensive Computer Aided Facilities Management (CAFM) System which used to plan and monitor maintenance issues.

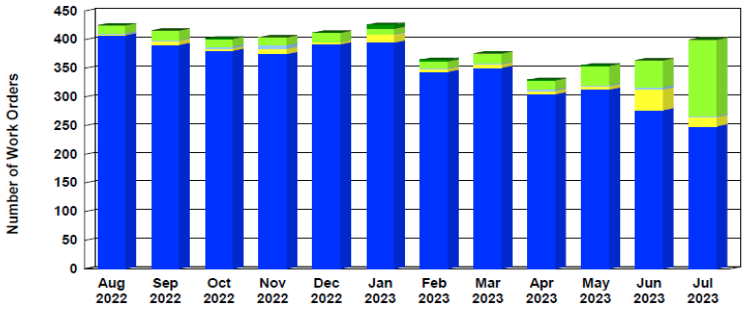
**Planned Maintenance**

**Work Order Life Cycle Status Statistics**

NHS East Sussex Healthcare NHS Trust

| | |
|---|---|
| End Month | July 2023 |
| Enable Drilldown * | Yes |
| Work Order Group | Water Systems / Equipment |
| Source | Planned |
| Life Cycle Status | All except Discarded |
| Session Time Zone | Europe/London |






| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 0.00% | Pending | | | | | | | | | | | |
| | 114 | 2.44% | Notification Due | | 1 | 7 | 4 | 9 | 4 | 14 | 5 | 6 | 6 | 6 | 36 | 16 |
| | | | Discarded | | | | | | | | | | | | | |
| | 25 | 0.53% | On Hold | | 2 | 1 | 3 | 6 | | 1 | 1 | 1 | 2 | 2 | 4 | 2 |
| | 342 | 7.32% | Open | | 14 | 17 | 13 | 14 | 16 | 9 | 12 | 18 | 16 | 33 | 47 | 133 |
| | 13 | 0.28% | Resolved | | | | 1 | | | 7 | 3 | | 1 | 1 | | |
| | 4,181 | 89.43% | Completed | | 408 | 391 | 381 | 375 | 392 | 395 | 344 | 351 | 305 | 313 | 277 | 249 |
| Totals | 4,675 | | | | 425 | 416 | 402 | 404 | 412 | 426 | 365 | 376 | 330 | 355 | 364 | 400 |

## Microbiological Sampling

### Legionella Sampling:

A revised Legionella sampling regime has been put in place, with the exception of Eastbourne which is currently under review. The Results are reviewed and corrective measures taken.

### Pseudomonas Sampling:

Samples for Pseudomonas aeruginosa sampling is carried out every 6 months. The sampling regime has been reviewed and updated.

### Independent Adviser

The Trust employees the services of an Independent Advisor for Water Safety Issues, currently Alan Hambidge of Empathy Limited, who is a member of the Trust Water Safety Group. An Audit is carried out each year and is planned for December 2023.

### Summary of Current Risks:

| # | Description | Risk | Actions | Target date |
|---|---|---|---|---|
| 1 | Localised colonisation of tap outlets in augmented care areas at Conquest Hospital. | ↓ Low | Extended flushing of water outlets. Disinfection and introduction of Point of use filters on outlets with elevated microbial samples. **Copper/Silver Ionisation has been** | Continuous |

| | | | | |
|---|---|---|---|---|
| | | | **Installed (December 2021) and has significantly reduced the Risk.** | |
| 2 | Lack of current Water Risk Assessments at Acute Sites. | ⬇ **Low** | Undertake Water Risk Assessment re-assessments. **Completed at all sites.** | September 2022 |
| 3 | Completion of remedial tasks following Water Risk Assessments. | ➔ **High** | Completion of, at least high priority, remedial tasks. | March 2025 |
| 5 | Risk of patients being exposed to Legionella bacteria due to poor water management at Rye Hospital. | ➔ **Moderate** | ESHT working with landlords to ensure effective water safety management.<br>Chlorine Dosing System Installed in 2021.<br>Risk Assessment and WSoC due in August 2022. | September 2022 |
| 6 | System colonisation of HSDU water system due to failure of Water Treatment Plant on Bore Hole and very poor condition of water pipes. | ➔ **High** | Local disinfection and POU Filters added.<br>Water Treatment Plant to be replaced.<br>Water Pipes to be replaced. | December 2022<br><br>TBC |

## 11. Risk Register

A new risk was added in relation to the potential risk relating to the limited use of specific kits to facilitate complex orthopaedic surgery. The risk has been assessed with members of the decontamination group and additional information received from the company. The risk was recorded on the risk register for Orthopaedics and overseen in the decontamination group and TICPG. Processes have been agreed to mitigate the risk and it has been acknowledged that for a very small number of patients the use of the kit is important. There have been no infections attributed to the use of the kit to date.

Ongoing risks include lack of isolation facilities, inability to carry out planned deep cleaning due to lack of decant facilities.

**Appendix 1 – TIPCG Reporting Schedule for 2022-23**

| Reporting Item | Apr 22 | May 22 | June 22 | July 22 | Aug 22 | Sept 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Mar 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HCAI Update Report | Cancelled | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Cancelled | ✓ | ✓ | ✓ |
| IPC BAF | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ |
| PEAM minutes and NSC Audit Report | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ |
| Annual Programme of Work and Regulation 12 | | | | | | | | | | | ✓ | |
| Serious Incident and Amber Report Action Log | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ |
| Emergency Preparedness Group Minutes *(for information)* | | | ✓ | | | ✓ | | | | | | |
| Trust Decontamination Group Minutes *(for information)* | | | | | | | | | | | ✓ | |
| Antimicrobial Stewardship Group/Pharmacy Report | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ |
| DAS Report | | ✓ | | ✓ | | | ✓ | | | ✓ | | |
| Medicine Report | | ✓ | | ✓ | | | ✓ | | | ✓ | | |
| WC&SH Report | | ✓ | | ✓ | | | ✓ | | | | | ✓ |
| Maternity Report | | | | | | | ✓ | | | | | ✓ |
| Urgent Care Report | | ✓ | | ✓ | | | ✓ | | | | | ✓ |
| CHIC Report | | ✓ | | ✓ | | | ✓ | | | ✓ | | |
| Core Services Report | | | | | | | ✓ | | | | ✓ | |
| Sussex Premier Health Report | | | | | | | ✓ | | | ✓ | | |
| Quarterly HCAI Report | | | | ✓ | | | | | | | | |
| Water Safety Group Report | | ✓ | ✓ | | ✓ | | | ✓ | | | | ✓ |
| Estates & Facilities Report Quarterly Report | | | ✓ | | ✓ | | | ✓ | | | ✓ | |
| Decontamination Group Progress Report | | ✓ | | | ✓ | | | ✓ | | | ✓ | |
| CEF Report | | | ✓ | | | ✓ | | | | | | ✓ |
| SSISS Quarterly Report | | | ✓ | ✓ | ✓ | ✓ | | | | | | |
| Risk Register (all Trust risks linked to IPC) | | | ✓ | | | ✓ | | | | | | ✓ |
| Flu Planning | | | | | | | ✓ | | | | | |
| Infection Prevention & Control Annual Report | | | | | | | ✓ | | | | | |
| Policies | | | | | ✓ | | ✓ | | | | | ✓ |