EAST SUSSEX HEALTHCARE NHS TRUST

BOARD OF DIRECTORS

TRUST BOARD MEETING IN PUBLIC

LECTURE THEATRE, EDUCATION CENTRE, CONQUEST HOSPITAL

10TH DECEMBER 2024, 09:30-12:45

East Sussex Healthcare NHS Trust Board Agenda

Date: Tuesday 10th December 2024

Time: 09:30 – 12:45

Venue: Lecture Theatre, Education Centre, Conquest Hospital

	Opening Business	Lead	Action	Time	Enc.
1.	Welcome and apologies	Vice-Chair	Information	09:30	
2.	Colleague Recognition	Vice-Chair	Information	09:30	Yes
3.	Veteran Awareness	Sarah Feather/Garry East	Information		Yes
4.	Declarations of Interest	Vice-Chair	Information		
5.	Minutes of Trust Board Meeting in public 08.10.24	Vice-Chair	Approval	09:45	Yes
6.	Matters Arising	Vice-Chair	Approval		Yes
7.	Chief Executive's Report • 65 week wait letter	Acting CEO	Information	09:50	Yes
8.	Committee in Common Update	Acting CEO/ Vice-Chair	Information	10:00	Yes
9.	Board Committees Chair's Reports	Committee Chairs	Assurance	10:00	Yes
Quality, Safety and Performance					
10.	Integrated Performance Report, Month 7 (October) (i) Chief Executive Summary (ii) Quality & Safety (iii) Our People (iv) Access and Responsiveness (v) Financial Control and Capital Development	Acting CEO CNO/CMO Acting CPO COO CFO	Assurance	10.10	Yes
11.	Maternity Overview Q2	DOM	Assurance	11:05	Yes

Break – 10 minutes

Governance and Assurance					
12.	1. Freedom to Speak Up Guardian Update 2. Trust Response	Acting CEO Acting CPO	Assurance	11:35	Yes

13.	Annual Reports: 13.1 Infection Control 13.2 Safeguarding 13.3 Organ Donation 13.4 Guardian of Safe Working Hours	CNO CNO COS CMO CMO	Assurance	11:45	Yes
For Information					
14.	Use of Trust Seal	Vice-Chair	Information	12:15	Yes
15.	Questions from members of the public	Vice-Chair		12:15	
16.	Agenda Forward Plan	-	Information	12:30	Yes
17.	Date of Next Meeting 25th February 2025	Vice-Chair	Information		
18.	Close	Vice-Chair			

Key:	
Chair	Trust Chair
Acting CEO	Acting Chief Executive
CNO	Chief Nurse and DIPC
COO	Chief Operating Officer
CFO	Chief Finance Officer
COS	Chief of Staff
CMO	Chief Medical Officer
Acting CPO	Acting Chief People Officer
DOM	Director of Midwifery

Steve Phoenix
Chairman

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: 2025

Month	Location	Timing	Any other information
25th February 2025	St Mary's Boardroom, EDGH	0930-1245	
22nd April 2025	Bexhill	0930-1245	Venue TBC
24th June 2025	Lecture Theatre, Conquest Hospital	0930-1245	
26th August 2025	St Mary's Boardroom, EDGH	0930-1245	
23rd September 2025 (**AGM**)			Venue TBC
28th November 2025	Bexhill	0930-1245	Venue TBC
23rd December 2025	Lecture Theatre, Conquest Hospital	0930-1245	

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	Trust Board	**Date of Meeting**	10 December 2024
Report Title:	Colleague Recognition		
Purpose of the Report/Outcome/ action requested:	The Board is asked to receive this report for information and to receive assurance about the formal recognition of our people over the last two months.		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐		
Authority for Decision:	Not applicable		
Executive Summary	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. This is an opportunity for the Trust to acknowledge the exceptional performance, behaviour, achievements and contribution that our colleagues and volunteers have made to the organisation.		
Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	4	**Appendixes**	No
Name, position and contact details of author:	Melanie Adams, People Experience Manager Melanieadams1@nhs.net		
Report Sponsor	Jacquie Fuller, Assistant Director of HR – People Engagement	**Presenter:**	Steve Phoenix, Chair
Governance and Engagement pathway to date:			
What happens next?	Changes made to policy will be communicated across the organisation		
Publication	Yes		

The last two months has seen the launch of retirement celebration events hosted by the Chairman and funded by East Sussex Healthcare Charitable Fund. These events have been held at the Conquest Hospital and Eastbourne DGH where colleagues have been presented with a framed retirement celebration certificate. Feedback so far is that the events have been extremely well received by our retiring colleagues. The celebration events will take place on a monthly basis, alternating between the two main acute sites.

In January we will be moving to five yearly intervals for long service recognition, an increase from 10, 25 and 40+ years' service. Additionally, long service will now take into account continuous NHS service, rather than service specific to this trust and reporting arrangements have been reviewed to accommodate these changes. Colleagues will be notified early in the new year and the improved long service recognition will provide greater opportunity for divisional and trust-wide recognition of the contribution and effort our people make.

The Partnership Forum was asked to consider the current annual trust awards model and gain feedback from across the organisation on whether it continued to meet the needs of the trust. The feedback is being reviewed and considered, with a recommendation to be made to the Executive Leadership team in the near future.

Hero of the Month

August 2024

Winner – Kelly Death, Clinical Research Midwife, Corporate Division

'Kelly is a Clinical Research Midwife who, through determined pursuit and skilled negotiation has worked to generate enormous change within the culture and working practices in midwifery. Solely as a result of Kelly using her position, passion and determination, the OBS UK study was opened at ESHT. OBS UK (obstetric bleeding study UK) will make childbirth safer through introducing new equipment that can assess the optimal intervention to treat maternal bleeding.

OBS UK aims to concurrently change the culture in obstetrics to de-normalise blood-loss in childbirth. This study was complex to negotiate set-up, involving multiple departments and directorates. Kelly showed enormous integrity and grit in successfully and persistently working to overcome barriers to opening OBS UK; initiating, overseeing and supporting every department involved to understand the virtues and necessity of opening OBS UK at ESHT.

Kelly's unfailing thoughtfulness and kindness in supporting, explaining and guiding staff has resulted in many people being involved, and in doing so they have been upskilled within their areas of expertise, and beyond. Many staff have gained insight and skills in the requirements and practices of Clinical Research. As a direct result of the formal qualifications MANY staff have gained thanks to Kelly's determination in opening OBS UK at ESHT, we are more strongly positioned to positively influence the direct care and standards of people birthing at ESHT.

Inclusivity is impacted through Kelly's actions because the safety of minority individuals more adversely affected in childbirth is being actively addressed and improved. Kelly has worked hard to ensure inclusion in Clinical Research for the OBS UK cohort- every birthing person at ESHT can expect to receive safer care as a result.

Kelly's input into OBS UK has brought income to the Trust to generate additional employment, raised standards of care and safety, and increased the capacity our staff have to participate in future research. Kelly's determination in opening OBS UK has also resulted in ESHT achieving record-breaking number Clinical Research recruitment numbers this year.

It cannot be overstated how the staff, patients and reputation and future of ESHT will benefit from Kelly's modest way of working - she is an inspiring colleague, and asset to ESHT who embodies the Trust values. Kelly deserves widespread recognition for her wealth of skills and achievement.'

Long Service Awards

October 2024				
10 Years' Service		**25 Years' Service**		**40 Years' Service**
Aisha Atkinson		Katherine Baker		
Julie Ball		Lisa Church		
Lauren Benton		Sylvia Harris		
Hannah Clark		Mark Hawkes		
Lauren Deadman		David Lewis		**50 Years' Service**
Jennifer Dickson		Mahesh Narayan		
Andrew Donno		Maria Ravelo		
Emma Fairweather		Esperanza San Juan		
Lena Fouracre		Tristan Sherwood		
Donna Headech		Maria Singson		
Emma Heskett		Jesus Uyengco		
Kim McGowan		Charito Uyengco		
Kamala Pandey				
Laura Pattenden				
Stephen Roberts				
Frances Samuels				
Katrina Sawyer				
Kirsti Severino				

Celebrating our people

Leanne Wood receiving her 10 years' long service award

Linda Wratten receiving her retirement celebration certificate

Rachel Brook receiving her retirement celebration certificate

Gillian Grattan receiving her retirement celebration certificate

Our colleagues who retired in November with Steve Phoenix, Chairman

NHS
East Sussex Healthcare
NHS Trust

Being a Veteran Aware Trust

VETERAN AWARE

EMPLOYER RECOGNITION SCHEME

SILVER AWARD
Proudly supporting those who serve.

ARMED FORCES COVENANT

KINDNESS

INCLUSIVITY

INTEGRITY

Our Journey so far

East Sussex Healthcare NHS Trust

- **Launched initiative to become Veteran Aware**
- **Over 25 staff volunteered to join the Steering Group**

September 2023 - Steering Group Formation

November 2023: Armed Forces Covenant

- Chief Executive signed the Armed Forces Covenant

February 2024: Bronze Award

- Awarded Bronze Defence Employer Recognition Scheme (ERS) status

March 2024: Veteran Aware Accreditation

- Officially accredited as a Veteran Aware Organisation

Armed Forces Week June 2024:

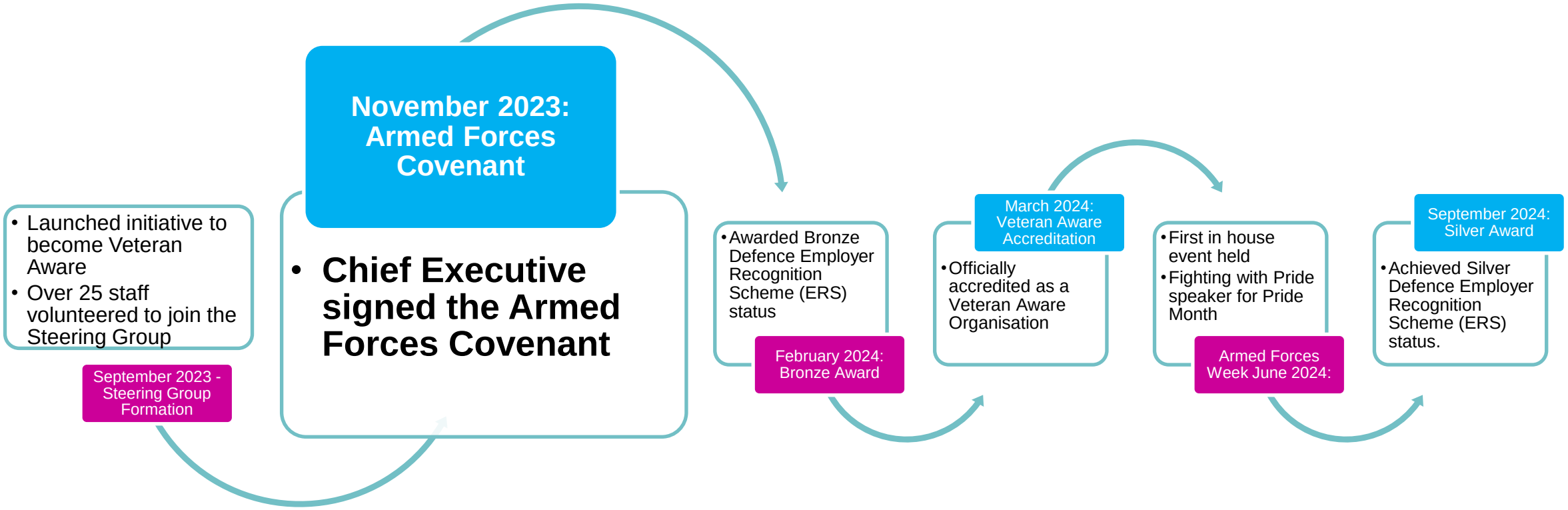
- First in house event held
- Fighting with Pride speaker for Pride Month

September 2024: Silver Award

- Achieved Silver Defence Employer Recognition Scheme (ERS) status

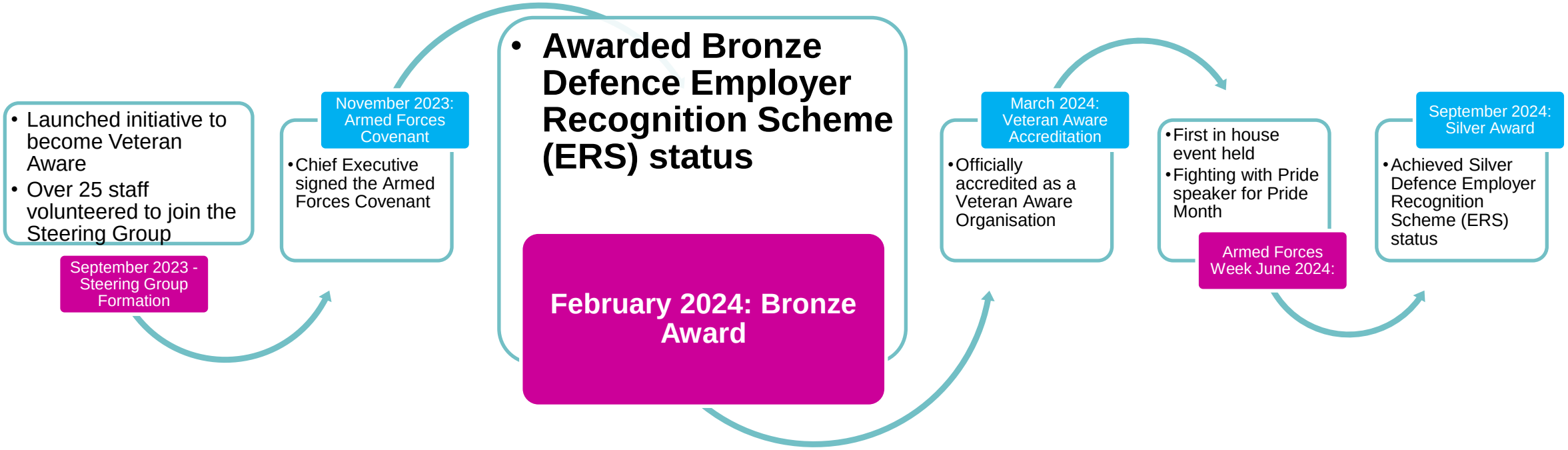
Our Journey so far

East Sussex Healthcare NHS Trust



Our Journey so far

East Sussex Healthcare NHS Trust



Our Journey so far

East Sussex Healthcare NHS Trust

Becoming Veteran Aware Accredited

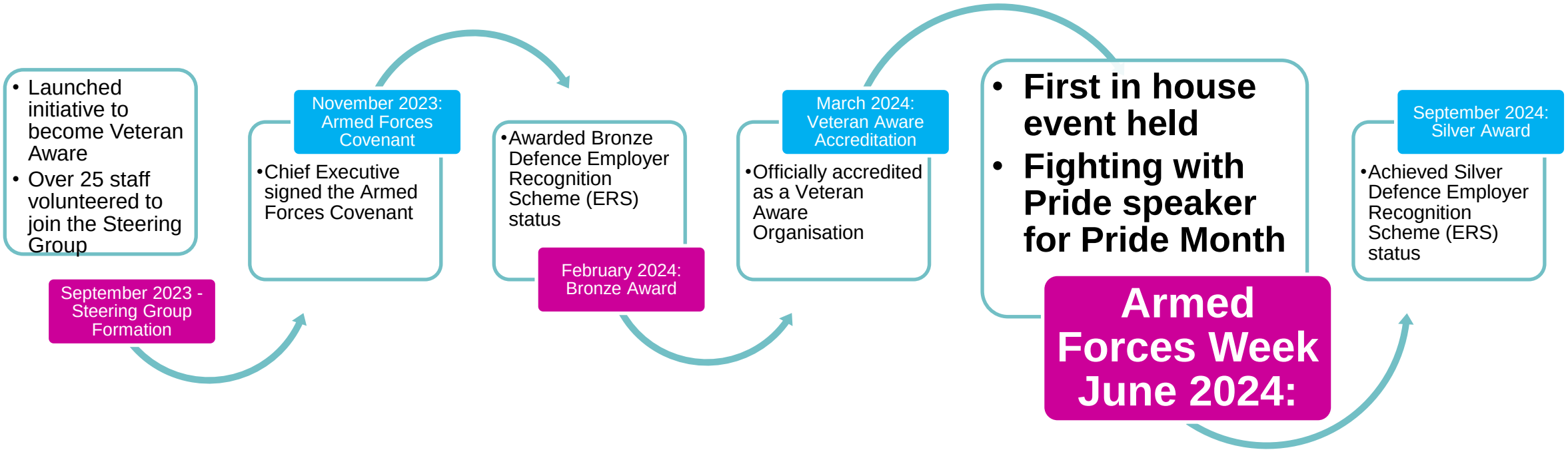
East Sussex Healthcare NHS Trust

Submitted information against eight manifestos covering:

- Trust Armed Forces Champions
- Exploring patient identification
- Supporting the Armed Forces as an employer
- Training and education for colleagues
- Linking with the South East Armed Forces Network and our local reservists
- Raising awareness in the community

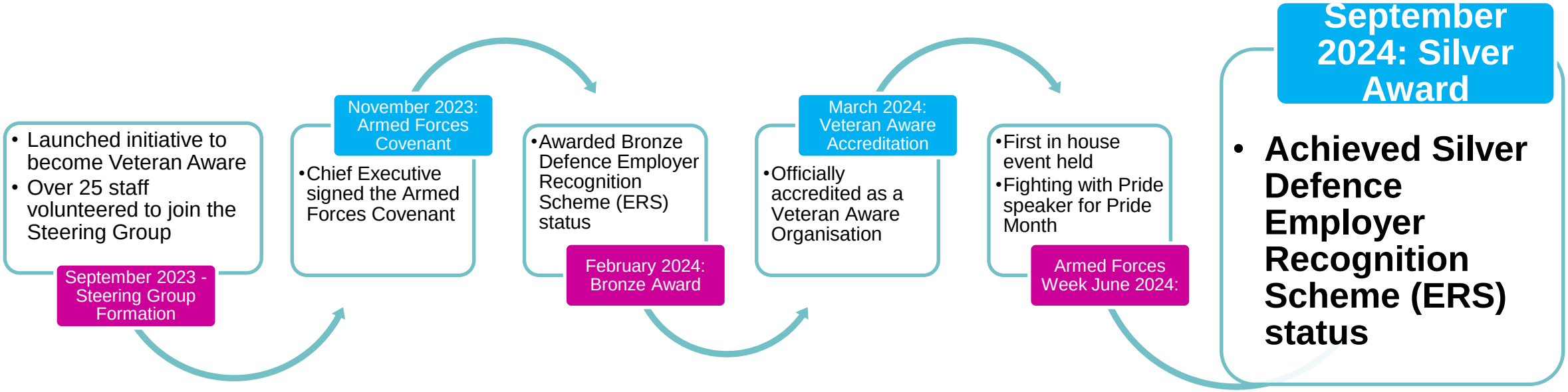
Our Journey so far

East Sussex Healthcare NHS Trust



Our Journey so far

East Sussex Healthcare NHS Trust



Engagement work

NHS East Sussex Healthcare NHS Trust

NHS East Kent Hospitals University NHS Foundation Trust

NHS Dartford and Gravesham NHS Trust

Eastbourne and District Veterans Community

Armed Forces Network

Combat Stress – For Veterans' Mental Health

The Blue Van – Armed Forces Veterans' Drop-In

Royal Naval Association

Fighting With Pride

TheChaseleyTrust – Supporting People with Disabilities

ssafa the Armed Forces charity – Lifelong support for our Forces and their families


ARMED FORCES
COVENANT


ROYAL NAVAL ASSOCIATION
COMBAT STRESS
WE OFFER THE MOST COMPREHENSIVE VETERAN MENTAL HEALTH SERVICE IN THE UK.


SILVER AWARD


ssafa
Lifelong support for our Forces and their families
ssafa.org.uk


THE BLUE VAN
Ex-Forces Veterans' Drop-in
Come On In


ARMY MEDICAL SERVICES RESERVE
Radiology


OUR VALUES
KINDNESS
INCLUSIVITY
INTEGRITY
East Sussex Healthcare NHS

COMBAT STRESS
FOR VETERANS' MENTAL HEALTH


ARMY MEDICAL SERVICES RESERVE
Radiology

Why is this important

Our patients –

Macmillan nurse approached for support with a patient

Trained armed forces champion stepped into help

Guidance and information shared with Macmillian nurse for any future

Website support

Our people –

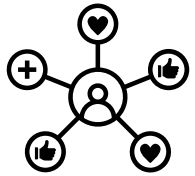
Member of the Armed Forces Community supported to work remotely.

‘I really appreciate the flexibility my manager has shown since I have been working here. It’s really comforting that my manager’s door is always open and that I can approach her with any questions or issues that I may have. I am very grateful for their support and guidance.’

Internal support

Next Steps

East Sussex Healthcare NHS Trust

- Continued working with our reservists 
- Exploring the best way to identify patients who are within the armed forces so additional support can be offered.
- Work with Cadets 
- Armed Forces Champions network 
- Going for gold! 

What can Board members do to support?

East Sussex Healthcare NHS Trust

- Endorse the Veteran Aware initiative and act as advocates within and beyond the Trust.
- Champion Veteran-Friendly Practices: promote veteran-friendly practices in their areas of influence, setting an example of inclusivity and understanding that reinforces the Trust's commitment.
- Propose that the Board include Veteran Aware progress as part of their regular monitoring and oversight activities.

Thank you for listening

East Sussex Healthcare NHS Trust Board Minutes

Date: 8th October 2024

Time: 09:30 – 12:45

Venue: St Mark's Church Hall, Green Lane, Bexhill-on-Sea, TN39 4BZ

		Actions
	Attendance: Steve Phoenix, Chairman and Non Executive Director Joe Chadwick-Bell, Chief Executive (CEO) Vikki Carruth, Chief Nurse & Director of Infection, Prevention and Control (CN) Amanda Fadero, Non-Executive Director Karen Manson, Non-Executive Director Simon Merritt, Chief Medical Officer (CMO) Charlotte O'Brien, Chief Operating Officer (COO) Paresh Patel, Vice Chair and Senior Independent Director Damian Reid, Chief Finance Officer (CFO) Nicki Webber, Non-Executive Director Carys Williams, Non-Executive Director <u>Non-Voting Directors</u> Ama Agbeze, Associate Non-Executive Director Steve Aumayer, Deputy Chief Executive and Chief People Officer (DCEO) Amber Lee, Associate Non-Executive Director Richard Milner, Chief of Staff (COS) Frank Sims, Associate Non-Executive Director <u>In Attendance</u> Dan Asamoah, Associate Director of Corporate Governance and Compliance (ADCG) Penny Boxall, Clinical Research Governance Officer (for item 66/024 only) Brenda Lynes, Director of Midwifery (DoM) Prof. Nik Patel, Consultant Cardiologist (for item 66/024 only) Jo-Anne Taylor, Head of Research (for item 66/024 only) Dr Rick Veasey, Consultant Cardiologist and Electrophysiologist (for item 66/024 only) Pete Palmer, Board Secretary (minutes) <u>Observing</u> Dr Gez Gould, Deputy Medical Director Paul Smith, Deputy Director of Nursing	
	Apologies: None received	
64/024	**Chair's Opening Remarks** It was confirmed that the notice of the meeting had been duly issued to the members of the Board entitled to receive notice and attend Board meetings. The meeting was quorate according to the Constitution of the Trust. The Chair welcomed everyone to the meeting, noting that this was Amber Lee's (ANED) first meeting of the Trust Board. He reported that this would be the CEO's last Board meeting, as she had recently been appointed as Group Chief Executive at the Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust. He congratulated her on her new role explaining that she would be hugely missed. The Trust had been successful	

	over recent years due in large part to the work that she had done, both as COO and CEO. He wished her all the best in her new role. The CEO explained that she had worked for the Trust for 16 years in total and had lived and worked locally for many years so the new role would be a large change for her. She would start her new role on 26th November.	
65/024	**Staff Recognition** The Chair reported that June's joint Hero of the Month winners had been Lucy Bates from the Histopathology team, Lincy Issac from Sussex Premier Health and John Hinkley from the Estates and Facilities team. July's winner was Matthew Bilton, from the Acute Stroke Physiotherapy team.	
66/024	**ESHT Clinical Research 2024-2025** Jo-Anne and Penny made a presentation to the Board on research that was taking place in the Trust and how this research benefitted and impacted on the lives of patients. Rick then made a presentation on the recent nationally acclaimed Sham-PVI cardiology study that had taken place at ESHT. Nicki, NED asked about the clinical outcomes for patients who had been given sham procedures under the cardiology study. Rick explained that patients who had sham procedures had received pulmonary vein isolation at the end of the trial if this was still clinically warranted, so there had been no worse outcomes as a result. Frank, NED asked why the Sham-PVI trial had not previously been undertaken elsewhere and Rick explained that sometimes the way treatments were offered were accepted in medicine. There had been calls to undertake the study over the last ten years, and after the successful study at ESHT it was now being replicated elsewhere. Nik explained that the cardiology department at ESHT had a fantastic track record for carrying out research with a culture that was supportive of doing this; this helped to support the recruitment of medical and nursing colleagues who had a track record of undertaking research. He praised the work of Rick and his cardiology colleagues. The Chair thanked Jo-Anne, Penny and Rick for their presentations and the Board noted the presentation.	
67/024	**Declarations of Interest** There were no interests declared for any item to be considered on the agenda. All declarations of interest were noted as held on the Register of Directors' Interest.	
68/024	**Minutes** The minutes of the Trust Board meeting held on 13th August 2024 were reviewed and approved as a correct and accurate record of the meeting.	
69/024	**Matters Arising** The Chair led discussion on the Matters Arising and Action Log and the following was noted: • 56/024 – Board Assurance Framework. The Action was noted as complete as this had been added for to the Board Development Day Planner for March 2025. Carys, NED, asked whether a list of open Board actions could be included within future Board packs and this was agreed.	
70/024	**Chief Executive's Report** The CEO presented her report and the following points were noted: • Outcomes of Lord Darzi report	

- The system changes required to deliver the Sussex wide Improving Lives Together system strategy.
- The reopening of Eastbourne Midwifery Unit
- A recent joint training emergency response exercise at Eastbourne DGH

The CEO thanked colleagues for all that they had done to meet the challenges seen within the organisation during the past couple of weeks; winter pressures were starting to be seen, resulting in a change to the acuity of patients being treated.

She explained that three key themes had emerged from Lord Darzi's report, with aspects of this report feeding into the anticipated NHS ten year plan. The themes were:

1. Moving care from acute services to the community, which was aligned to the Trust's strategy. Progress was being made in increasing community capacity, including bedded care and planned care pathways. The challenge faced by the Trust was to undertake this without additional investment.
2. A focus on prevention, which would also need to be done with confined resources.
3. Moving from analogue to digital. With work already underway to develop a digital culture for the organisation.

The CEO hoped that recent agreements would mark the end of industrial actions. The Trust had become good at managing during these periods, but they detracted from the care that the Trust could offer to patients.

Work was commencing on implementing the Sussex-wide Improving Lives Together strategy, with a major service review to be undertaken looking at what organisations could do collaboratively to achieve the best outcomes for patients. This review was expected to take two and a half years.

The midwifery service at EDGH had reopened at the beginning of September; six babies had been born in the unit in September with another born in October.

The CEO reported that Angela Colosi, the Trust's Deputy Chief Nurse had recently retired after many years with the organisation, and thanked her for all she had done. She welcomed Paul Smith, who had recently joined the Trust as the new Deputy Chief Nurse.

The Board noted the CEO's report.

71/024 **Board Committees Chairs' Upwards Reports**

Audit Committee
Paresh, NED presented his report.

Finance and Productivity Committee
Nicki, NED presented her report; she highlighted the key risk section of the report, in particular the range of outturn outcomes.

Inequalities Committee
Paresh, NED presented the Inequalities Committee Chair's report. The Chair noted that the Committee had reviewed important and valuable data across a range of metrics.

People and Organisational Development Committee
Carys, NED presented her report

Quality and Safety Committee
Amanda, NED presented her report. She reported that there had been interesting recent conversations about the cultural and reporting changes that had come about since the introduction of the Patient Safety Incident Response Framework (PSIRF) at the Trust.

	The Quality and Safety (Q&S) Committee had received a comprehensive report at their last meeting which had demonstrated the impact of PSIRF. The Trust was now effectively categorising events and reviewing and learning from these using different methodologies, with trends expected to emerge over the coming months. A paper would be presented to the next Q&S describing how the balanced scorecard approach would be used moving forward to identify areas of concern. Nicki, NED explained that she had discussed PSIRF with Amanda, NED prior to the meeting and had taken reassurance. She looked forward to seeing the trend data. Nicki, NED explained that she would love the Trust to be brilliant at end of life care and asked whether a further report on this was expected to be presented to Q&S. Amanda, NED explained that the new Deputy Director of Nursing would be working to provide patients with a better end of life experience. The Trust was not an outlier in comparison to other organisations but it was important to maintain a continued focus on improving. The CNO explained that the care offered to patients at the end of their lives was good, but the Trust had experienced challenges in effectively recording this care, particularly when patients died more quickly than anticipated. The CMO agreed that data showed that the Trust was good at end of life care, but that more could be done. ***The Board noted the Committees Chairs' upward reports.***	
72/024	**Integrated Performance Report (IPR) for Month 5 (August)** The IPR was jointly reported by the CEO, CNO, CMO, DCEO and CPO, CFO and COO. The CEO summarised that colleagues continued to successfully balance issues including workforce, patient quality and good access to care for patients. The Trust's performance during month five had been good, with no concerns raised externally about the Trust apart from about the current financial position. The Trust had recently offered support to the Sussex system in managing long waiting elective patients. <u>Quality and Safety</u> The CNO presented the update. Highlights from this section included: • Key quality measures remain stable in the face of significant and sustained challenges. • The Trust continued to see an increase in clostridium difficile cases and had been working with regional and national teams to understand and address this. • Significant escalation continued due to ongoing pressures; the CNO thanked operational teams for their collaborative approach in managing this. • There had been a huge recent increase in Friends and Family responses despite some technical issues. Some feedback was now recorded and could be played back to staff. There had been an increase in recommendation rates for both EDs, with negative feedback largely about waiting times • A methodology for harm reviews had been agreed and data was beginning to emerge from this work. Outcomes would be analysed and shared with Q&S. • The CNO had recently undertaken a service visits to the Trust's mortuaries and praised the work of the small teams who worked their who did an incredibly important job. Paresh, NED asked whether plans were in place to tighten the reporting ranges included within the IPR as improvements that were being realised through changes to policies and procedures were not clear within the current reporting. The CNO explained that the Trust had recently employed an Associate Director of Performance who would be looking at improving the IPR as part of his role. Carys, NED explained that she hoped the introduction of PSIRF would enable the Trust to learn lessons and implement actions more quickly, and asked if this was happening. The CNO explained that alongside the introduction of PSIRF, the Trust had also introduced DatixCloudIQ (DCIQ) which had more capability to provide analysis; however, some clinical teams were struggling to input the correct data to enable analysis. Support was being offered to teams to build this capability. She explained that robust challenge of	

events took place at Weekly Patient Safety Summit meetings; human factors and failure to escalate were key themes with actions often taken immediately following events. The CMO noted that a detailed report would be discussed in the Private Board meeting.

Frank, ANED noted that there was a theme running through the IPR where the pressure on the Trust appeared to be having a negative on effect on length of stay, discharges and falls. He asked what work was being undertaken with the system to address this. The COO reported that the Trust was working closely with the system and a paper would be discussed with the Board later in the meeting.

Nicki, NED noted that the IPR indicated that inpatient falls had reduced, but from looking at patient safety data it felt like they had increased. She asked whether more consideration could be put into how data was presented to the Board to ensure that a consistent story was being told by. Amanda, NED noted that the Board were reviewing old data mechanisms and accepted that it was challenging to link this to learning from PSIRF. The DCEO explained that he was keen to begin triangulating all the available data to provide greater understanding of how well the Trust was doing.

Amanda, NED noted that it would be helpful if reporting could include assurance about the internal Trust processes used to review areas of concern, such as falls. Paresh, NED agreed explaining that this would provide context for the reporting being received. He also explained that it would be useful to summarise overarching trends in a single place.

Action: Executives were asked to reflect on how reporting to the Board could be improved moving forward. **Execs**

The CMO reported that mortality metrics remained within statistically expected ranges for Summary Hospital-level Mortality Indicator (SHMI). He explained that SHMI data had been rebased (represented by the solid line in reporting) from the original value (represented by the dotted line) to exclude deaths from Covid. The Risk Adjusted Mortality Index (RAMI) was calculated differently and the Trust was below its expected range by a considerable margin. The Trust utilised crude mortality as an internal control which demonstrated that 1.57% of people who came to hospital would die as an inpatient, a reduction from 1.85%. Reporting looked at expected deaths and was used to drive deep dives into any areas of concern.

<u>Our People – Our Staff</u>
The DCEO presented the update. Highlights from this section included:

- Workforce metrics had remained relatively stable, but the increased pressure on the organisation had led to an overspend on workforce of £145k in month due to the need for additional agency staff. It was hoped that this would reduce in September.
- Spend in month was £1.2m down from June, and £1m down from March 2024.
- The vacancy rate had increased slightly as a result of the introduction of enhanced workforce controls linked to financial performance.
- The turnover rate was slowly increasing and was being monitored, although was not considered to be a significant concern at present.
- The monthly sickness rate had significantly dropped in month.
- The mandatory training rate was above the target rate for the seventh month in a row, and appraisal rates were the highest on record.
- The Trust had received a Silver Defence award for veterans and a Silver Award for Wellbeing at Work during August.

The Chair praised the achievement of improving mandatory training and appraisal rates; he asked whether vacancy rates should be dropping, and whether workforce budgets had reduced to sustainable levels. The DCEO explained that the increase in vacancy rates was due to a correction in budgets; workforce budgets continued to reduce month on month.

Paresh, NED asked whether an increase in the use of bank workforce was being seen. The DCEO reported that bank usage remained relatively stable despite the reduction in agency usage, with some movement from expensive agency usage to the bank. Some colleagues had transferred from agency positions to become permanent members of staff.

Frank, ANED explained that he was pleased to see initiatives to increase exit interviews and asked when it was expected that themes would emerge from these. The DCEO explained that consistent data was already gathered from exit interviews and hoped that the enhanced processes would lead to an increase in the quality of this data over time.

Amanda, NED praised the work that had been done in look after the wellbeing of colleagues and in improving appraisal rates. She asked how this was being balanced against the increased pressure being seen within the Trust to ensure that that patient safety and the quality of treatment was maintained. The DCEO explained that Executives discussed maintaining the right balance between staff safety, patient safety, wellbeing and the delivery of targets all the time. It was vital to get this right as more people than ever before were leaving the NHS and the Trust also had high levels of people who were of an age that they were able to retire.

Amanda, NED asked how staff were managing when colleagues left and were not replaced. The CNO explained that everyone understands the current financial challenges that the Trust was facing and the need to do things differently. Divisions had been asked to develop plans for reducing staff numbers in a clinically led manner. The DCEO noted that some staffing changes had been made in order to reduce variation between services. The Trust was identifying opportunities to make changes through improvement and transformation rather than by cutting staffing levels.

Amber, ANED noted that undertaking research could impact on colleagues if they did this over and above their normal roles and asked how this had been factored into discussions about staffing levels. Steve, Chair explained that the Trust had added 1,600 staff to its payroll since 2020 so was looking to reduce staffing numbers following that increase. The CEO explained that it was important to allow staff the time to be more productive; research had been a priority for the Trust during 2023/24 and all consultants had job plans which included non-clinical time to allow them to contribute to research.

<u>Access and Responsiveness</u>
The COO presented the update. Highlights from this section included:

- The Trust had remained compliant with the four hour ED standard in August, and was the fifth best regional performer, delivering 78.6%. The Trust was in the top quartile nationally for the fourth time in a row. The number of breaches of the four hour standard had reduced. The Trust needed to eliminate seven breaches a day on each site to return to its previous high performance levels and was working hard to achieve this.
- There had been a reduction in non-elective stays but patients with no criteria to reside continued to be a challenge for the Trust; work was being undertaken with partners to support a culture of reconditioning.
- At the end of September, seven patients had waited for more than 65 weeks for elective treatment. The Trust was supporting system colleagues with 300 patients having transferred from University Hospitals Sussex NHS Trust (NHSx).
- Performance had been 79.3% against the faster diagnostic standard and 68.9% against 62 day performance. Recovery plans were in place, with performance stabilising. The DM01 position was improving and the Trust's overall waiting list had reduced.
- Virtual ward occupancy had increased after a slight dip. Community paediatric waiting times had improved with no children waiting for more than 104 weeks.

Steve, Chair asked how quickly the Trust would return to its previous good performance. The COO explained that more capacity was required to manage the number of patients

attending hospital to ensure that patients went to the right place in order to improve productivity. In addition, overnight performance could be improved. She hoped that improvements would be rapidly realised over the next month, noting that the Trust should not rely on others to improve performance. Nicki, NED noted the need to implement the improvements at pace in order to improve the care that patients received.

Financial Control and Capital Development

The CFO presented the update. Highlights from this section included:

- Income in August had reduced but was in line with the Trust's forecast. Some additional ERF money had been received but the Trust had recorded a £2.1m deficit in month.
- At month five, the Trust was £4.8m behind it's annual plan. To meet its annual target a surplus position would need to be delivered in each of the remaining months of the year.
- Support was being received from the ICB to improve financial performance and a reset on how the financial plan would be delivered was being developed by divisions. Progress would be reported to the Finance and Productivity (F&P) Committee and to the Board at November's Development Day.
- Pay costs were £3.2m behind plan due to the necessity of using temporary staff associated with increased demand.
- Non-pay costs were also off plan as a result of increased activity.

Amanda, NED noted concern about the Trust's financial performance, asking about the £4.6m of non-pay attributed to Cost Improvement Plans (CIPs) that was centrally held. The CMO explained that he was confident that the overall principles of the Use of Resources (UoR) programme remained correct. The reset of the programme for the second half of the year would ensure that it would accurately reflect where savings would be delivered, as the plan was backloaded with increased savings anticipated towards the end of the financial year.

Carys, NED noted that divisions were being asked to make some potentially difficult decisions and asked what more the Board could do to support them. The CEO explained that divisions were being proactive in making bold decisions about how they could save money without impacting patient care, as well as using best practice data to improve productivity. She explained that any proposals that required collective agreement would be brought to the Board.

Frank, NED asked how colleagues could be supported in ensuring that proposed savings plans were realistic and deliverable. The CFO explained that it was important to have honest conversations about the scale of challenge faced by the organisation, particularly as bed pressures were already increasing with winter approaching.

Paresh, NED explained that he would like to see benchmarking of service lines against Getting it Right First Time (GIRFT) data in reporting, as well as information about how the Trust was maximising ERF income. He noted that any comparison with 2019/20 productivity would need to reflect changes in how services were delivered. The CFO explained that a significant number of the 1,600 additional employees had been employed due to changes to how the Trust operated since 2019/20, including Sussex Premier Health employees and changes to how community services were delivered. The CEO explained that GIRFT data was available through UoR workstreams.

Amanda, NED explained that she felt that it was becoming clear that the Trust would not meet its financial target for 2024/25 and that the Board should now focus on making the choices that would allow the Trust to meet its targets in 2025/26. Steve, Chair explained that the financial position was the most challenging that he had seen during his time in the organisation, noting that not meeting financial targets might lead to losing control of other aspects of the organisation due to oversight. He recognised how hard colleagues were working to try to meet financial targets, noting the Trust had a legal obligation to meet its budget.

	Nicki, NED noted that she was concerned that the financial situation might lead to performance issues. She explained that she would welcome a conversation about the biggest challenges that were driving the financial position and about the most difficult decisions that would need to be taken. ***The Board noted the Integrated Performance report.***	
73/024	**Learning From Deaths Q4** The CMO explained that the report being presented was mandated; the Trust reviewed deaths that met certain criteria to identify whether there had been any avoidability. Between 35-60 deaths a quarter which had not been straightforward were discussed by the Learning from Deaths Group. Deaths were graded between one and six for avoidability and the Trust reported on all deaths assessed as being probably avoidable or greater. Between 2,000 and 2,100 patients had died while under the Trust's care in 2023 and only a very small number had been found to have an element of avoidability. Carys, NED noted that the report did not include any examples of learning, noting that this had been requested in the past. The CMO explained that the form of the report was mandated and agreed that it was not helpful in demonstrating learning. He reported that themes that had emerged from reviews included improved identification of when a patient was at the end of their life and the identification of some delays in providing medication. No major learning had emerged from the process and levels of avoidability were comparable to those found in other trusts. Carys, NED noted that taking the time to review the experience of patients would provide the Trust with a continuous opportunity to improve. The Chair noted that learning from this process and other incidents was shared with the relevant colleagues and teams; the CMO explained that it was also shared through Weekly Patient Safety Summits and Patient Safety meetings. Nicki, NED asked whether a third page could be included within the report which set out how many avoidable deaths had been identified, what learning was found from these cases and what actions had been taken. **Action: the CMO to consider how more detailed information about avoidability of deaths and learning arising from the Learning from Deaths process could be shared through the Quality and Safety Committee.** ***The Board noted the Learning from Deaths Q4 report***	**CMO**
74/024	**Maternity Overview Q1** The DOM explained that evidence demonstrated that maternity services in the Trust continued to be safe. She reported that maternity colleagues had raised concerns with the Trust's Speak Up Guardians during Q1 2024/25 about culture and behaviours in acute services. As a result, listening events had been organised with the team supported by Executives. In addition, an externally commissioned review of the culture of the team had been undertaken and was expected to conclude soon. Staff had been offered support throughout the period and she felt that the team was now in a much improved position. She presented the Q1 2024/25 maternity report to the Board which confirmed: • The neonatal medical workforce met the relevant British Association of Perinatal Medicine (BAPM) recommendations • The workforce was also complaint with the BAPM Nurse staffing standards as per the Neonatal Nursing Workforce Calculator • The midwifery workforce funded establishment was compliant with outcomes of BirthRate+. • Board safety champions met on a bimonthly basis with the perinatal leadership team through the MatNeo Clinical Board.	

	• Progress with MatNeo culture improvement was monitored on a quarterly basis, supported by the current external cultural review. There was a recruitment and retention strategy and plans were progressing well with a vacancy rate of less than 1%. Active listening events continued across maternity services. • The Trust continued to work closely and effectively with the Maternity Voices Partnership, with 24 hour visiting established, the launch of a maternity website and continued work to improve regional data processes. Areas of focus moving forward included improving communication and discharge. • The service had maintained a 100% 1:1 care rate during labour in Q1, with fill rates at 89%. A reduction in the time to hire by almost 10 days had been realised since the previous year. • The service had been fully compliant with CNST safety actions during Q1 and had increased mandatory training rates to above 80%. There had been no avoidable perinatal events during Q1. • The established perinatal mental health service, which included access to specialist support was being reviewed following an increase in demand of about 25%. The specialist bereavement service was now available seven days a week. Steve, Chair noted that he was pleased to see the very low vacancy rate for the service. Amanda, NED reported that Q&S had been presented with a detailed report which had supported the more focussed report made to the Board. She noted the tremendous work that the team had done over the last couple of years, praising the depth of information and assurance that they were able to provide about their service. Nicki, NED asked whether she should be pleased that cultural issues had been identified, or concerned that previous maternity reports to the Board had been positive without mention of any concerns about the culture. Steve, Chair noted that there was always the possibility of concerns being raised in any team and it was important not to ignore these when this happened. He explained that it was to the team's credit that despite their concerns they had maintained their high standards and improved in a number of metrics. The Trust's staff were encouraged to raise their concerns, so he was pleased that this had happened. ***The Board noted the Maternity Overview Q1 report.***	
75/024	**Draft Health Inequalities Strategy 2024-27** The COS presented the Draft Health Inequalities Strategy 2024-27, explaining that the report was being presented for the Board's approval having previously been approved by the Inequalities Committee. This was the first time that the Trust had had an inequalities strategy, which included services and initiatives that were already underway as well as future projects. The strategy was aligned with NHS Sussex requirements and other local initiatives. He noted that a question had been received from a member of the public prior to the meeting about the feasibility of developing an inequalities strategy prior to the establishment of Integrated Care Teams (ICTs) and explained that it was important to agree broad areas of focus which could be further refined and developed as other initiatives and improvements were confirmed. Steve, Chair agreed, noting that how the Trust addressed health inequalities for patients was important whether or not ICTs had been established. Therefore the Trust would do what it could now and adjust the plans as required. The CNO asked whether the strategy would be subject to coproduction with local people and the COS confirmed that it had already been shared with Healthwatch, the Trust's staff networks and the staff forum. Steve, Chair explained that the strategy utilised system wide information which had a large degree of engagement focus. The CEO praised the work that had gone into developing the strategy, explaining that it was a big step forward for the Trust. She noted that coproduction of the strategy would be taken forward within a wider engagement plan for the Trust which was being developed. She explained that it was important to balance the need to look after local people with the Trust's responsibility to support people across Sussex as part of the ICS.	

	The CFO asked whether it would be helpful to include information about deprivation and smoking cessation within the strategy. Steve, Chair explained that compared to historic standards, smoking rates in East Sussex were now low, but were higher in areas of deprivation and low income. It was important that interventions were targeted, which he expected to be a function of ICTs undertaken on a multi-agency basis. The CMO asked whether a review of waiting time databases would be undertaken. The COS explained that data could be broken down by age, deprivation, gender and ethnicity and would be utilised as part of the Trust's planning processes for 2025/26. Nicki, NED noted that the traveller community would not be included in the indicators mentioned, noting that unknown unknowns would also need to be included within future plans. Steve, Chair agreed explained that this was why the Trust's partnership with local authorities was helpful; ICTs would being information from a range of sources together to allow systems to address the health needs of the local population more effectively. ***The Board approved the Draft Health Inequalities Strategy 2024-27***	
76/024	**Winter Preparedness 2024/25** The COO explained that the report being presented included anticipated capacity gaps during winter and plans for how these would be mitigated to ensure safe care for patients during this busy period. It was anticipated that there would be a deficit of between 9-14 beds at the Conquest and the Trust was working hard to reduce lengths of stay and to identify opportunities in general, geriatric and gastroenterology care. No bed gap had been identified at EDGH, provided schemes delivered their anticipated benefits. An increase to Pathway One capacity was being considered and it was hoped that external funding would lead to an improvement in unscheduled care avoidance, alongside work to develop ICTs and to support discharge and reconditioning. The CNO reported that discharge work had three main aims: to reduce and avoid patients being admitted unless absolutely necessary; to ensure that patients in the Trust's care were kept as conditioned as possible and to ensure that internal processes were as efficient as possible. She noted that improving external processes was not within the Trust's gift. The system's priorities were aligned with this approach. Carys, NED explained that she viewed delayed discharge to be a moral issue with patients being kept in hospital when they did not need to be there. She asked how previous plans to improve discharge had evolved and been included within the plan presented to the Board. The CNO explained that the current plan built on the previous plans in a structured and measurable manner. Indicators would play an important part in measuring success and digital solutions were being explored. Carys, NED asked how the Board would receive assurance about the delivery of the plan and the CNO explained that progress and metrics would be discussed in a number of forums including POD and Q&S. Updates would also be provided at each Board meeting on SAFER, discharge and reconditioning. The CEO explained that it had been helpful to separate what the Trust was able to improve and control and what was outside its gift. The plan incorporated best practices from across the country and would be supported by a programme manager. She explained that Sussex-wide improvement plans were also being developed, but it was important that the Trust was able to identify that its internal improvement plans were effective. The CNO explained that clearly defined KPIs would ensure that plans were effective, noting that the challenge was compounded by the number of heavily dependant patients who were waiting for supported accommodation. This impacted on the Trust's workforce and might lead to an increase in the average stay if it was not resolved. Paresh, NED asked what was stopping additional virtual ward capacity from being utilised. The COO explained that while some additional funding had been secured by the Trust for winter additional virtual ward capacity had no further funding attached to it. The	

	CEO explained that it was within the Trust's gift to decide where patients should be treated within the funding that it received; this was being reviewed from a strategic perspective to understand whether the Trust's existing underlying assumptions about cost and capacity remained correct. Paresh, NED asked whether more patients could be discharged before midday and the CNO explained that the Trust had recently needed to use discharge lounges to provide additional bedded capacity which had affected numbers of patients able to be discharged early in the day. Amanda, NED asked whether escalation wards would be opened and the COO explained that this was not included in plans as capacity had needed to be reduced in order to make improvements to fire safety in the Trust. Amanda, NED explained that she had found the plan to good, and approved of its emphasis on best practice. She asked whether the system had the same view of the Trust's need and demand. The CEO explained that the Trust needed to undertake a clear capacity and demand strategy which would be used by the system to review every part of patients pathways and hold providers to account, driving conversations about provider responsibility and affordability. Looking after more people in their own homes would reduce the demand on high cost acute hospital capacity and would allow more patients to be treated for the same money. Ama, ANED explained that is was helpful to see the bed modelling tables and asked how the predicated deficit gap at Conquest would be met. The COO explained that patients were moved between sites when the Trust had capacity. In addition improvements were being driven to length of stay which would help to bridge the gap along with moving patients out of the Trust and on to virtual wards. Steve, Chair noted that winter plans would continue to be revisited by the Board and its Committees as the year progressed. ***The Board noted Winter Preparedness 2024/25 report.***	
77/024	**Discharge Update** Discussed under item 76/024 ***The Board noted the Discharge Update.***	
78/024	**Board Assurance Framework Q2** The COS reported that the Q2 BAF had been subjected to review by the Board's Committees. Carys, NED noted that there had been discussions about whether BAF2 should continue to be included on the BAF at POD, and it had been agreed that this should remain on the BAF for now with a further review in Q3. ***The Board noted the Q2 BAF report.***	

79/024	**Annual Equality Report** Highlights of the report were: • Brings together individual equality reports that the trust is required to deliver. Thanked Sarah and Ali • Action plans against specific areas of the report and six high impact interventions set out at end of report. • Had been through POD and inequalities • Asked Board to approve report for publication. ***The Board noted the Annual Equality Report, thanking SA and his team for their hard work.***	
80/027	**Use of Trust Seal** One use of the Trust seal since the last Board meeting was noted.	
81/024	**Questions from members of the public** Mrs Walke commended the Board for the openness of the discussions about finance during the meeting, noting that this had not been her experience at some public meeting in the past. Steve, Chair explained that he encouraged colleagues to be as open as possible about the challenges that they faced, and he hoped that the Trust was always as open and honest as possible . Mrs Walke asked whether every patient with an appropriate condition was asked to participate in clinical research by the Trust. The CMO confirmed that this was the case, explaining that the Trust tried to undertake as many research projects as possible with patients who were eligible. Mrs Walke asked for an update on the changes to the paediatric pathway at EDGH. The CMO explained that the changes were working well with significantly more children receiving a specialist paediatric review than before. There had been no increase in transfers to the Conquest hospital as a result of the changes, and no patient safety incidents had been raised. Steve, Chair reported that he had recently spoke to the Chief of the service who had been explained that the improvements had been more effective than had been anticipated. Mrs Walke suggested that more publicity about the success of the changes would be helpful as members of public remained concerned about them. Mr Hardwick noted that the mortality reporting included 12 deaths from sepsis and asked whether there was an issue with diagnosing this quickly enough and whether ambulance crews could diagnose sepsis. The CMO explained that the 12 deaths reported were lower than the expected number for the Trust. Some ambulance crews diagnosed sepsis, explaining that the prompt use of antibiotics made a big difference to outcomes for patients. He explained that some patients would die no matter what as they got infections that were so rapid or severe, often coupled with severe frailty, that they could no be saved. Cllr. Smart thanked the Trust for the work that it did to provide healthcare in East Sussex. He explained that he had submitted a question prior to the meeting about how the Trust's expenditure to date on the New Hospital Programme and whether outline plans could be shared. The CEO noted that a response had been sent to Mr Smart on behalf of the Trust. However, she was happy to ask the national team if more information could be shared. Cllr. Smart asked whether any update on the purchase of the Welkin Building in Eastbourne was available. The CFO reported that it had been agreed that the building would transfer to the Trust in March 2024. The transfer of students leaving post summer would take place on 1st October, so the trust was focussing on housing new students as well as moving single occupants from the Trust's EDGH accommodation to Welkin. Additional capacity would be made available through an agency. It was important that the	

	accommodation was fully utilised as this was a key source of income for the Trust in the second half o f the year. Cllr. Smart noted that he was delighted that the Trust was moving into the accommodation and offered to help in any way he could.	
82/024	**Agenda Forward Plan** The Board's forward plan was noted.	
83/024	**Date of Next Trust Board Public Meeting** Tuesday 10th December 2024	

East Sussex Healthcare NHS Trust

Matters Arising from the Board meeting of 8th October 2024

MEETING DATE	MINUTE NO:	ACTION	BY WHOM	BY WHEN	COMMENTS – INCLUDING ANY UPDATES
	OPEN ACTIONS				
08.10.24	72/024	Executives were asked to reflect on how reporting to the Board could be improved moving forward.	Execs	Ongoing	
08.10.24	73/024	The CMO to consider how more detailed information about avoidability of deaths and learning arising from the Learning from Deaths process could be shared through the Quality and Safety Committee.	CMO	December	Update to be given in meeting
	NOT YET DUE				
There are no actions not yet due					
	ACTIONS COMPLETED				
There are no completed actions					

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	Trust Board	**Date of Meeting**	10th December 2024

Report Title:	Chief Executive's Report
Purpose of the Report/Outcome/ action requested:	To update on key items of information which are relevant but not covered in the performance report or other papers
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐
Authority for Decision:	Not applicable

Executive Summary

Chief Executive's report

This is my first report in the acting CEO role and the operating context is no less fast-moving than Joe Chadwick Bell's final update to the Board in October.

Nationally, the October budget talked of significant investment into the NHS, and we anticipate greater clarity on timescales from the review of the New Hospitals Programme (NHP) early in the new year. It is likely to be a busy Q4 2024/25 with the NHS 10-year plan also expected for publication in the Spring.

Closer to home, we are focused on operational preparations for winter, strengthening our financial controls and planning for 2025/26 alongside colleagues across Sussex.

NHSE recognition for our support to tackle long waits for elective procedures

One of our priorities is to reduce the time people are waiting for care and treatment, and we recognise that this includes residents across the whole of Sussex. We have agreed with NHS Sussex that we will take around 2,000 patients from Brighton and West Sussex, across a targeted number of specialties where we will be able to provide surgical interventions that reduce their existing long waits. While this is necessarily a complex logistical exercise, we believe that patients waiting longer simply due to where they live is an issue of inequalities, and we are pleased to be able to support colleagues in the county to tackle this issue.

Treating these patients at ESHT will have a direct impact on how our performance is reported with the number of people showing as waiting over 65 weeks for treatment increasing. This is not due to East Sussex residents waiting longer, but to us taking a cohort of patients who have already been waiting for an extended period of time for treatment. NHS England have formally recognised both our support for the system and the impact that taking these patients will have on our reported 65 week wait performance in a letter to us. The letter is presented to Board as an Appendix to this report.

Day Surgery consolidation pilot to test waiting time reduction

In another example of our commitment to tackle waiting times, we have identified an opportunity to increase day surgery procedures – meaning that more people will be able to receive their surgery more quickly – by bringing non-complex day cases currently at Uckfield onto our main sites at Eastbourne and Conquest Hospitals.

To test this opportunity, a six-month pilot will show us how many additional procedures we are able to undertake with this new arrangement. We estimate that we will be able to see around 20% more patients than the current model, and the pilot will enable us to assess the accuracy of our assessment. Our latest data shows that of the patients recently treated at our day surgery unit in Uckfield, almost 90% live nearer to our two main hospitals in Hastings and Eastbourne, so for the vast majority of our patients receiving surgical treatment at Uckfield, a change in location should also bring care closer to home. The wider range of services at Uckfield Community Hospital - outpatient consultations, minor injuries unit, GP and rehabilitation services - remain unchanged.

Unscheduled care navigation hub launches

A further additional initiative that launched for this winter is the Unscheduled Care Hub. This is a joint initiative with SECAmb, which will see our community staff working alongside ambulance staff at the Polegate ambulance station, using their expertise to advise ambulance crews of the best course of treatment for patients they attend on a 999 call, as well as the best place to take them should they need treatment that the crew can't provide. By doing this, we believe we can reduce the number of conveyances to our Emergency Departments – not only freeing up our department staff, but ambulance staff as well.

Preparing for winter

With levels of demand on our services already high going into our busy winter period, we have been working on comprehensive plans both across our organisation and with our partners to try to manage this downwards as much as we can. As an integrated trust, we're in a helpful position in that we can look at and actively intervene on a patient's journey before they get to our acute sites, as well as manage parts of their care outside of a hospital setting.

So among our focuses are hospital avoidance, using our community teams to actively manage higher risk patients, to keep them as healthy as we can and utilise systems such as remote monitoring and services such as Virtual Wards so that we can step in to escalate support in the community to avoid them needing a hospital admission. For patients that do need additional care beyond what our community teams can provide, we are exploring additional ways of bringing patients directly into specialist services such as SDEC and hospices; focusing on managing admissions consistently to keep our processes swift and streamlined; using the SAFER bundle (a set of guidelines for adult inpatient wards to improve patient flow and prevent unnecessary waiting) to keep patients moving through hospital and speed up discharge; and keeping patients healthier and preventing deconditioning which can lengthen hospital stays.

The final part of this work is a renewed focus on discharge to help free up our beds, utilising a 'Home First' approach where we look to deliver as much follow-up care as possible at home rather than in hospital. As well

as this, we are aiming to utilise our Transfer of Care Hub more effectively to begin to arrange discharge packages - particularly complex discharge packages – earlier to reduce the length of time clinically well patients spend in a hospital bed waiting to go home.

New MSK services

Earlier this year we won a contract to deliver community musculo-skeletal (MSK) services to patients across East Sussex, part of a wider contract for MSK services provision across Sussex that was commissioned by NHS Sussex. We won that contract as part of a partnership bid with Horder Healthcare, and will be delivering the services as a new partnership body – East Sussex MSK Community Partnership. The change will ensure that MSK services are delivered to a consistently high level across all of the Sussex system.

TICH-3 research study to improve post-stroke outcomes

As part of our objective to strengthen clinical research at the Trust, the TICH-3 study is concerned with effective drug-led treatment for intracerebral haemorrhages (ICH). The project, which began recruiting patients earlier this year and involves both our Stroke team and ED teams, assesses the potential to reduce the risk of death and/or improve disability six months after having a stroke by testing whether a drug, already standard care treatment in other emergency medical conditions, can reduce post-stroke bleeding and aid recovery. Stroke can have a devastating effect on patients and families, and I am proud that our research could help improve treatment and outcomes.

Giving Parkinson's patients a voice

The Community Speech and Language Therapy (SLT) team have recently introduced a new therapy programme for people with Parkinson's.

The Speak Out! Therapy Programme, developed by Parkinson Voice Project, helps people with Parkinson's and related neurological disorders regain and retain their speech. The treatment combines education, individual and group speech therapy, daily home practice, and continuous follow-ups.

The programme is an evidence-based therapy and has been well received by patients across the service. The SLT team have reported that early outcomes, in terms of improvements to patients' speech, their perceptions of their communication ability and their confidence to be able to communicate in scenarios they had avoided, have improved significantly on previous results.

Armed Forces Award

We were recently formally presented with the Silver Award in the Defence Employer Recognition Scheme (ERS) by the Lord-Lieutenant of Hampshire, Sir Neil Atkinson. We have made significant, rapid progress on supporting our Armed Forces and through initiatives such as the ERS, where we are committed to ensuring veterans, reservists and armed forces families get the support and flexibility they need to work here at the trust.

Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues had been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	4	**Appendixes**	None
Name, position and contact details of author:	Steve Aumayer, Acting Chief Executive		
Report Sponsor	Not applicable	**Presenter:**	Steve Aumayer
Governance and Engagement pathway to date:	Not applicable		
What happens next?	Not applicable		
Publication	Report is for publication		

To:

Joe Chadwick- Bell
Steve Phoenix
East Sussex Healthcare Trust
Kings Drive
Eastbourne BN21 2UD

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 November 2024

Dear Joe and Steve

Thank you for your ongoing support to the Sussex ICS plan to recover the elective waiting position at UHSx. We recognise the considerable work that has gone in at trust level to deliver the 65-week waiting position for your patients to date, and the mutual aid you have provided across the ICS has been a key part in reaching our current position.

However, we know that we need to go further in our collective working endeavours rapidly to reduce the extended waits across the ICB, and you have committed to support this, accepting direct transfers onto your PTL to ensure that patients are rightly offered the choice of timely and high quality treatment across the ICS. In doing this, we recognise that there will be an apparent increase in your Trust's waiting times, with a potentially steep rise in the numbers of patients waiting over 65 weeks on your PTL as we collectively support reducing overall system-level waits.

We recognise that between now and March 25, the Trust may show a position that is non-compliant with the national planning direction to ensure that no patient waits more than 65 weeks after September 24. We will continue to represent at all oversight meetings regionally and nationally around segmentation and performance, and where necessary with other regulatory bodies, that your long waiting position as part of this plan is a reflection of your duty to collaborate. Any change to Trust long waiters driven by these patient transfers should be seen through the lens of support for other challenged providers rather than this being symptomatic of trust performance: indeed, your ability to offer this wider system mutual aid should be seen and celebrated as a sign of the strength of your delivery.

We will continue to discuss the position at our formal fortnightly regional tiering meetings with the national team, and to ensure that we are maintaining progress against our plan, which will then allow us to collectively assure delivery of our recovery plan.

Yours

Dan Bradbury
Chief Operating Officer
NHS England | South-East Region
Wellington House | Waterloo Road | London | SE1 8UG

Cc Adam Doyle – Sussex ICB CEO

East Sussex Healthcare NHS Trust

Report to:	Board of Directors	**Agenda Item:**	9
Date of Meeting	**10th December 2024**		

Title of Report:	Audit Committee Chair's Report
Status:	For Discussion
Sponsor:	Paresh Patel, Chair Audit Committee
Author:	Paresh Patel, Chair Audit Committee
Appendices:	None

Purpose

This report summarises the discussions, recommendations and approvals made by the Audit Committee on 28th November 2024 to provide the Board with an update of the Committee's activities.

Background

The Audit Committee holds delegated responsibility from the Board of Directors as set out in ToRs; this report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.

Business Undertaken

As below

Alert, Advise and Assure

Alert
None

Advise/Inform/Update

- The Committee received an update on Data Protection and Cybersecurity in the Trust, which highlighted the progress that was being made on completing the Data Security and protection Toolkit, along with the challenges of meeting some of the cybersecurity objectives in the organisation. The Committee requested for a high-level plan and timeline for addressing cybersecurity gaps to be included in the next Data Protection and Cyber Security report.

- The Committee received an update on the Trust's Security Service, noting an increase in violent and aggression incidents and the important of publicising sanctions to deter such behaviour. The increased complexity and acuity of mental health patients attending the Trust for treatment were noted as this could sometimes lead to violent behaviour.

- The Committee received an update from external auditors about plans for the end of year audit of the Trust due to take place in April 2025, and about the ongoing audit of Trust Charity's accounts for 2023/24.

- The Committee received an update from internal auditors including reports from competed audits of workforce planning and data quality. It also received an update on counter-fraud activities, including the completion of the national procurement exercise and the ongoing work to update policies and checklists.

Assurances

- The Committee reviewed the annual fire safety report, highlighting the improvements to fire compartmentation, risk assessments and staff training that were being undertaken to address the enforcement notice received by the Trust from the Fire and Rescue Service. Challenges in decanting patients to enable work to be undertaken as a result of recent pressures on the Trust were noted by the Committee. The Committee noted that the Trust would be engaging with the Fire Brigade in December to discuss progress and the challenges faced in complying with the enforcement notice. An update on fire compartmentation progress, including timelines, was requested to be sent to the Committee before Christmas.

- The Committee was provided with updates on improvement work to the Trust's risk management process, including changes to the risks team's processes and areas of focus, enhanced processes for monitoring the corporate and divisional risk register and processes for reviewing and updating risks more effectively. Progress on the allocation of risks to Board Committees, and an update on the progress of the Integrated Governance Group to be presented to the next Audit Committee meeting in 2025.

Key Risks or Opportunities and their impact on the Trust

Key risks are captured on the BAF

Key Decisions

- The Committee approved the updated Gifts, Sponsorship and Hospitality Policy.
- The Committee approved the Tenders and Waivers report.

Exceptions and Challenges

None

Recommendations

The Board is asked to note this report.

East Sussex Healthcare NHS Trust

Report to:	**Board of Directors**	**Agenda Item:**	9.
Date of Meeting	**10 December 2024**		

Title of Report:	**Finance & Productivity (F&P) Committee**
Status:	For Discussion
Sponsor:	Nicki Webber, Chair of F&P Committee
Author:	Nicki Webber, Chair of F&P Committee
Appendices:	None

Purpose

This report summarises the discussions, recommendations and approvals made by the Finance & Productivity Committee at its meetings on the **31 October 2024** and the **28 November 2024**.

Background

The Finance & Productivity (F&P) Committee holds delegated responsibility from the Board of Directors as set out in Terms of Reference; this report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.

Business Undertaken

As below

Alert, Advise and Assure

Alert (*Alert to matters that require the board's attention or action*)

- **M6 & M7 Financial Performance** – The committee discussed a revised range of full year forecast outturns; an improvement plan is being discussed with our Finance Recovery Director and with the ICB
- **M6 Capital Position** - The Committee reviewed the overspend of £1.5m above the forecast. The Committee was assured that the year end target was likely to be met as the Trust will be requesting for additional capital.

Advise (*Advise of areas of ongoing monitoring or development or where there is negative assurance*)

- **System Update** - The Committee noted the ICB guidance on starting the 25/26 budget process in advance of the operating framework. The Committee also received an update of the Trust's £5.7m deficit and the context of the pressure across Sussex ICB.
- **M6 Workforce Report** – The Committee noted the workforce usage with a slight cost increase due to higher reliance on Staff bank and recruitment agencies which were mainly due to short notice sickness in escalation areas.
- **Geothermal proposal** which was to form part of the Building for the Future (BFF) which is part of the New Hospital Programme. The Committee requested for alternative options to be explored and brought back.
- **25/26 Business Planning Process** - The Committee received an update on the 25/26 planning process. It was noted that business planning process had been launched at the beginning of October and a number of divisional workshops had taken place during October.

Assure (*Inform the board where positive assurance has been achieved*)
Nothing to report.

Key Risks or Opportunities and their impact on the Trust

The relevant risks are on the BAF.

Key Decisions

Cuckmere Tender Award

A report was presented for capital work to adapt and refurbish the existing Cuckmere ward to enable the current East Dean service to relocate as an enabling scheme for the EDGH Cardiology Transformation project. The Committee reviewed the report and upon due consideration approved for the award of contract to PD Harris Ltd, the cost was to be funded from the 2024/25 and 2025/26 capital programmes.

Digestive Diseases Diagnostic Centre Business Case (Endoscopy)

The Committee reviewed and approved a report to authorise the development of a Digestive Disease Centre at the Sussex Surgical Centre to increase capacity for Endoscopy procedures in the Trust. The Committee approval was in the following form:

- to progress development of the Digestive Diseases Centre on the first floor of the Sussex Surgical Centre.
- to reprioritise the 2025/26 capital programme to support the completion of the Centre.

Sussex Premier Hospital (SPH)

The Committee received and discussed the SPH three year business plan and supported an investment opportunity to combat constraints that needed to be overcome.

Acute Electronic Patient Record (EPR) Business Case

Following the Board's review of the EPR business case and the decision to delegate authority to the Committee, the EPR full business case was reviewed. The Committee approved the EPR business case subject to legal advice and the outcome of discussions with the Trust's external auditors being shared with the Committee.

Exceptions and Challenges

None of note

Recommendations

The Board is asked to note the content of the report.

Finance and Productivity Committee ("the 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.

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
  - Tracking performance against planned productivity improvement trajectories

3. Membership and attendance

The Committee membership shall comprise of:

- at least three non-executives
- Chief Executive
- Chief Finance Officer
- Chief Operating Officer
- Director of Transformation and Improvement
- Chief Nursing Officer

To ensure that non-executive directors hold the majority of votes on the Committee, only the Chief Financial Officer and Chief Operating Officer shall be invited to vote on any matter. The Committee Chair will have a second and casting vote in the event of a tie.

Where executive directors are in attendance at a Committee meeting, attendance of their deputies is optional, other than where such deputies are presenting an agenda item. Other members of staff including members of the divisional leadership and the finance teams will attend by invitation.

4. Quorum

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

5. Frequency

Meetings shall meet at least ten times a year. Additional meetings may be arranged as required.

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. In 2024 this included approving business cases between £500k-£2.5m and recommending cases above £2.5m to the board.
- 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
- Escalating material deviation from planned financial performance to the Board.

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. Chair of the Committee) shall have a second and casting vote.

8. Reporting arrangements

The Chair of the Finance and Productivity Committee will provide an upward report on key items for escalation to the Board which will be issued at the next Public Board meeting. However, in some instances including commercial, sensitive and confidential issues and early discussions on the forecast a report will be presented at the Private Board.

The Chair of the Committee shall make recommendations to the Board deemed appropriate by the Committee to be (on any area within the Committee's remit where disclosure, action or improvement are needed).

The Committee shall undertake a self-assessment of its effectiveness on at least an annual basis. The Associate Director of Corporate Governance and Compliance 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.

Terms of Reference approved by the Finance & Performance Committee on 31 October 2024

Ratified by the Board of Directors on [date] October

East Sussex Healthcare NHS Trust

Report to:	Board of Directors	**Agenda Item:**	9
Date of Meeting:	10 December 2024		

Title of Report:	People & Organisational Development (POD) Committee
Status:	For Discussion
Sponsor:	Carys Williams, Chair of POD Committee
Author:	Carys Williams, Chair of POD Committee
Appendices:	None

Purpose

This report summarises the discussions, recommendations and approvals made by the POD Committee at the 24 October and the 21 November meetings, providing the Board with an update of the Committee's activities.

Background

The POD Committee holds delegated responsibility from the Board of Directors as set out in Terms of Reference; this report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.

Business Undertaken

As set out below:

Alert, Advise and Assure

Alert

None to report

Advise

- **The Committee reviewed the workforce data at both meetings. Key highlights are set out below:**

September 2024 data reported in the October meeting

- **WTE Planned v Usage** in September, usage whole-time equivalents (wte) dipped below budget wte at 8,221 compared to the reduced budget of 8,225 (budget reducing in line with CIP). Although month on month, the workforce expenditure increased by £0.8m compared to August, the £688k overspend in month had reduced.
- **The Trust vacancy rate had reduced by 0.5% to 3.4%** (266.2 wte vacancies). This was due to the reduction in the substantive budgeted establishment in respect of the Cost Improvement Programme (CIP).
- **The mandatory training rate had increased by 0.4% to 91.0%,** a new high**.**
- **The Turnover rate had increased slightly by 0.1% to 10.8%,** equating to 773.2 wte leavers, an increase of 11.0 wte leavers.
- **The monthly sickness rate had increased by 0.2% to 5.2%** whilst the annual sickness rate was unchanged at 5.3%. Long term sickness had reduced since last month to 49.1% of the total (a reduction of 5.1%).
- **The appraisal rate had reduced by 1.7% to 82.8%**. This was due to a higher proportion of appraisals being scheduled for the Autumn, post summer holidays, not all of which have been renewed.

Workforce data for October 2024 was reported in the November meeting

- **WTE Planned v Usage** - Usage wte slightly reduced by 7 wtes to 8,214 vs a significant reduction of 69 wte in budget in line with CIP. Workforce expenditure had increased but this was due to the pay award being implemented in October.

- **The Trust vacancy rate reduced by 1.4% to 2.0% -**_153.3 wte vacancies. Due to the reduction in the substantive budgeted establishment in respect of the CIP plan plus successful recruitment to substantive posts.
- **The Turnover rate had reduced by 0.2% to 10.6%-**_Equating to 760.5 wte leavers, a reduction of 12.7 wte leavers. The Vacancy Control Panel continued to review requests for replacements to ensure a balance between operational needs and cost reduction.
- **The appraisal rate increased by 1.2% to 84.0% -**_There were increases in the compliance rates. All staff groups showed an improvement in compliance, except Additional Clinical Services staff who were unchanged.
- **The mandatory training rate reduced by 0.4% to 90.6%**_Remained historically high and above target**.** All courses at over 90% compliance, except for Information Governance, Fire Safety, Infection Control and Basic Life Support.
- **The monthly sickness rate has increased by 0.7% to 5.9% whilst the annual sickness rate remained unchanged at 5.3%**
- Wte days lost in month increased by 1,923. Year on year monthly sickness revealed a rate of 5.9% against last year for the same month at 5.5%.

The Committee was concerned that though the agency and other costs decreased in the month the total cost for staffing increased. The Committee was assured that the increase was due to unplanned escalation at the Emergency department and other areas for staff sickness and short notice absence. Improved rostering has resulted in reduction in nursing agency use but staff movement across wards and challenges remained in high-cost areas like theatres where roles were harder to fill.

- The Committee received a verbal update regarding Security Colleagues and the challenges they and staff across the Trust face. A personal safety training course had been developed and rolled out to staff members aiming to better equip them to manage violence and aggression. The Committee was concerned about how the Trust prevents repeat offences to ensure there was zero tolerance to violence and aggression. The Committee requested a further update in 2025.

- The Committee received the Freedom to Speak Up Guardian's report which will be presented to the Board at the meeting. The Committee noted that listening events have been conducted focussing on staff survey intelligence regarding bullying and harassment and line managers were been encouraged to be more proactive in addressing concerns

- The Committee reviewed the Attendance / Sickness Absence report which included an update on sickness hotspots within the Trust, reasons for sickness absence and the actions taken. The Committee has requested for quarterly update report for assurance throughout 2025.

- Other regular reports that the Committee reviewed were update on Mental Health first Aider training, public and staff engagement and staff survey update.

Assure
None to report

Key Risks or Opportunities and their impact on the Trust

Key risks are recorded on the BAF

Key Decisions

None to report

Exceptions and Challenges

None to report

Recommendations

The Board is asked to note the content of the report.

Report to:	**Trust Board**	**Agenda Item:**	9.
Date of Meeting	**10 December 2024**		

Title of Report:	**Quality & Safety Committee (QSC) – Chair's Report**
Status:	For Discussion
Sponsor:	Amanda Fadero, Chair of QSC
Author:	Amanda Fadero, Chair of QSC
Appendices:	None

Purpose

This report summarises the discussions, recommendations and approvals made by the QSC at the 30 October and the 28 November 2024 meetings, to provide the Board with an update of the Committee's activities.

Background

The QSC holds delegated responsibility from the Trust Board as set out in Terms of Reference. This report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.

Business Undertaken

As below

Alert, Advise and Assure

Alert

None.

Advise/Inform/Update

- The Committee reviewed a Harms Review Reports from Diagnosis, Anaesthetics and Surgery (DAS), Medicine and Urgent Care Division – the report acknowledged associated risk (e.g. falls, psychological harm and physical deconditioning etc) for vulnerable patients whose length of stay in the hospital extend beyond 14 days. The Committee noted update on reviews on patient whose length of stay was beyond 100 days. The Committee noted that the harm's reviews were done with the knowledge of the patient's friends and family and the reports were to be shared with the ICB level meetings.
- Maternity Dashboard and Ockenden Perinatal Quality Surveillance Report - the Committee noted Perinatal mortality and morbidity rates were tracking well against national averages despite the challenges linked to the Maternity workforce. The Committee were concerned assisted birth rates remained slightly higher than national and requested for a report on a recent audit finding.
- Governance Quality Report – the Committee noted that implementation of PSIRF remained a core focus, along with Safety Learning modules in the Datix system. The Committee was concerned about Duty of Candour compliance remaining low and requested for further update
- Safer staffing report – the Committee review the staffing issues and vacancy held by the Community teams and the Emergency department which were up to 16%. And the challenges exacerbated by sickness and stressed related conditions. The Committee advised that it importance of proactively seeking new approaches to improve staffing provision and requested that a further update focused on targeted recruitment strategies be brought to the Committee within the coming months
- The Committee received the Seven Day Service (7DS) BAF, which is a regulatory requirement. The Committee was concerned that the Trust was not fully compliant with all the requirement

of the 7DS BAF as it was not fully embedded within the Trust. The Committee requested for an update in a future meeting.

- The Committee received an update the Human Tissue Authority inspections on the Mortuary. The Committee reviewed the Action Plan and requested for future updates to be reported through the External visits' tracker.

Assurances

The Committee reviewed the following annual reports:

- Infection Prevention and Control Annual report
- Organ Donar Annual report

Key Risks or Opportunities and their impact on the Trust

- Related risks are recorded on the Committees Corporate Risk Register and the BAF
- Risks around non-compliance with the 7-day services standards
-

Key Decisions

The Committee approved the following:

- Infection Prevention and Control Annual report
- Organ Donar Annual report

Exceptions and Challenges

None.

Recommendations

The Board is asked to note this report.

East Sussex Healthcare NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

KINDNESS

INCLUSIVITY

For the Period October 2024 (Month 7)

INTEGRITY

Content

East Sussex Healthcare NHS Trust

1.	About our Integrated Performance Report (IPR)
2.	Chief Executive Summary
3.	Balanced Scorecard and Benchmarking
4.	Quality and Safety
5.	Our People
6.	Access and Responsiveness
7.	Financial Control and Capital Development

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 (2024/25), 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

The Trust is working towards delivering the 2024/25 operational planning guidance and is focused on continuing to improve several key indicators and standards to support the provision of high-quality care for our patients, building upon the improvements already seen across elective and urgent care in 2023/24. The Trust continues to prioritise front door performance, length of stay optimisation and efficient discharge processes to ensure that patients receive timely and effective non-elective care. In addition, the Trust is committed to improving elective recovery, especially in critical areas including cancer treatment, diagnostics, routine long waits and supporting system partners with reducing the number of long waiting patients.

Cancer 62-day pathway and Faster Diagnostic Standard (FDS) has been meeting its trajectories since June 24 and May 24 respectively. Recovery plans are in place for challenged cancer tumour sites to ensure continued delivery of 62-day performance.

It has been a challenging few months for the Trust's 4-hour Emergency Access Clinical Standard. In October 2024, 70.5% of patients were seen and discharged or treated and admitted within 4 hours, against the 78% target. The Trust is working collaboratively with system partners where performance is impacted by high bed occupancy in our hospitals due to limited ability to discharge patients to their onward care destination.

Key Areas of Success

- The Trust is showing a positive position over the last eight months against FDS. FDS in September was 81.9% against the national cancer waiting time standard of 77%
- Cancer 62-day performance in September was 70.2% against the national cancer waiting time standard of 70%. The Trust is performing above the national average
- Elective recovery fund activity targets are being achieved
- The Trust is supporting patient care and provide better waiting times for all patients across Sussex. We are working with University Hospital Sussex to treat their elective long waiters
- Sustainably delivering above target for our 2-hour urgent community response
- The diagnostic standard was 92.5% in October 2024. The Trust is focusing on under performing modalities to achieve the national ambition of 95% by March 25.

Key Areas of Focus

- Delivering the actions from our Urgent and Emergency care improvement plan to ensure sustainable delivery of the 4-hour performance continues to be a priority for the Trust
- Year end projection is £14.9m deficit with risks including winter pressures. Run rate controls are in place.
- Deliver on the workstreams in our Use of Resources (UoR) programme. UoR YTD delivery at month 7 of £16.1m against plan of £16.2m
- Continued focus on both Trust and Divisional level to improve productivity and ERF performance against plan.

Balanced Scorecard

East Sussex Healthcare NHS Trust

Safety	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Number of Patient safety events (severity 1-5)	0	863	994	931	Common Cause	Not Met
Number of Patient safety events (severity 3)	0	22	28	13	Concern	Not Met
Number of Patient safety events (severity 4 ...	0	2	3	5	Common Cause	Inconsistent
Never Events	0	0	0	0	Common Cause	Inconsistent
Inpatient Falls per 1,000 Bed days		4.44	5.06	3.86	Improvement	Target required
Cat 3 ESHT Acq. PU (rate) per 1,000 bed days	0	0	0	0	Common Cause	Inconsistent
Cat 4 ESHT Acq. PU (rate) per 1,000 bed days	0	0	0	0.0444	Common Cause	Inconsistent
Healthcare Associated MRSA Bacteraemia (r...	0	0	0	0	Common Cause	Inconsistent
Healthcare Associated C Diff Infections (rate)...	0	0.404	0.390	0.178	Common Cause	Inconsistent
Healthcare Associated MSSA Bacteraemia (r...	0	0.0807	0.312	0.133	Common Cause	Inconsistent
RAMI	100	87.2	87.7	80.3	Improvement	Achieving
SHMI (NHS Digital monthly)	100	101	101	110	Concern	Inconsistent
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	91.1%	91.9%	95.2%	Improvement	Not Met

Patient Experience	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Complaints received		47	36	54	Common Cause	Target required
Complaints Response Compliance (60 w...		57.5%	80.8%		Common Cause	Target required
Reopened Complaints		9	4	6	Common Cause	Target required
A&E FFT Score	85%	80.8%	80.9%	90.6%	Common Cause	Inconsistent
A&E FFT Response Rate		15.4%	14.5%	4.98%	Improvement	Target required
Inpatient FFT Score	95%	98.1%	97.4%	97.5%	Concern	Achieving
Maternity FFT Score	95%	82.1%	92.3%	98.8%	Common Cause	Inconsistent
Outpatient FFT Score	95%	95.2%	95.2%	96.7%	Concern	Inconsistent
Post Covid19 Assessment FFT Score	95%	100%	100%		Common Cause	Inconsistent

Our People	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Establishment (WTE) All		8,225	8,156	7,184	Common Cause	Target required
Agency Rate	3.6%	0.699%	0.711%	1.44%	Improvement	Achieving
Vacancy Rate	7.5%	3.4%	2%	10.8%	Improvement	Achieving
Staff Turnover	11.6%	10.8%	10.6%	10.4%	Common Cause	Achieving
Retention Rate	90%	92.8%	92.0%	91.7%	Common Cause	Achieving
Monthly Sickness - Absence %	4.7%	5.23%	5.9%	4.5%	Common Cause	Inconsistent
Sickness - Average Days Lost per Fte	17	19.4	19.5	16.1	Concern	Not Met
Staff Appraisals	85%	82.8%	84%	79.6%	Common Cause	Not Met
Statutory & Mandatory Training	90%	91%	90.6%	88.4%	Improvement	Inconsistent

Our Performance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
4 hour standard	75.0%	74.3%	70.5%	81.2%	Common Cause	Inconsistent
A&E > 12 hours from arrival to discharge	0	1046	1162	218	Concern	Not Met
A&E waits over 12 hours from DTA	0	22	71		Concern	Inconsistent
Conveyance handover >60 mins	0%	1.66%	3.23%	1.22%	Common Cause	Inconsistent
Non Elective Length of Stay	4.36	4.96	5.12	3.97	Common Cause	Inconsistent
Average daily NCTR	164	231	218		Common Cause	Not Met
Cancer 62 Day	63.5%	72.7%	70.2%	70.2%	Common Cause	Inconsistent
28 Day General FDS	75.0%	80.4%	81.9%		Improvement	Inconsistent
104 day Backlog	29	31	25	36	Common Cause	Inconsistent
Elective Activity (ELIP,DC,OPFA, OPFUP P...	122%	120%	120%		Improvement	Not Met
RTT under 18 weeks	92%	55.3%	53.7%	90.4%	Common Cause	Not Met
RTT 65 week wait	0	8	66	0	Improvement	Not Met
RTT Total Waiting List Size	55250	56536	55592	29434	Common Cause	Inconsistent
Diagnostic <6 weeks	1%	13.1%	7.45%	0.572%	Common Cause	Not Met
Urgent Community Response within 2 h...	70%	80.2%	83.2%		Improvement	Achieving
CHIC wait times < 13 weeks	75%	76.7%	79.5%	89.5%	Concern	Achieving
Intermediate Care Length of Stay	30	38.9	39.4	23.3	Common Cause	Inconsistent
% Discharges delayed 1+ days		22.2%	21.3%		Common Cause	Target required
Total delay days from monthly Discharges		5334	5017		Common Cause	Target required
Number of Deferred visits/ care plans	0	7107	7262	1364	Concern	Not Met

Finance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Surplus/(deficit) (£'000) - in month	283	9,734	(1,430)	n/a	n/a	Not met
Surplus/(deficit) (£'000) - YTD	(1,766)	(7,769)	(9,199)	n/a	n/a	Not met
ERF (£'000) - in month	12,538	10,249	23,591	n/a	n/a	Achieving
ERF (£'000) - YTD	77,237	57,601	81,192	n/a	n/a	Achieving
Efficiency (£'000) - in month	3,175	1,287	5,815	n/a	n/a	Achieving
Efficiency (£'000) - YTD	13,596	10,319	16,134	n/a	n/a	Achieving
Capital (£'000) - YTD	9,422	14,799	19,846	n/a	n/a	Achieving
Capital (£'000) - FOT	75,314	76,599	75,314	n/a	n/a	Achieving

Constitutional Standards | Benchmarking

*NHS England has yet to publish all October 2024 Provider based waiting time comparator statistics

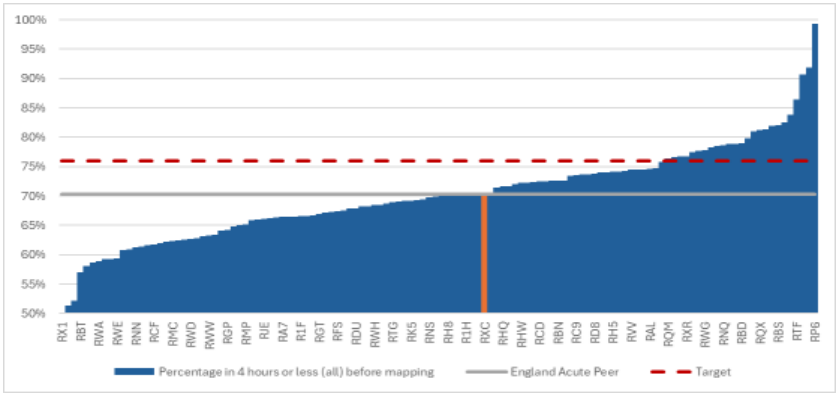
East Sussex Healthcare NHS Trust

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

October 2024 Peer Review

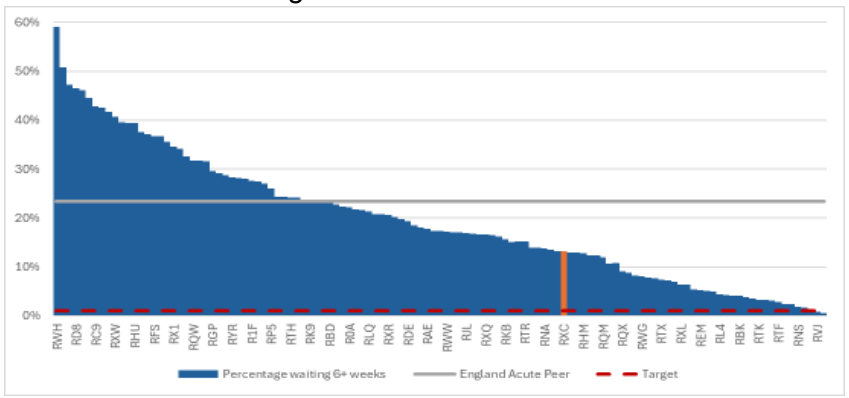
National Average: 70.4% ESHT Rank: 55/124



Planned Care – Diagnostic Waiting Times

September 2024 Peer Review*

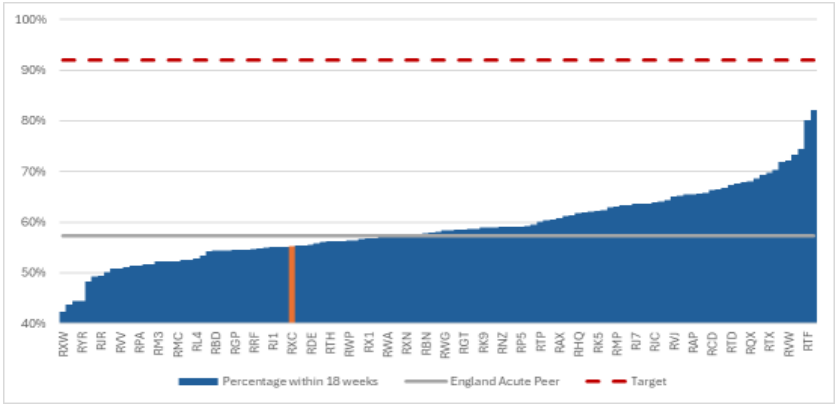
National Average: 23.4% ESHT Rank: 41/119



Planned Care – Referral to Treatment

September 2024 Peer Review*

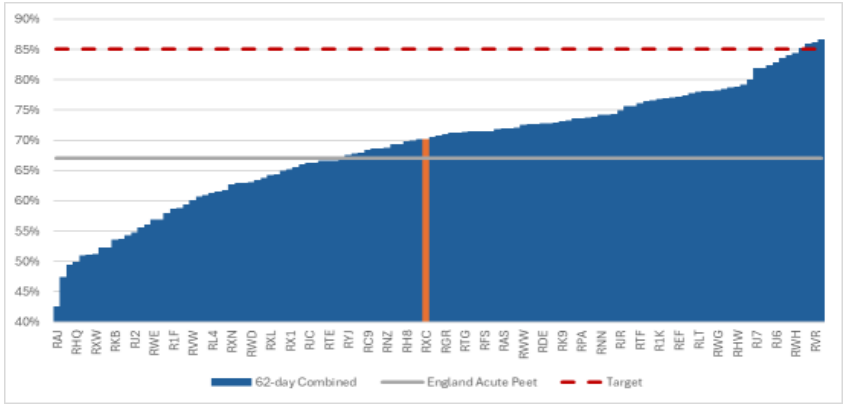
National Average: 57.3% ESHT Rank: 83/119



Cancer Treatment – 62 Day Combined Standard

September 2024 Peer Review*

National Average: 67.0% ESHT Rank: 62/119



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

Infection Control
Healthcare Associated Infection limits have been set by NHSE for 2024/25. ESHT limits are: C. difficile 67;E. coli 109; P. aeruginosa 19; Klebsiella sp. 47. There have been no limits set for MSSA and the expectation for MRSA is zero avoidable bloodstream infections.

ESHT is likely to exceed the CDI threshold as 66 cases reported thus far, with discussions at TIPCG and QSC in relation to causes and mitigations. This is multifactorial due to very high occupancy, frailty, antibiotic stewardship and transmission. National CDI incidence has increased by over 20% since Jan 23; the reason is not fully understood yet.

For October, we reported ten cases of CDI. Nine were HOHA and one COHA. No further case of 002 were identified at EDGH. There were no MRSA bacteraemias for October. 8 MSSA in October; 3 COHA and 5 HOHA, none assessed as avoidable. COVID outbreaks have reduced. Low level flu and RSV being detected. Mpox and high consequence infection preparedness continues, further staff training required in new high level PPE procedure.

Safety Events
Reporting on DCIQ has levelled for the month of October 2024 and is at 1122 (ESHT only and filtered for duplicates). 81% of the total patient events were no harm/near miss, with the national average at 71%. We have a good reporting culture at ESHT: it was noted for the last two months that this was percentage was lower, but it has returned to a more consistent level

The themes of the top three categories for October 2024 were:
Slips, Trips and Falls (180) : a slight increase from the previous month 2024, this is monitored further by the Trust Falls Steering Group.

Medication Errors (132): this is an increase on September. This is monitored and reviewed by the Trust MSO and overseen by the MSG and MOG.

Patient Discharges & Transfers (83). With the additional internal work, we are now seeing a consistent decrease in patient safety events.

Harm Level:
There was **0 Catastrophic events** (Severity 5) reported in October 2024
Also, 2 **Major events** (Severity 4) were reported by all with planned review at the **WPSS** (reported dates are all in the final days of October 2024). One severity 4 has been discussed at WPSS and has been downgraded to a severity 1.

Safeguarding
There has been a further dip in attendance for Think Family level 3 training, with 59.7% of staff marked as compliant within the October scorecard. Level 3 training applies to all clinical staff Band 5 and over. The training is a hybrid model with staff accessing e-learning prior to a facilitated session. As a result, all facilitated sessions for the next few months are virtual to accommodate more staff. Trust attendance at MCA/DOLS training demonstrates 91.9% of staff as compliant.

NHSE developed a new data reporting site, and this will now be the platform to submit Prevent and FGM data. Additionally, there will also be a requirement to submit the data around the children in care health assessments. Whilst data has been submitted for Q2 ,the new portal has since glitched, denying access, and this has been escalated to NHSE IT services with hopes of resolution prior to the next reporting date.

We are now able to access data regarding the use of the rapid assessment screening tool in ED and a meeting is booked to improve compliance. Discussions are ongoing to extend the use beyond ED. New workstreams are being developed around neglect and self-neglect.

Mortality
RAMI indices of mortality rolling 12 months is 88 for the current period and positioned at 44 out of 120 Acute Peer Trusts. SHMI is showing a value of 101 and is within the expected range. EDGH has an index of 100 and Conquest 102.
Weekend RAMI continues to show a value below the national average for HES Acute peers. SHMI contextual data is not yet available for the period.

Author(s)

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

Simon Merritt
Chief Medical Officer

Quality and Safety | Executive Summary

East Sussex Healthcare NHS Trust

Patient Experience

As a percentage of total PE feedback, complaints and PALS concerns remain negligible.

We received 36 new complaints, a decrease of 11 vs. September's number. Against our internal targets, 3 complaints were overdue at the end of October (the oldest being 29 working days over). Of the complaints closed in-month: Against the timeframe of 60 working days, 81% were completed in time (September =58%).

Reviewing the monthly risk rating of all complaints, most were 'low' in common with the general pattern: 3 high risk (September =3),15 moderate risk (September =30) and18 low risk (September =14).

We take re-opened complaints/PHSO contacts as proxies for where we can learn. 4 complaints were reopened (September =9), 2 to Medicine, 1 to CHIC and 1 to WCSH (2 were unhappy with the Trust's response and 2 were seeking further clarification).

The Trust received 2 enquiries and 4 outcomes from the PHSO in October

Of the 36 complaints in October, 67% came from two categories: Clinical Treatment =14 and Patient Care =10.

Top complaint location in October was typical: ED =7 (EDGH =2 and CQ =5) and Outpatient Department =3 (EDGH=4).

701 contacts were recorded by PALS in October, which is an increase of 76 when compared to September (=625), no themes identified. Of these contacts, 371 PALS contacts were recorded as "concerns" (September =346). The top three primary PALS subjects recorded as a "concern" were as follows: Communication =96 (of these 49% related to communication with patients, relatives and carers), appointments =73 (of these 63% related to long waiting times and cancelled

The Trust's digital FFT model continues to be successful in securing higher rates of responses. FFT responses for October (=12,414) were a further increase on September (the revised activity figure for September was 10,158), which was in part due to the restoration of the Community FFT.

Trust wide positive feedback rate was 93.47%. This was on a par with September (93.30%). Of the 12,414 FFT responses, 8,586 (70%) were received by SMS or the IVM service, 1,532 (12%) were completed via online FFT's and 2,296 (18%) were completed on paper. The comments patients provide as to why they gave the score generate word-based themes; in October, the top positive theme was Staff Attitude (6,112 positive comments), followed by Implementation of Care (3,322) and Environment (1,953). Conversely, the top negative theme was Staff Attitude (363 negative comments), followed by Waiting Time (281) and Environment (276).The increase in FFT responses contributed to the increase in plaudits for October to 8,413, compared to 7,345 for September, with FFT plaudits accounting for 99.00% of these.

Workforce

We have continued to see a high level of attendances to the Emergency Departments and continued high occupancy, despite a consistent focus on discharge, successful use of Minerva to support packages of care and our improvement programmes regarding length of stay. There are still significant numbers of patients whose primary need is psychosocial in our Emergency Departments (ED) and gateway/inpatient areas, requiring specialist Mental Health support/skills, especially at EDGH.

Ward and Community staffing in Oct remained stretched to cover the additional requirements. In all areas this is likely to have had an impact on key quality KPIs. This is also impacting on compliance with some training and, at times, staff wellbeing. Overall, however, there continues to be an improvement in appraisals and mandatory training (all staff) compliance. The focus continues on Healthroster efficiency, use of temporary workforce, authorisation of additional shifts and supernumerary time. There are significant improvements noted regarding the reduction in use of agency and additional shifts through roster efficiency and fortnightly oversight from the CNO and DCN. This needs to include other staff groups/rosters going forward applying the same methodology.

Author(s)

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

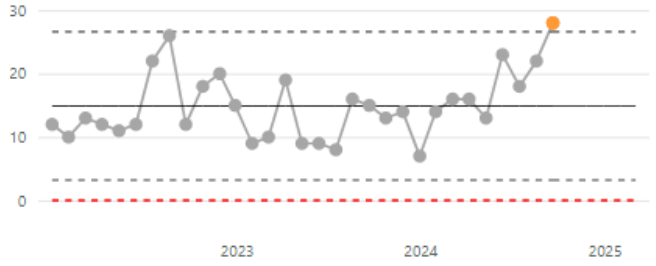
Simon Merritt
Chief Medical Officer

Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

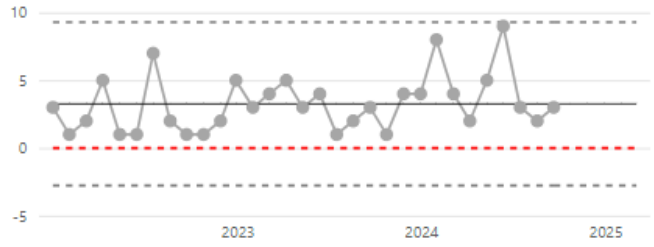
Number of Patient safety events (severity 3): Total, Safety

Not Met	Concern	28



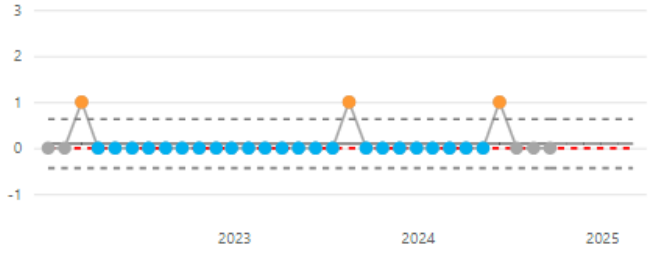
Number of Patient safety events (severity 4 and 5): Total, Sa...

Inconsistent	Common Cause	3



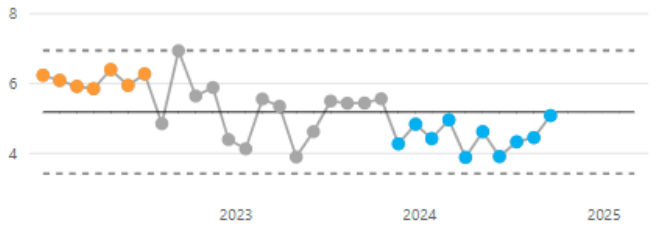
Never Events: Total, Safety

Inconsistent	Common Cause	0



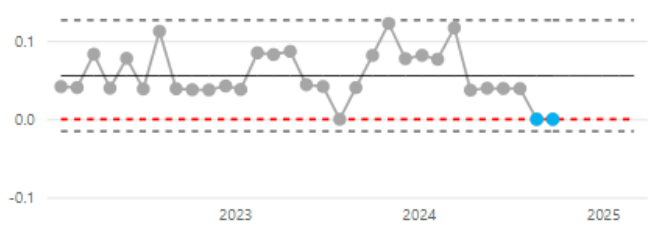
Inpatient Falls per 1,000 Bed days: Total, Safety

Target required	Improvement	5.07



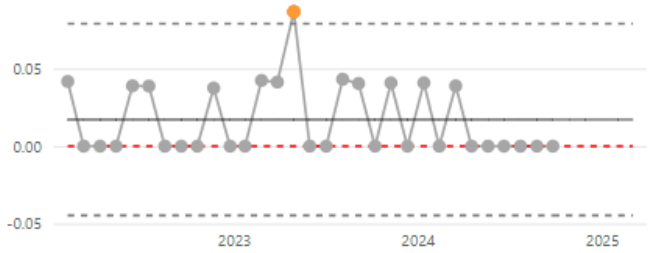
Cat 3 and 4 ESHT Acq. PU (rate) per 1,000 bed days: Total, S...

Inconsistent	Improvement	0



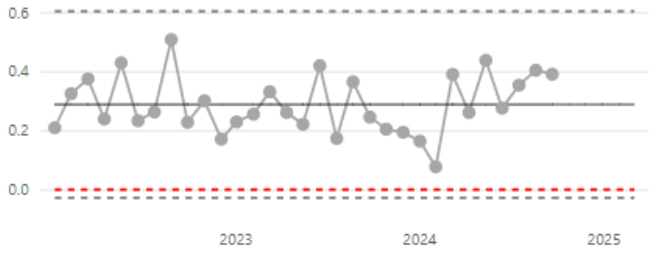
Healthcare Associated MRSA Bacteraemia (rate) per 1,000 ...

Inconsistent	Common Cause	0



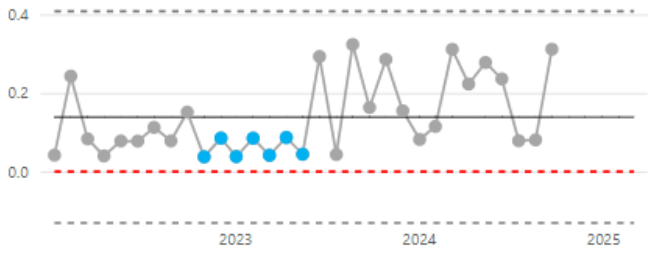
Healthcare Associated C Diff Infections (rate) per 1,000 Bed ...

Inconsistent	Common Cause	0.390



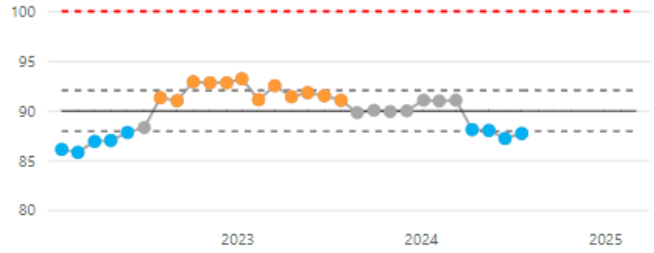
Healthcare Associated MSSA Bacteraemia (rate) per 1,000 ...

Inconsistent	Common Cause	0.312



RAMI: Total, Safety

Achieving	Improvement	87.7

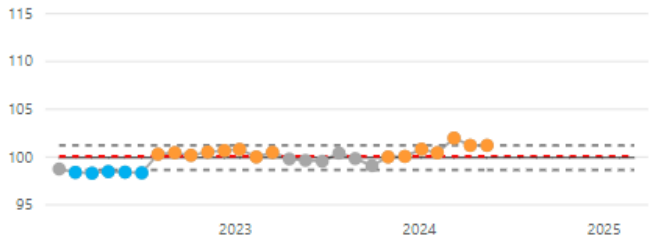


Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

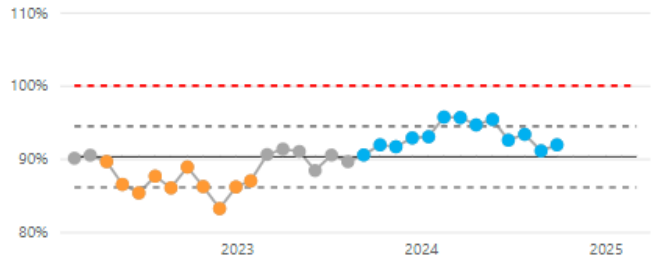
SHMI (NHS Digital monthly): Total, Safety

Inconsistent	Concern	101



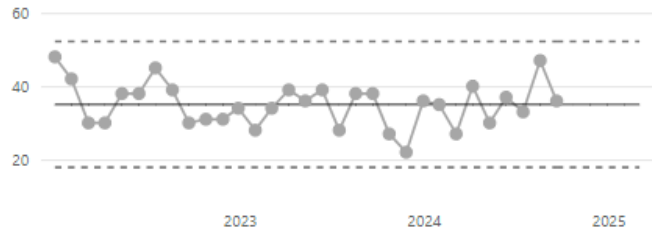
Nursing Fill Rate (IP - RN, RNA and HCA): Total, Safety

Not Met	Improvement	91.9%



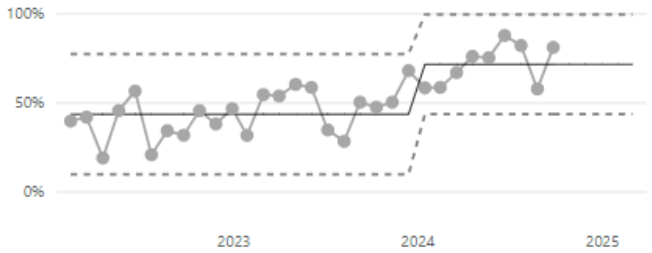
Complaints received: Total, Patient Experience

Target required	Common Cause	36



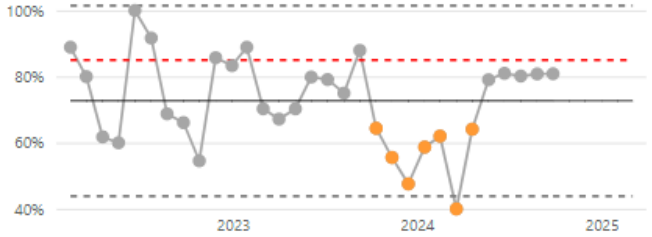
Complaints Response Compliance (60 working days as of 1...

Target required	Common Cause	80.8%



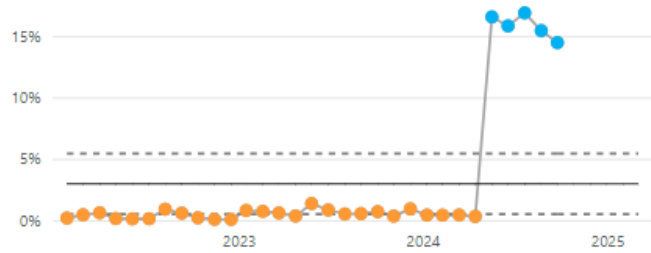
A&E FFT Score: Total, Patient Experience

Inconsistent	Common Cause	80.9%



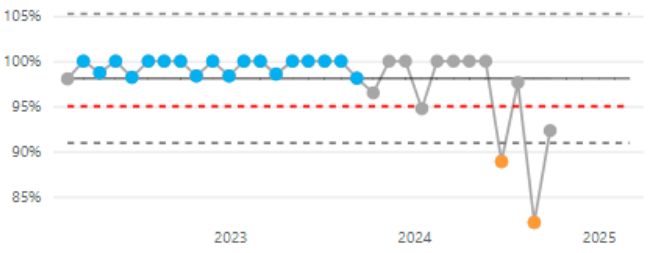
A&E FFT Response Rate: Total, Patient Experience

Target required	Improvement	14.5%



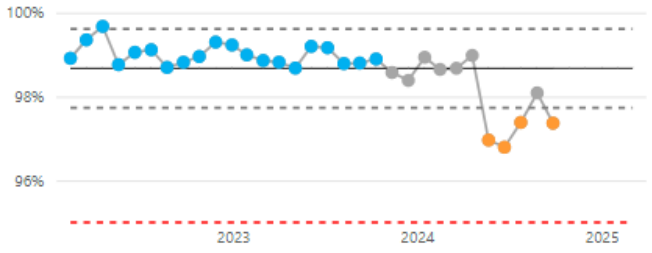
Maternity FFT Score: Total, Patient Experience

Inconsistent	Common Cause	92.3%



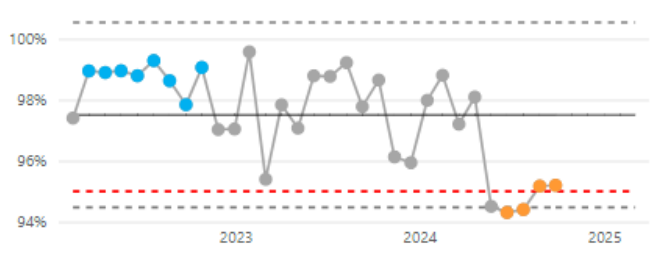
Inpatient FFT Score: Total, Patient Experience

Achieving	Concern	97.4%



Outpatient FFT Score: Total, Patient Experience

Inconsistent	Concern	95.2%



Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Patient Safety Incident Response Framework (PSIRF)	The Duty of Candour percentage continues to be low following on from the previous month. The position for verbal is at 43% (this continues to be monitored, and Divisions are supported to complete in a timely manner; the percentage this month is lower again compared to the previous two months of 54% and 56% respectively. 'Written' has moved to a lower percentage of 38% compared to the previous two months, when it was in the 60% plus percentile. This reduction overall has been observed to be due to the reporting on Psychological harm, which is now being validated as part of the WPSS process and in discussions with the Divisions and Patient Safety Team. The process remains in situ for reporting, triaging and deciding on level of harm of events at this time and will continue to be reviewed as PSIRF develops. The PSIRF Working group are reviewing the processes and will be collaborating closely with DCIQ to leverage the digital capability of the system to facilitate both process and documentation, which ultimately positively impacts oversight, benchmarking, reporting and analysis overall. The “Safety Learnings” Module in DCIQ has been reviewed and a pilot will commence by the QI lead with T&O department in January 2025. The Patient Safety Team are reviewing to see how the data can enable and support the embedding of learning across Divisions and their services.	• All reporting under the SIF has now ceased and we are now fully on the PSIRF. • The PSIRF Working Group focus on moving learning from PSIRF moving forward within Divisions. The PSIRF Plan and Policy has been updated and will seek approval from PSQG and Q&S Committee. The approved Documents will be shared with the ICB at the quarterly monitoring meetings. . • Processes are being reviewed with a digital lens to move from paper to digital documentation, which is being achieved through collaboration with the Datix team. • Weekly meetings with Senior Nursing Leadership within the Divisions and the CNO continue, to monitor PSIRF template compliance continues. • Uptake of Training for All Staff Level 1 PSIRF training – the report for October shows a consistent percentage of 90.5%.
Nursing & Midwifery Workforce	During October, occupancy remained very high with ongoing use of additional super surge beds, pre-emptive boarding and significant numbers of patients requiring enhanced observation re high risk of falls or patients with challenging/violent behaviour. Controls remain in place to ensure staffing continues to meet the needs of our patients and there is an overall reduction in the reliance on agency staffing in our inpatient areas. Ward nursing CHPPD overall was 8.2 for Oct (noting distortion by specialist areas). Nursing fill rates for day shifts = RN 90% and HCSW 88%. Nursing fill for night shifts = 94% for RN and 100%.	• Data collection to inform the annual Nursing Establishment Review (NER) is complete using the new national tool piloted/tested in the Spring. • Recruitment to the Mental Health Outreach team has commenced and a review of training for staff and a review of the estate in high-risk areas is also in progress. • Nursing/Midwifery monthly Roster Compliance sessions continue, led by the DCN to ensure effective/efficient nursing rosters. There is a fortnightly roster assurance panel in place with the CNO, to support working within budget and review of temporary staffing requests. There is evidence of good controls and work in progress to support enhanced observations and requests for additional staff. The focus is now on reducing our reliance on Agency staffing. Other roles now need to follow the same methodology. • Job specific skills review and training needs analysis has commenced to ensure staff receive the training to meet the needs of our people. • We are working with integrated education on improving the education and career progression framework including restorative supervision and reviewing the role of practice educators and current resources.

Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

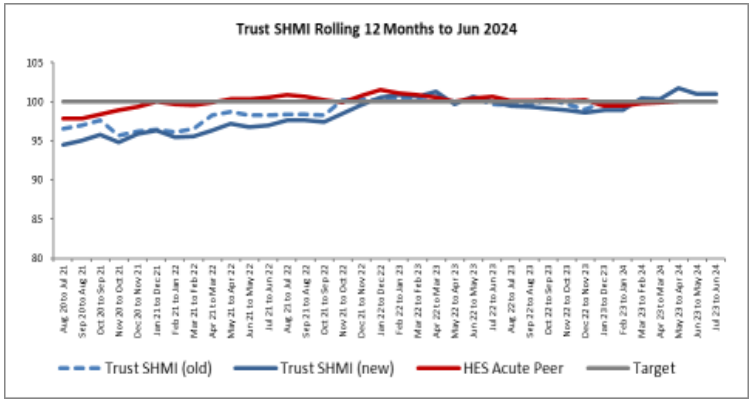
Title	Summary	Actions
Inpatient Falls	**Slips, Trips and Falls** (**180**), an increase from September 2024 (**140**). There were no Catastrophic events/incidents for Slips Trips & Falls, there was 1 major events/incident and 4 Moderate harm (Severity 3) and all others Minor or no harm. SWARM falls templates are completed by the service and discussed at the Trust Falls group bi-monthly by the Divisions. The falls rate for **all** falls for ESHT per 1000 bed days was **6.76** in October 2024; this is a slight increase from the **5.64** reported in September 2024. The top sub-category was 'patient fall whilst mobilising independently', The main locations for patient falls were Newington ward (15), the Emergency Department CQ (11) and EDGH ED (9).	• The Quality Improvement Lead Nurse is working with ward areas and teams to close the loop in responding to the learning outcomes identified. • There is an ongoing Falls QI project looking to reduce inpatient falls by 20% within the BIU. • SWARM Forms have been updated and there will be a report from the Divisions going to the Falls Steering group to review themes and trends as well as consider further quality improvement potential. The SWARM Falls template continues to be monitored, and peer reviewed by the PSIRF Review Group and they are part of our completion of our learning tool in the implementation of PSIRF in ESHT.
Patient Experience	Continued increase in FFT responses and overwhelmingly positive feedback. Complaints response rate improved.	• Explore how the learning from complaints, PALS and FFT can be used to make changes.
Harm reviews	Ensure there is a process of review for patients who experience long waits and/or who have domiciliary visits deferred.	• Systems now in place for snapshot reviews of patients with a LLoS and who have community/domiciliary visits deferred with results going to relevant Div IPR and summary overview to PSQG. • A formal overview of Harm Reviews has been prepared for Board and external partner review
Pressure Damage	There have been no Cat 3 or 4 PUs reported amongst inpatients in the last 2 months. Originally none were reported in August, however a PU reported as category 2 deteriorated and was now been recoded as Category 3. A review is underway to determine any potential learning. Two category PUs were reported in the community setting, in patients in their own homes, in October. On assessment one was found to be a category 3, the other a category 4.	• The Pressure Ulcer Steering Group (PUSG) is working with the Trust Patient Safety Lead, to ensure a PSIRF approach to pressure ulcer prevention going forward. • A new national PU categorisation tool was published in June 2024 and is under review by the PUSG for implementation. • New Pressure Ulcer & Wound care training has been produced by the National Wound Care Strategy Programme and has been added to training for clinical staff to complete.

Effective Care - Mortality

East Sussex Healthcare NHS Trust

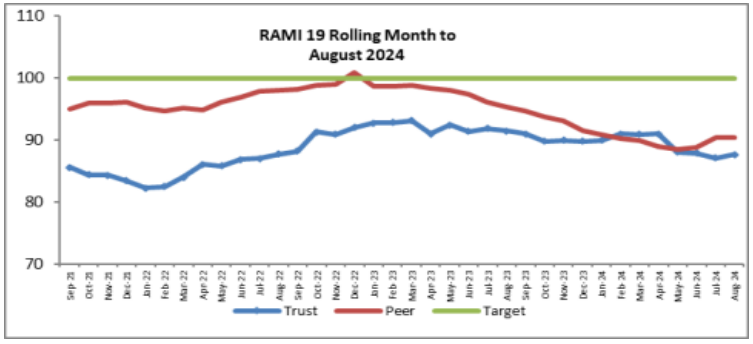
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

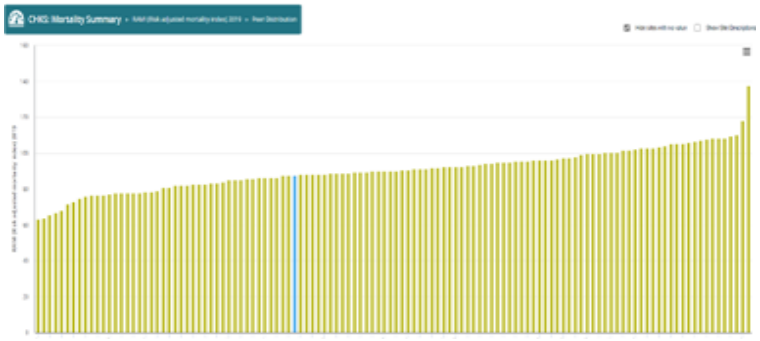
Summary Hospital Mortality Indicator (SHMI)
Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures



- SHMI – July 2023 to June 2024 is showing an index of 101 and is within the expected range. EDGH is showing 100 and Conquest is 102. Peer SHMI for the latest period is not yet available. The graph shows two lines for SHMI with the new methodological changes compared to the previous calculations. SHMI is rebased each time it is published but RAMI was last rebased in 2019. It is due to be rebased shortly.
- RAMI 19 – Sep 2023 to Aug 2024 (rolling 12 months) is 88, and 92 for the same period last year. Aug 2023 to Jul 2024 was 87.
- RAMI 19 was 90 for the month of August only and 79 for July. Peer value was 109 for August only. The line graph below shows the rolling 12 month figure
- Crude mortality shows Sep 2023 to Aug 2024 at 1.57% compared to 1.78% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 64% for August 2024 deaths compared to 58% for July 2024 deaths.

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





This shows our position nationally against other acute trusts – currently 44/120

Effective Care - Mortality

East Sussex Healthcare NHS Trust

October 2024 Main Cause of In-Hospital Death Groups (ESHT)

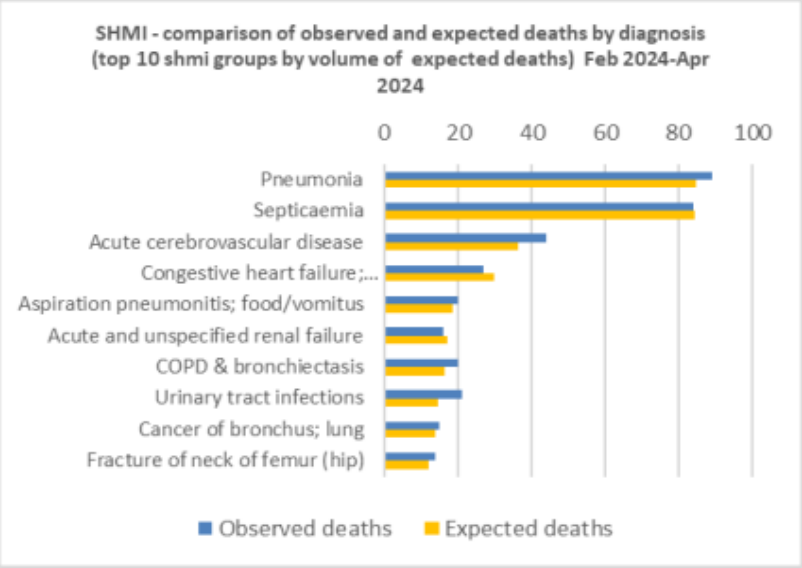
Description	Deaths
Cancer	17
Pneumonia	13
Sepsis/Septicaemia	12
Heart Failure	8
COVID-19	7
Hospital-acquired Pneumonia	6
Stroke	6
Community-acquired Pneumonia	5
Frailty of old age	5
Chronic Obstructive Pulmonary Disease (COPD)	4
Dementia	4
Myocardial Infarction (MI)	4
Aspiration Pneumonia	2
Bowel Obstruction	2
Liver Disease	2
Urosepsis	2
Atrial Fibrillation (AF)	1
Bowel Perforation	1

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

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

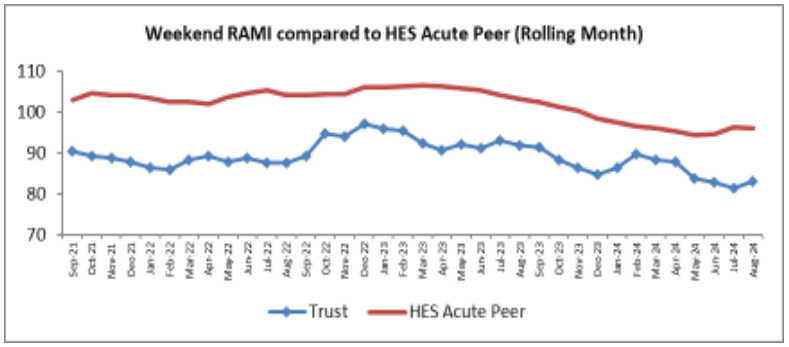
NB: Delays in recording cause of death can be due to awaiting results from an inquest, post-mortem or other reasons.

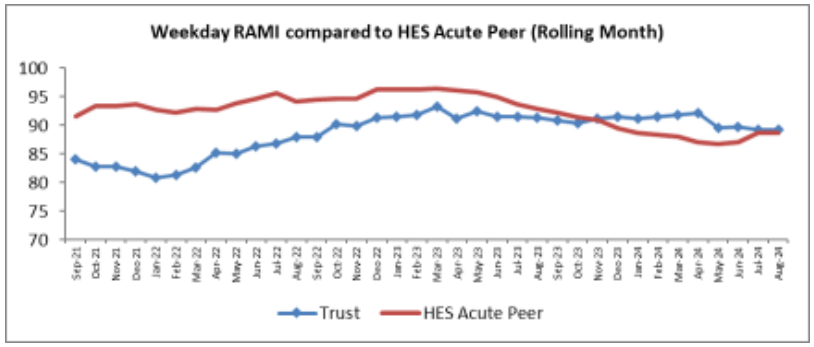
SHMI Diagnosis Main Groups



Risk Adjusted Mortality Index (RAMI)

Weekend and Weekday Mortality Trends





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

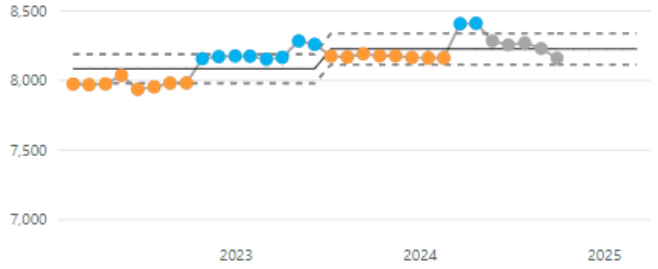
Responsive	**Positives:** Turnover reduced by a further 0.2% to 10.6% and within target. Vacancy rates reduced by 1.4% to 2.0%, well within 7.5% target. Mandatory Training rate is compliant with the 90% standard, though fell slightly by 0.4% to 90.6%.	**Challenges and Risks:** Monthly sickness increased by 0.7% to 5.9% with an increase in seasonal illness. Average days lost per fte increased slightly to 19.5, above target. Appraisal rate increased by 1.2% to 84.0% but still 1% below target.	**Author** 
Overview:	In October, usage wte did reduce slightly by 7 wte to 8,214. There was a reduction of 69 wte in budget, however, to 8,156 in line with the Cost Improvement Plan (CIP), usage is now 58 wtes above budget. Workforce expenditure has increased but this was due to the pay award being implemented in October. The net pay position actually shows an improvement of £0.2m month on month. The Turnover rate has reduced by 0.2% to 10.6%, which equates to 760.5 wte leavers, a reduction of 12.7 wte leavers. This is the first reduction in the rate since Jul 24. The turnover rate has reduced for Medical & Dental staff (-1.2% to 8.6%), Registered Nurses & Midwives (-0.4% to 9.4%) and Admin & Clerical staff (-0.3% to 10.6%) but has increased for AHPs (+0.8% to 10.6%). The Vacancy Control Panel continues to review requests for replacements to ensure a balance between operational needs and cost reduction. The Trust vacancy rate reduced by 1.4% to 2.0% (153.3 wte vacancies). This is due to the aforementioned reduction in the substantive budgeted establishment in respect of the CIP plan plus successful recruitment to substantive posts. The monthly sickness rate has increased by 0.7% to 5.9% whilst the annual sickness rate remains unchanged at 5.3%. Wte days lost in month increased by 1,923 (Oct has an additional calendar day compared to Sept). The uplift continues to be driven by an increase in Cold/Cough/Flu absence (+741 wte days lost), as the seasons change, with Chest & Respiratory illnesses also increasing by 212 wte days lost. There was also a noticeable increase, however, in Anxiety/Stress absences (+447 wte days lost) which have hit a new high at 2,916 wte days lost. Sickness absence is generally c.70% covered by TWS so these metrics track hand in hand i.e. an increase in sickness invariably drives an increase in TWS costs. Backfill for A&C roles are minimal and primarily it occurs for clinical roles to maintain safe staffing levels. The mandatory training rate reduced by 0.4% to 90.6%, but this is still a historic high, and above target. All courses are at over 90% compliance, with the exception of Information Governance at 87.3% (-0.7%), Fire Safety at 88.3% (-0.7%), Infection Control at 89.8% (-0.4%) and Basic Life Support which remains the outlier at 72.1% (-0.9%). The appraisal rate increased by 1.2% to 84.0%. There were increases in the compliance rates for Medical & Dental staff (+8.6% to 91.7%), AHPs (+3.9% to 87.9%), Registered Nursing & Midwifery staff (+0.3% to 83.2%) and Admin & Clerical staff (+1.8% to 82.4%). All staff groups showed an improvement in compliance, except Additional Clinical Services staff who were unchanged at 84.1% compliance.		**Jenny Darwood** Acting Chief People Officer

Our People Core Metrics

East Sussex Healthcare NHS Trust

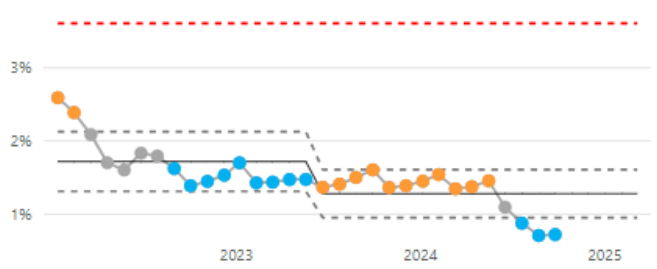
Establishment (WTE) All: Total, Our People

Target required	Common Cause	8,156



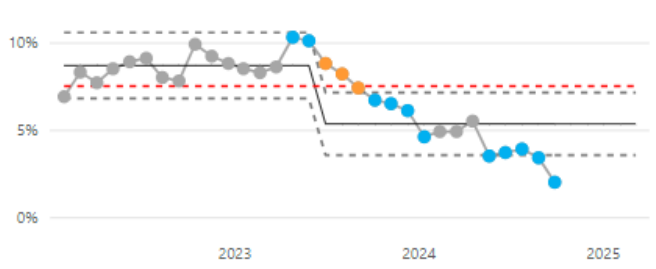
Agency Rate: Total, Our People

Achieving	Improvement	0.711%



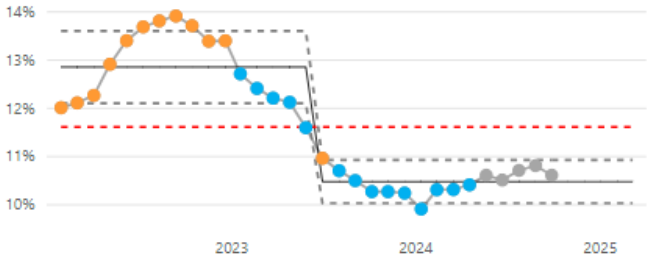
Vacancy Rate: Total, Our People

Achieving	Improvement	2%



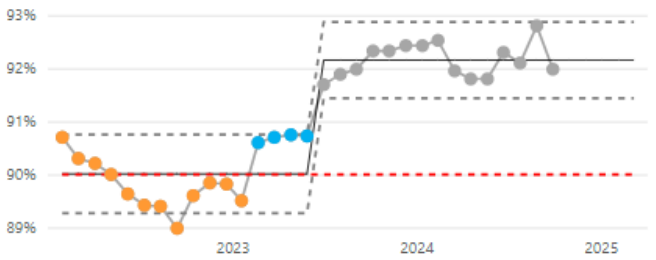
Staff Turnover: Total, Our People

Achieving	Common Cause	10.6%



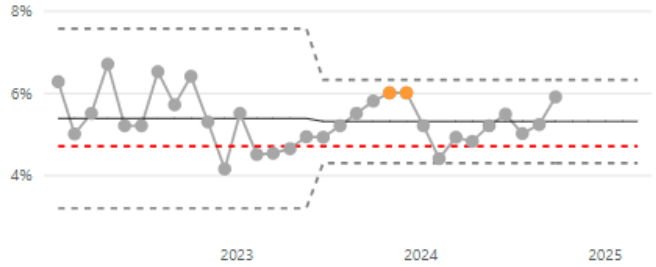
Retention Rate: Total, Our People

Achieving	Common Cause	92.0%



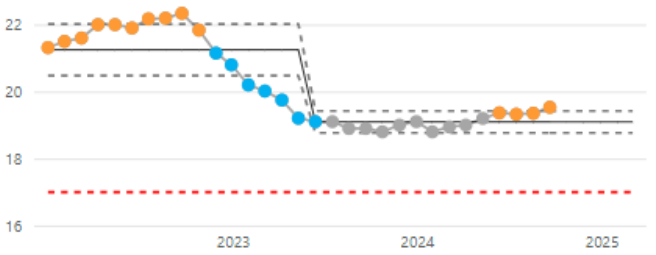
Monthly Sickness - Absence %: Total, Our People

Inconsistent	Common Cause	5.9%



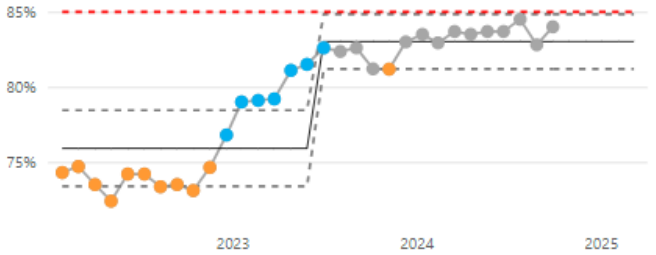
Sickness - Average Days Lost per Fte: Total, Our People

Not Met	Concern	19.5



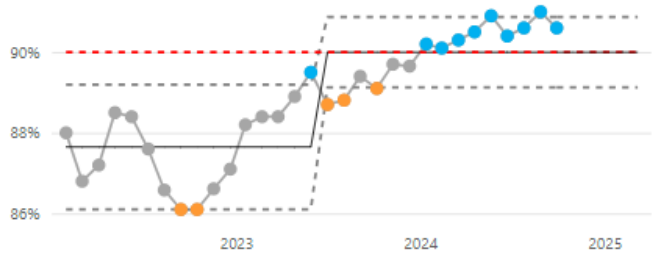
Staff Appraisals: Total, Our People

Not Met	Common Cause	84%



Statutory & Mandatory Training: Total, Our People

Inconsistent	Improvement	90.6%



Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Turnover & Retention	Turnover rate has dropped for the first time in 3 months but is under target. The stability rate dropped in Oct but is still healthy at 92.0% of colleagues staying with ESHT for more than 12 months.	Workstreams and programmes to support retention of our people continue to progress as summarised below: • Flexible working: Continue to work with services in trying to secure and implement a self-rostering pilot. Developing extranet resources for managers and colleagues. The Trusts financial priorities around staffing costs are posing a significant risk to the progress of this work and the ability for managers to fully engage with flexible working options. • Legacy Mentoring: Some engagement from areas wanting to participate in Legacy Mentoring Programme. Extended opportunity to ESHT Alumni, (former employees) to participate on a voluntary basis. Aim to commence training in Jan 2025. • Action Learning Sets: Delivered the first session to 3 cohorts, (matrons in Medicine), as part of our pilot. Early indications show that the pilot group have valued this approach and would like it to continue. Extending the ALS pilot to Head of Nursing in a different division, with a specific focus on leading teams through change. Also received interest and engagement from clinical leaders in other areas to participate in this approach. • Restorative supervision: Supporting those who have completed Restorative Supervision training in the first phase to roll out supervision to clinical staff in their areas. The Health Visiting Service has successfully set up a Restorative Supervision structure as part of this programme and is now delivering to groups of staff. Recruiting for further cohorts in 2025.
Vacancy Rate	Vacancy rate reduced by 1.4% to 2.0% (153.3 wte vacancies). This is due to both a reduction in the substantive budgeted estab in respect of the CIP plan plus successful recruitment to substantive posts	• Focussed recruitment activity to address hard to recruit posts with recruitment activity around Medics, Community and AHPs. Retained headhunters engaged for Microbiology and Dermatology Consultants. • Medical recruitment activity to address hard to recruit posts is ongoing. Success with finding candidates in specific areas e.g. Radiology and ED due to increased direct candidate numbers. • Ongoing social media activity to promote Trust and hard to recruit posts as well as specific online job boards. • Continued success with direct applicants has assisted the reduction in overall vacancies, for example with the number of Occupational Therapy applicants.

Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Sickness	Monthly sickness increased by 0.7% to 5.9% whilst annual sickness was unchanged at 5.3% Average sickness days per fte have increased again by 0.1 to 19.5	We have seen an increase in monthly sickness this month which is associated with an increase in seasonal cold, cough and respiratory illnesses. Occupational Health are encouraging the uptake of the flu vaccine and updates are being shared with Divisions. In the first 6 weeks of the campaign 1,625 vaccines were administered, with 64 employees informing us that they do not wish to have the flu vaccine and 222 employees informing us that they've had the vaccine elsewhere. HR representatives continue to work with managers in supporting long term sickness cases and ensuring all relevant support is in place. Some areas have requested action plans of support for individual colleagues, giving considerations to work adjustments/placements allowing for an earlier return to work. This month, long term sickness accounts for 44.1% of the total figure, which is a reduction from last month when it was 49.1%.
Statutory & Mandatory Training	Trust compliance reduced by 0.4% to 90.6%, but still above target. .	Compliance for Basic Life Support has dipped slightly (from 73.0% to 72.1%). We are working with the Resuscitation Lead to "deep dive" into both the training requirements and audiences in MyLearn as well as focusing in on areas of low compliance. There has been a marked improvement in Resident Doctors compliance rates across the Divisions and most are now at 80% or higher. We will continue to follow up with those who remain non-compliant. Dementia Care Level 1 training has significantly increased and compliance now stands at 52% across the Trust an increase of 23.9%. Oliver McGowan eLearning continues to improve and currently stands at 82.8% Safeguarding Level 3 has reduced slightly but a total of 687 webinar places between now and the end of March have been booked. We have contacted the Safeguarding Leads for further dates for April 2025 onwards – due to their current capacity no further dates can be added before then, however we will continue to monitor for DNAs and if they increase we will overbook session if appropriate.
Appraisal	Compliance rate increased by 1.2% to 84.0%.	Despite significant pressures, appraisal compliance has increased to 84% compliance in Oct.

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

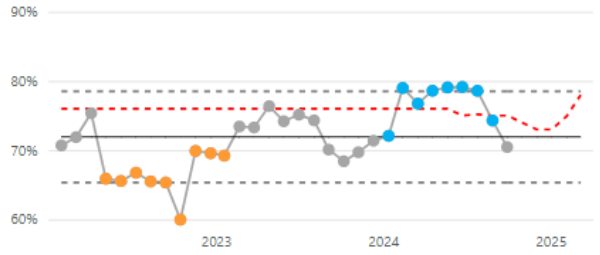
	Positives	Challenges & Risks	Author
Responsive	**Cancer** The Trust delivered 81.9% against the Faster Diagnosis Standard in September (national standard 77%). Performance against the 62 day standard also improved to 70.2% versus a trajectory of 63.5%. **DMO1** DM01 performance significantly improved in October, from 86.9% in September to 92.5% in October 2024. Improvement was seen in every modality and the Trust will continue to work through the action plans that are supporting improvements in DMO1 compliance. **Urgent Community Response (UCR)** The UCR standard of 70% has been consistently achieved year to date, with 83.2% of patients seen within the 2-hour response window in October.	**4 Hour Emergency Access Clinical Standard** In October 2024, 70.5% of patients were seen and discharged or treated and admitted within 4 hours, against the 78% target. Drivers for the position include the high bed occupancy in our hospitals, our growing length of stay and our limited ability to discharge patients to their onward care destination. We are working collaboratively to address these issues. There were 71 patients who remained in ED for greater than 12 hours following a decision to admit. **Cancer** The backlog of patients waiting over 62 days at the end of October 2024 was 236 against a trajectory of 208. A backlog trajectory is in place for each tumour site, and this is monitored weekly. **Elective long waits (RTT)** As anticipated, the number of patients waiting more than 65 weeks increased in October. The increase is a result of long waiting patients being transferred from another NHS provider as part of ESHTs efforts to support patient care and provide better waiting times for all patients across Sussex.	 **Charlotte O'Brien** Chief Operating Officer
Actions:	• Focus on reducing non admitted breaches and overnight waiting times in ED to support delivery of the 78% Emergency Access Clinical Standard • Cancer pathways remain a trust priority, and we will continue to focus on all elements of the patient journey to ensure patients are seen, diagnosed and treated in a timely way. • Focus on eliminating >65 week waits across Sussex by March 2025 and sustainably reducing elective waiting times. • Building on the workstreams from both the outpatient and theatre productivity programmes to reduce waiting times for elective care and improving productivity.		

Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

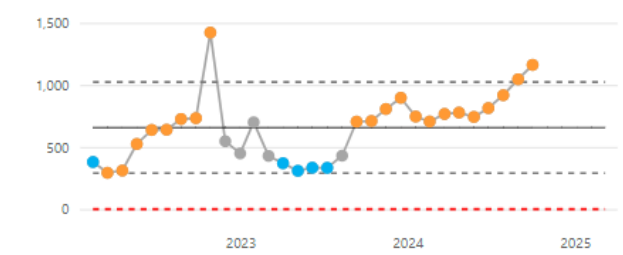
4 hour standard: Total, Our Performance

Inconsistent	Common Cause	70.5%



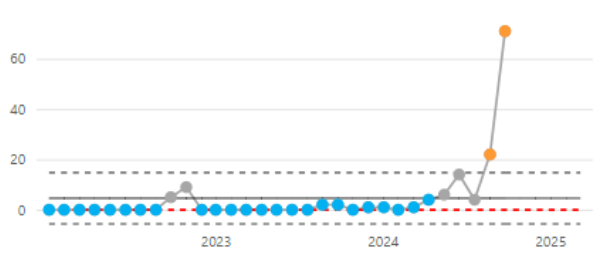
A&E > 12 hours from arrival to discharge: Total, Our Perfor...

Not Met	Concern	1162



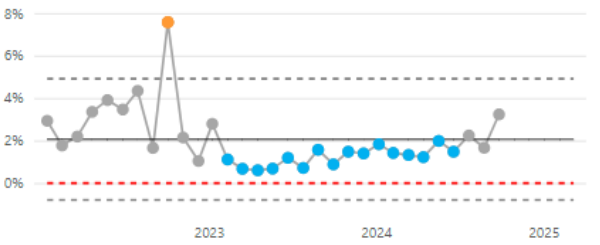
A&E waits over 12 hours from DTA: Total, Our Performance

Inconsistent	Concern	71



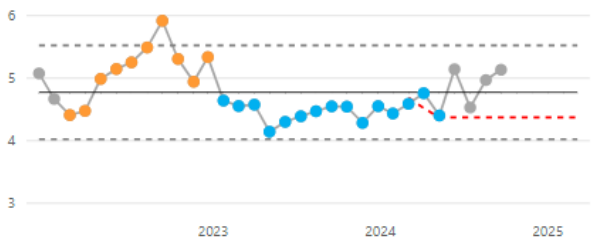
Conveyance handover >60 mins: Total, Our Performance

Inconsistent	Common Cause	3.23%



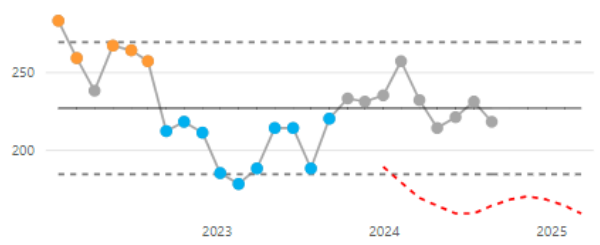
Non Elective Length of Stay: Total, Our Performance

Inconsistent	Common Cause	5.12



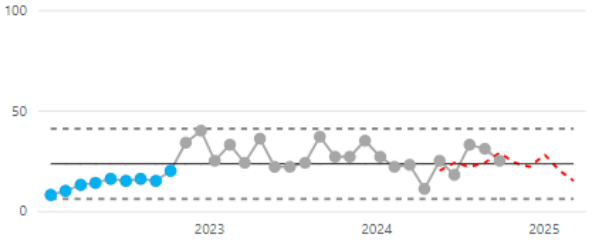
Average daily NCTR: Total, Our Performance

Not Met	Common Cause	218



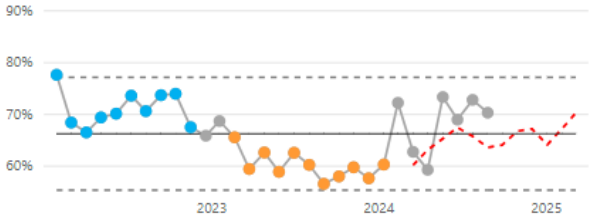
104 day Backlog: Total, Our Performance

Inconsistent	Common Cause	25



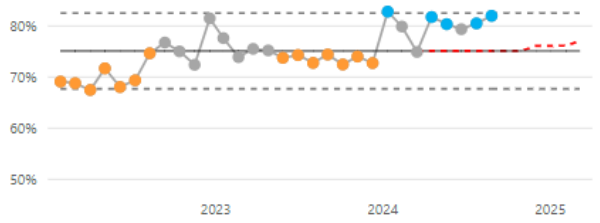
Cancer 62 Day: Total, Our Performance

Inconsistent	Common Cause	70.2%



28 Day General FDS: Total, Our Performance

Inconsistent	Improvement	81.9%

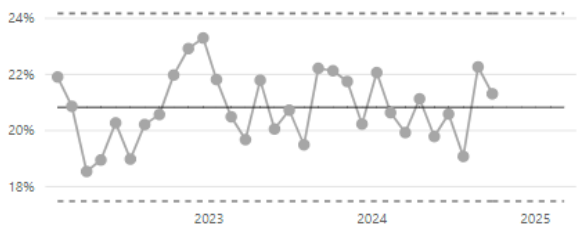


Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

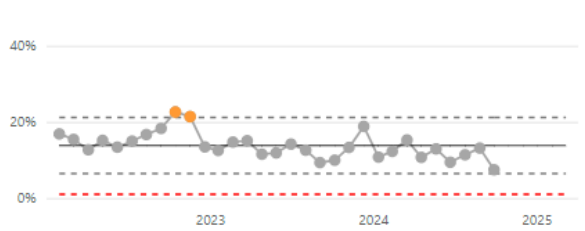
% Discharges delayed 1+ days: Total, Our Performance

Target required	Common Cause	21.3%



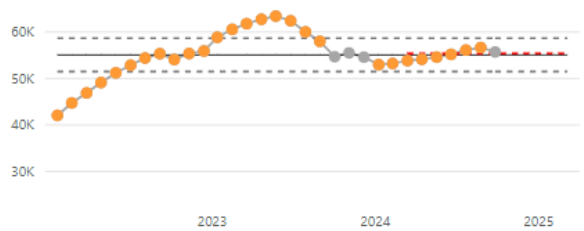
Diagnostic <6 weeks: Total, Our Performance

Not Met	Common Cause	7.45%



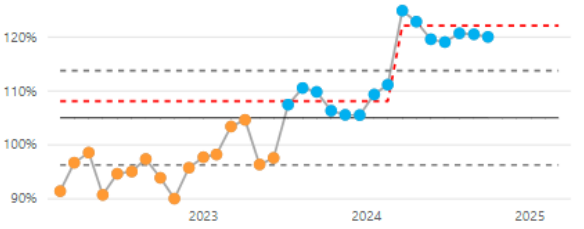
RTT Total Waiting List Size: Total, Our Performance

Inconsistent	Common Cause	55592



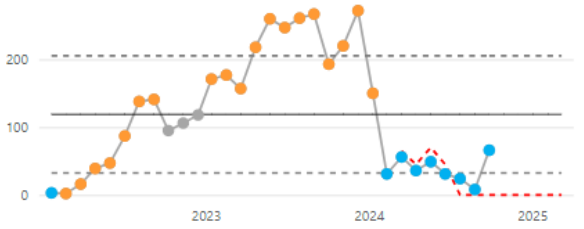
Elective Activity (ELIP,DC,OPFA, OPFUP Proc): Total, Our Perf...

Not Met	Improvement	120%



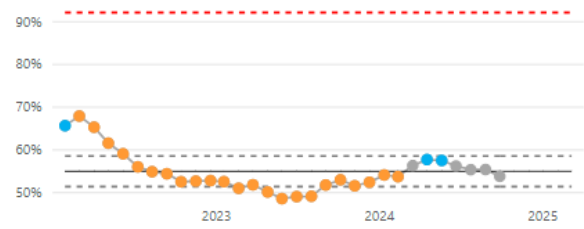
RTT 65 week wait: Total, Our Performance

Not Met	Improvement	66



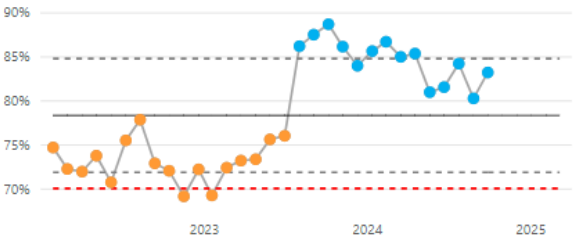
RTT under 18 weeks: Total, Our Performance

Not Met	Common Cause	53.7%



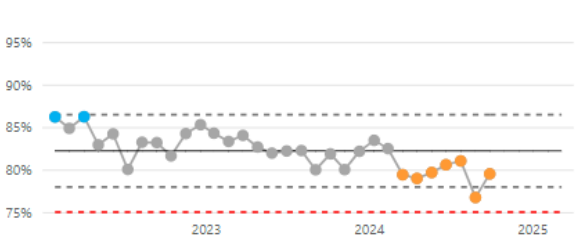
Urgent Community Response within 2 hours: Total, Our Perf...

Achieving	Improvement	83.2%



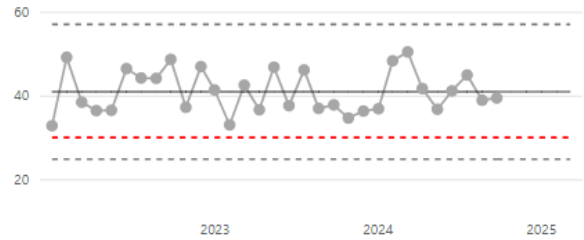
CHIC wait times < 13 weeks: Total, Our Performance

Achieving	Concern	79.5%



Intermediate Care Length of Stay: Total, Our Performance

Inconsistent	Common Cause	39.4



Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Emergency Access Clinical Standard	In October 2024, 70.5% of patients were seen and discharged or treated and admitted within 4 hours, against the 78% standard This places our Trust at 55 out of 124 trusts nationally, ranking us in the second quartile.	• Focus on reducing time to triage and time to treatment. • Escalation of delays and pathways that are not optimised with support of all divisions and site teams. • Continuation of 78% meetings with all divisions • Focus on roles and responsibilities to support overnight resilience • Ringfence CDU for Emergency Department • Continue to work with SeCAMB to ensure crews are not waiting longer than 15 minutes to offload.
Patients in department over 12 hours from arrival to discharge	There was an increase in number of patients waiting over 12 hours from arrival to discharge, from 1046 in September to 1162 in October. 71 patients remained in ED for >12 hours following a decision to admit in October.	• A detailed review has taken place for each of the patients who remained in ED for more than 12 hours following a decision to admit, including an assessment of clinical harm and lessons learnt are being taken forward. • A number of actions have been agreed by the Urgent Care Division to ensure timely and effective escalation. • Continued focus on reducing LOS and the number of patients not meeting the criteria to reside to enable flow
Conveyance Handover >60 mins	The percentage of patients handed over >60 mins was 3.23% in October. This represents an increase in the number of patients the Trust were not able to offload within 60 minutes	• Increase focus on ambulance handover times, early escalations and actions to mitigate delays and support decompressing the department • Reviewing the Rapid Assessment and Triage process

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Non elective Length of Stay (LOS)	The Trusts non-elective length of stay increased slightly from 4.96 days in September to 5.12 days in October.	Discharge Improvement workstreams: • Embedding Safer on wards • Embedding the Choice Policy, planning discharge from point of admission. • Reconditioning and rehabilitation on wards, including trialling a mobility volunteer role, pilot wards reviewing mobility assessments, undertaking harm reviews and getting patients up and dressed to be active. • Optimising the Transfer of care Hub • Increased P1 capacity to support same day/ next day discharges, 7 days week • Additional System Funding to support a further increase in P1 capacity and a night sitting service.
Community Waiting Times (Paediatric)	Outsourcing to an independent sector provider continues to support improvements in community paediatric waiting times. The number of children waiting >104 weeks at the end of Oct was 0 (compared to 77 in Oct 23). There are 14 children waiting over 78 weeks and 166 children waiting over 52 weeks compared to 655 in November 2023.	• On going recruitment to both clinical & administrative roles in Community Paediatrics. • Redesign of service continues to be explored including a digital opportunities to optimise the patient pathway.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Community Waiting Times (Adult)	Urgent Community response 2 hour was achieved with 83.2% of patients seen within the 2-hour response window in October. Whilst there has been a reduction in the overall waiting times for new patients in planned care community services, further work is required in Dietetics, District Nursing, Joint Community Rehabilitation, Podiatry and Speech and Language Therapy.	• Aligning reporting methodology to national for UCR • Capacity demand modelling and services review for community services with longer waiting times for planned new and follow up care
Cancer	The Trust delivered 81.9% in September against the 77% Faster Diagnosis Standard. The Trust delivered 95.3% against the 31-Day standard of 96%. This is an improvement from the August position. Performance against the 62 Day standard in September was 70.2% against a trajectory of 63.5%. The backlog of patients waiting over 62 days (excluding tertiary referrals) at the end of October was 6.7% of the total Cancer Patient Tracking List. The Sussex position is 8.4% and the national position is 7.2%. The Trust continues to receive high number of urgent suspected cancer referrals and in September received 2483 referrals GP referrals. Cancer pathways remain a Trust priority, and we continue to focus on all elements of the patient journey to ensure patients are seen, diagnosed and treated in a timely way.	• Detailed Divisional Cancer Action Plans underpinned by improvement trajectories in place to support improvement and sustainability. • National Best Practice Timed Cancer Pathways and SSCA Optimal Pathways shared with Cancer Clinical Leads and being reviewed by Trust Cancer Clinical Lead and Lead Cancer Nurse to support improvements in local pathways. Initial pathway reviews are Skin and Lung - commenced. • Enhanced focus on patients early in the pathway to improve transfer dates to tertiary providers by Day 38. • Tumour site predictions of performance for in month and future month to ensure performance is aligned to the trajectory. • Implementation of a Tiering approach to challenged tumour sites to provide senior support to expedite pathways • Chief Operating Officer Led Recovery meetings for challenged specialties.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Elective Activity	In October the Trust delivered 120% of 2019/20 baseline activity levels, with improvement notes in day case productivity.	• Outpatient productivity programme progressing well, includes a focus on validation; targeted action on DNAs; reducing paper in Outpatients; improving governance arrangements around insourced/outsourced clinical services (to maximise efficiency) and improving management of follow-ups • Regular steering group meetings to support Theatre productivity • Review of counting and coding to ensure accurate capture of activity • Additional activity expected in H2 as a result of supporting system partners recover the long wait position in Sussex.
RTT long wait position (78 and 65 weeks) and waiting list size	In October the Trust reported 66 patients who had waited >65 weeks. 54 of these were patients who have recently been transferred over from UHSx as part of ESHT support for reducing the long wait position across Sussex. As part of H2 system mutual aid, ESHT has received 406 patients. This is in addition to the significant number received in H1 (>500). Despite the transfer of significant numbers of patients on to the ESHT PTL, focused validation alongside work to improve productivity has seen the PTL size decrease by 944 patients. This is the first time in seven months that the Trust has observed a decrease in the PTL size. RTT compliance has remained static at 55.7%	• Progressing mutual aid requests from neighbouring providers to support a reduction in waiting times for patients in Sussex continues, with the transfers expected to be completed early December 24. • Insourcing/Outsourcing in place within challenged specialties, including Neurology, Vascular, ENT and Gynaecology. • Daily monitoring of the longest waiting patients to ensure pathways are progressing. • Increasing FOPA attendances to reduce FOPA waits across all specialities.
Diagnostic DMO1	DMO1 significantly improved in October with performance improving from 86.9% in September to 92.5% in October. In October the overall size of the DM01 waiting list remained stable at 7,222 patients. Breaches fell from 935 in September to 538 in October. Radiology modalities are now all at 98% performance or better.	• Cardiac Echo waiting list reduced from 1,231 in September to 995 in October. Breaches also reduced from 732 in September to 384 in October. Recovery remains in line with expectations and agreed action plan. • Audiology waiting list rose slightly to 451 (from 326) but breaches reduced to just 26 (from 31 last month) • Endoscopy continue to perform well with their waiting list falling by 200 patients and breaches also falling.

Financial Control and Capital Development

Our Income and Expenditure

Our Elective Recovery

Our Run Rate

Efficiency

Capital

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

Finance | Executive Summary

East Sussex Healthcare NHS Trust

	Positives	Challenges & Risks	Author
Responsive	• In month deficit of (£1.4m) compared to a surplus plan of £0.3m, resulting in a (£1.7m) deficit to plan in month. This takes the YTD deficit to (£9.2m) which is an adverse variance of (£7.4m). • ERF overperformance in month with actual of £14.969m (excluding prior month catch up) compared to plan of £12.538m. Tariff increase M1-7 resulted in catch up of £2.2m YTD. • Capital overspent by £3.2m, however the plan is materially back phased so this does not at present mean there is an issue, we are currently revising the phasing to better align to expected profile, and FOT shows a balanced plan. • Pay run rate increased in month due to pay award, as a result discounted normalised pay costs reduced by £0.2m. TWs costs still lower, with agency half of what it was in M3. • Non Pay run rate lower in month with clinical supplies and high cost drugs reduced, maintaining similar lower trend in M6. • Use of Resources on plan YTD at £16.1m. • Financial Recovery Director identifying more initiatives to improve position. • H2 reset exercise is now live in M7-12 budgets, agreed with Divisional Leads. Use of Resources meetings monthly to discuss and drive forward improvements.	Current projection of year end (£14.9m) deficit with risks including winter pressures. In order to achieve this, the Trust is controlling monthly spend over the next five months and deliver agreed monthly efficiencies (the Use of Resources).	 **Damian Reid** Chief Financial Officer

Overview:

I&E: The Trust plan was for a surplus of £0.3m in month. Actual performance was a deficit of (£1.4m) so (£1.7m) deficit to plan in month. YTD adverse variance of (£7.4m). Variance YTD is driven by pay premium costs, unfunded escalation, Pay CIP and non-pay CIP, old year invoices, higher activity related non pay and drug costs, security for patients with mental health conditions, partly offset by realised old year income (catch up and contracts) and ERF performance.

UoR: Full year target of £36.7m, with scoped and fully developed schemes at M7 of £21m and initiatives in scoping phase total of £15.7m.

Total YTD delivery at month 7 of £16.1m against plan of £16.2m, an under-delivery of £0.03m. Workstreams Clinical improvement and Sustainable Service Configuration are delivering well overall.

Capital: Expenditure in month 7 was £19.8m, £7.9m above plan. Forecast outturn is breakeven. CRG will identify options to mitigate any risk and ensure allocation is maximised.

Cash: Cash position is above the £2.1m minimum, likely to be above target until January. Partner Trusts are being requested to pay their OCC share.

Finance | 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	46,261	46,242	(19)	274,879	275,960	1,081
Divisional	6,409	4,710	(1,700)	47,623	50,094	2,472
ERF	13,946	15,147	1,201	77,223	81,194	3,972
Total Income	**66,617**	**66,099**	**(518)**	**399,724**	**407,248**	**7,524**
Operating Expense						
Pay						
Permanent	(44,758)	(44,072)	686	(261,864)	(247,442)	14,422
Temporary	(1,416)	(4,040)	(2,624)	(9,513)	(29,797)	(20,284)
Total pay	**(46,174)**	**(48,112)**	**(1,938)**	**(271,377)**	**(277,239)**	**(5,862)**
Non-pay						
Drugs	(1,369)	(1,679)	(310)	(9,731)	(10,941)	(1,210)
TEDD	(3,691)	(3,299)	392	(26,418)	(27,502)	(1,084)
Clinical supplies	(4,518)	(4,520)	(2)	(31,687)	(34,033)	(2,347)
Purchased services	(1,195)	(1,517)	(323)	(8,406)	(8,223)	184
Finance costs	(2,677)	(2,753)	(76)	(18,741)	(18,874)	(133)
Other	(6,709)	(5,648)	1,062	(35,130)	(39,635)	(4,504)
Total non-pay	**(20,159)**	**(19,416)**	**743**	**(130,114)**	**(139,208)**	**(9,094)**
Total Expense	**(66,334)**	**(67,529)**	**(1,195)**	**(401,490)**	**(416,447)**	**(14,956)**
Surplus/(Deficit)	**283**	**(1,430)**	**(1,714)**	**(1,766)**	**(9,198)**	**(7,432)**
Memo:						
WTE (worked)	8,156	8,214	58	8,292	8,283	(9)

I&E position

- In M7 there is a deficit of (£1.4m) compared to a surplus plan of £0.3m resulting in a deficit of (£1.7m) in month. YTD the Trust is adverse to a (£1.8m) plan by (£7.4m). A bridge of the current variance is set out on the next page.

- M7 Note – Wage award for AFC and Other Medical posts was paid ytd in M7 resulting in higher pay costs and income in month.

Income

- The position is surplus by £7.5m ytd, the main drivers being;
  - One-off CDC invoice for £0.2m
  - One off benefit from old year on contract income of £0.1m
  - Overperformance of elective against baseline of £4.0m
  - £1.0m C&V Drugs in M1-7
  - £1.4m ERF 23-24 true up
  - TEDDS £0.9m, this is offset by non pay costs of £1.8m versus drugs.

Expense

- The Trust has a (£5.8m) adverse pay position ytd. This is driven by £1.2m unfunded Escalation costs in Litlington Ward/BIU, £1.0m Premium costs for EC staffing (Medical), and £0.8m Premium staffing costs in Theatres (ODPs), Medicine pressures £0.8m with CIP the balance. Accruals for M8 Pay Awards (funded via income) offset by M1-7 Pay Award benefit in month.
- Use of temporary staff at higher unit cost partially offset by WTE usage below budget but still overspent.
- Non Pay is overspent by (£9.1m) ytd. This is driven by one off old year invoices of £0.5m (Multifunctional Devices, Vascular, Oncology) that were above the accrued amount, Security costs £0.5m, Theatre activity £1.0m, Drugs £1.7m and Recovery/Inflationary pressures held centrally held to M7 of £5.0m. In month underspend due to run rate controls.

Finance | Variable income

East Sussex Healthcare NHS Trust

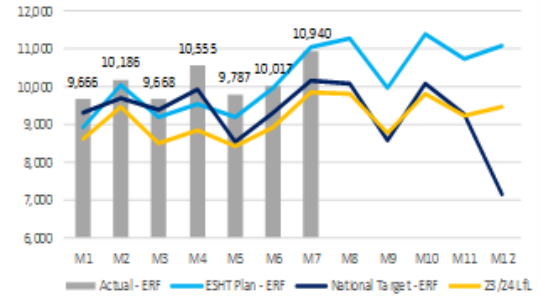
ERF - Trust

East Sussex Healthcare NHS Trust

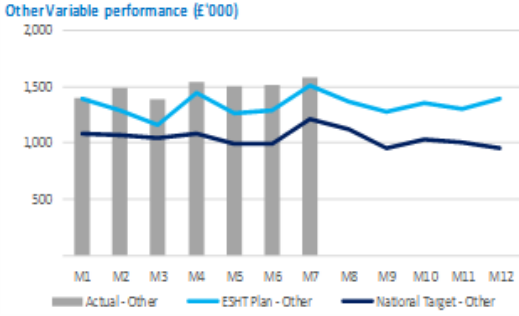
ERF performance

- The Trust over-performed its ERF plan by £0.7m in month with YTD over-performance of £3.0m. We expect this performance to increase as we report flex and freeze for previous months.
- Outside of this Ophthalmology (known coding issue in YTD) and general surgery have underperformed significantly.
- Other variable activity over-performed by £0.2m in month taking the total variable delivery to on plan in month and £0.8m over YTD.

ERF performance (£'000)



Other Variable performance (£'000)



	In Month				YTD			
	Plan	Actual	Var		Plan	Actual	Var	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Daycase	3,712	3,992	280	7.5%	22,958	25,826	2,867	12.5%
Elective	2,124	1,937	(187)	(8.8%)	14,021	12,992	(1,029)	(7.3%)
Outpatients - First	2,382	2,022	(360)	(15.1%)	13,272	13,419	147	1.1%
Outpatients - Procedure	2,261	2,371	111	4.9%	13,743	14,205	462	3.4%
Ward Attenders	158	158	(0)	(0.3%)	1,146	1,200	53	4.7%
ERS	57	103	45	79.1%	511	720	209	40.8%
SPH	333	357	24	7.2%	2,239	2,458	219	9.8%
Prior month catch up	-	2,279	2,279	n/a	n/a	n/a	n/a	n/a
ERF activity	**11,028**	**13,218**	**2,191**	**19.9%**	**67,891**	**70,819**	**2,928**	**4.3%**
Unbundled diagnostics	794	880	86	10.8%	4,954	5,560	607	12.2%
Direct Access	355	355	(1)	(0.2%)	2,137	2,243	106	5.0%
Chemo	361	338	(23)	(6.4%)	2,256	2,572	317	14.0%
Prior month catch up	-	178	178	n/a	n/a	n/a	n/a	n/a
Other Variable	**1,510**	**1,751**	**240**	**15.9%**	**9,346**	**10,375**	**1,029**	**11.0%**
Total	**12,538**	**14,969**	**2,431**	**19.4%**	**77,237**	**81,194**	**3,957**	**5.1%**

	In Month			YTD		
	Plan	Actual	Var	Plan	Actual	Var
	£'000	£'000	£'000	£'000	£'000	£'000
Endoscopy service	773	402	(370)	4,626	4,267	(360)
General Surgery Service	870	726	(144)	5,042	4,526	(516)
Gynaecology Service	705	616	(89)	4,356	4,019	(337)
Respiratory Medicine Service	193	124	(68)	1,090	862	(228)
Cardiology Service	806	742	(64)	4,586	4,930	344
Trauma and Orthopaedic Servi	1,772	1,712	(60)	10,797	11,128	332
Interventional Radiology Servi	60	1	(60)	246	355	109
Respiratory Physiology Service	78	27	(51)	343	520	177
Paediatric Service	188	142	(45)	1,369	1,021	(348)
Neurology Service	189	150	(39)	1,013	1,127	113
Acute Internal Medicine Servi	47	9	(38)	391	491	100
General Internal Medicine Se	63	34	(29)	196	448	251
Elderly Medicine Service	55	34	(21)	223	218	(5)
Clinical Haematology Service	283	271	(12)	1,758	1,762	4
Orthodontic Service	38	29	(9)	212	204	(8)
Stroke Medicine Service	13	5	(8)	71	88	17
Chemical Pathology Service	24	17	(6)	138	121	(18)
Transient Ischaemic Attack Se	46	40	(5)	300	284	(17)
Maxillofacial Surgery Service	136	131	(5)	1,033	936	(97)
Paediatric Surgery Service	11	8	(3)	75	68	(7)
Palliative Medicine Service	3	1	(2)	5	7	2
Paediatric Dermatology Servic	6	6	(0)	42	43	1
Paediatric Epilepsy Service	9	9	(0)	50	41	(9)
Plastic Surgery Service	-	-	-	6	-	(6)
Emergency Medicine Service	-	-	-	-	-	-
Physiotherapy Service	-	-	-	-	-	-
Paediatric Trauma and Orthop	6	6	1	41	35	(6)
Hepatology Service	0	2	1	2	8	6
Cardiac Rehabilitation Service	-	2	2	-	33	33
Ophthalmology Service	1,441	1,444	3	9,399	8,995	(405)
Endocrinology Service	68	73	6	431	525	94
Anaesthetic Service	13	19	6	82	134	52
BCSP	38	48	10	278	275	(3)
Rheumatology Service	322	333	10	1,817	2,010	194
Vascular Surgery Service	47	61	15	358	435	76
Diagnostic Imaging Service	15	32	16	51	32	(19)
Diabetes Service	19	42	23	109	306	197
SPH	333	357	24	2,239	2,458	219
Dermatology Service	238	267	30	1,766	1,855	89
Breast Surgery Service	249	306	57	1,572	1,833	261
Clinical Oncology Service	151	241	90	916	1,124	207
Urology Service	996	1,087	91	6,603	7,086	483
Sleep Medicine Service	-	140	140	-	548	548
Ear Nose and Throat Service	412	582	169	2,506	3,065	559
Gastroenterology Service	314	662	348	1,749	2,597	848
Prior month catch-up	-	2,279	2,279	-	-	-
Sub total	**11,028**	**13,218**	**2,191**	**67,891**	**70,817**	**2,926**
Other variable income	1,510	1,751	240	9,346	10,375	1,029
Total	**12,538**	**14,969**	**2,431**	**77,237**	**81,192**	**3,956**

Finance | Capital

East Sussex Healthcare NHS Trust

Trust Lead	Capital Scheme	In Month			Year to Date			Full Year			
		Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Fcast £'000	Fcast Risk	Variance £'000
	Original										
DIG	Digital Programmes	150	183	34	764	579	(185)	3,182	200	Low	(2,982)
DIG	Our Care Connected	-	-	-	-	-	-	2,500	2,500	Low	-
	Total Digital	**150**	**183**	**34**	**764**	**579**	**(185)**	**5,682**	**2,700**		**(2,982)**
EME	Diagnostic Equipment	-	33	33	652	316	(336)	2,000	2,000	Med	0
EME	MSC Implementation	-	-	-	476	-	(476)	476	-	Low	(476)
EME	Medical Equipment	47	5	(43)	332	297	(36)	500	500	Low	0
	Total Medical Equipment	**47**	**38**	**(9)**	**1,460**	**613**	**(847)**	**2,976**	**2,500**		**(476)**
EST	Fire	166	120	(46)	1,162	905	(257)	2,000	2,000	Med	(0)
EST	Backlog	184	(25)	(209)	1,022	3,029	2,007	3,100	4,602	High	1,502
EST	EDGH Cat 3 Labs	12	2	(10)	73	4	(70)	125	125	Low	-
EST	ICU adaptations (Phase 1)	12	171	158	73	454	381	125	500	Med	375
EST	Clinical Priorities - Prior Year	24	9	(15)	147	423	277	250	480	Med	230
EST	Endoscopy (Internal)	39	-	(39)	235	-	(235)	400	400	Low	-
EST	Sussex Surgical Centre (Trust Funded)	189	-	(189)	4,897	-	(4,897)	16,000	14,500	Low	(1,500)
EST	Ward Refurbishment	21	14	(7)	46	360	315	250	500	Med	250
EST	Ophthalmology Business Case	-	0	0	-	573	573	1,766	750	Low	(1,016)
EST	Cardiology business case	-	376	376	-	1,816	1,816	3,500	3,608	Med	108
EST	Emergency Department - WIS	84	-	(84)	84	-	(84)	500	500	Low	-
	Total Estates	**731**	**667**	**(64)**	**7,738**	**7,564**	**(173)**	**28,016**	**27,965**		**(51)**
FIN	Divisional Small Works	12	0	(11)	81	5	(76)	175	76	Low	(99)
FIN	Minor Capital	-	-	-	260	126	(134)	500	376	Low	(124)
FIN	Planned slippage/prioritisation	(191)	-	191	(1,739)	-	1,739	(6,439)	(500)	High	5,939
FIN	IFRS16 Lease Schemes	-	-	-	-	-	-	-	43	Low	43
FIN	ICB Brokerage	-	-	-	-	-	-	2,250	-	Low	(2,250)
	Total Finance	**(179)**	**0**	**179**	**(1,398)**	**131**	**1,529**	**(3,514)**	**(5)**	-	**3,509**
	System Capital	**749**	**888**	**139**	**8,564**	**8,887**	**323**	**33,160**	**33,160**		**(0)**
	New										
EST	Building For Our Future	150	227	77	735	578	(157)	1,519	1,519	Low	0
EST	Sussex Surgical Centre (TIF Funded)	-	4,214	4,214	-	9,700	9,700	9,271	9,271	Low	-
DIG	Diagnostics Digital Capability (LIMS)	49	2	(46)	49	157	108	607	607	Low	-
DIG	Diagnostics Digital Capability (OCS)	44	-	(44)	44	-	(44)	547	547	Low	-
DIG	Diagnostics Digital Capability (Image Sharing)	120	-	(120)	120	(66)	(186)	1,500	1,500	Low	-
DIG	Frontline Digitalisation (EPR)	-	(311)	(311)	-	311	311	8,000	8,000	Low	0
EST	NHP - Enabling Fees	167	-	(167)	351	-	(351)	10,200	10,200	Low	-
EST	Endoscopy (External)	500	22	(478)	2,000	251	(1,749)	10,000	10,000	Low	0
DIG	AI Diagnostics	13	5	(8)	13	28	15	165	165	Low	-
DIG	CoIN Network	-	-	-	-	-	-	345	345	Low	-
	Total Additional Capital	**1,043**	**4,159**	**3,116**	**3,311**	**10,959**	**7,648**	**42,154**	**42,154**	**0**	**0**
	Total Capital	**1,792**	**5,047**	**3,255**	**11,876**	**19,846**	**7,971**	**75,314**	**75,314**	**0**	**(0)**
FIN	Donated Expenditure	85	29	(56)	595	120	(475)	1,000	1,000	Low	-
FIN	Donated Income	(85)	(29)	56	(595)	(120)	475	(1,000)	(1,000)	Low	-
	Total Donated Capital	-	**(0)**	**(0)**	-	-	-	-	-		-
	Total Capital	**1,792**	**5,047**	**3,255**	**11,876**	**19,846**	**7,971**	**75,314**	**75,314**		**(0)**

Capital

- The planned capital allocation for 2024/25 is £75.3m.
- The capital expenditure incurred at month 7 totals £19.8m.
- Capital expenditure was largely driven by the following schemes:
  - Sussex Surgical Centre £9.7m.
  - Medical equipment £0.6m, including diagnostic equipment.
  - Estates works of £7.6m, the main schemes being, backlog maintenance (£3.0m), fire safety (£0.9m), cardiology services at EDGH (£1.8m), and ophthalmology (0.6m).
  - Building for Our Future £0.6m.
  - Frontline Digitalisation £0.3m.
- The Sussex Surgical Centre (Elective Care Hub) is scheduled to complete in February 2025 and is split funded in 2024/25 partly from system funding (£16.0m) and national PDC schemes (£9.3m). The project incurred costs of £9.7m in year.
- The Endoscopy Suite is scheduled to complete in 2025/26 and is split funded between system funding (£0.4m) and PDC funding (£10.0m). The suite will be incorporated into the new Sussex Surgical Centre building and in year costs to date total £0.3m.
- The demand for capital is greater than the funding envelope and the original plan included an overplanning margin of £9.3m. The plan has been reviewed and the slippage reduced to £6.4m.
- The forecast overspend in M6 has been mitigated by the brokerage deal agreed with the ICB of £2.25m together with the utilisation of EPR national funding in support of core digital (£2.16m).
- CRG will identify options to mitigate any expenditure risk and ensure allocation is maximised.

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	Trust Board Meeting in Public	**Date of Meeting**	10/12/2024

Report Title:	MatNeo Overview Board Report Q2 2024/25

Purpose of the Report/Outcome/ action requested:	As part of the National reporting findings and Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) requirement, all NHS Trusts are required to update Boards on the quality and safety aspects of our maternity services. This report follows discussion and presentation at the Quality and Safety Committee on behalf of the Trust Board. This report provides an overview of Maternity planning, progress and activity during quarter 2, 2024/25 and assurance 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.

Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐

Authority for Decision:	*Not applicable*

Executive Summary	ESHT Maternity and Neonatal services are managed effectively, and safety is maintained clinically. Perinatal mortality data shows normal variation and no cause for concern. Our services continue to focus on reducing maternal morbidity, we have seen an increase in women and people presenting with Mental Health and Safeguarding concerns and are currently reviewing service provision in line with our three-year delivery plan and more recently the Birth Trauma report. Focus to reduce health inequalities continues locally through our public health team and our transformation lead, supported by our Local Maternity and Neonatal System (LMNS), to ensure seamless service delivery between primary and secondary care. A minimum of a daily review of staffing levels takes place; 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. Following the completion of a commissioned external review of maternity services, the senior team are working closely with the Organisational Development (OD) department to focus on improving the workplace culture throughout our services. Actions include a review of leadership structure; communications back to specific staff with regards to the review; work to support the restoration of the good aspects of culture and to rebuild areas where poor culture was identified; and a commissioned peer review of clinical practice within the department. NHS Resolution are operating a sixth year of the Maternity Incentive Scheme (MIS) to continue to support Trusts in their delivery of safe

	maternity care. The MIS is a self-certification scheme, with submission requiring sign-off by Trust Board and ICB following conversations with Trust commissioners. This paper provides assurance that ESHT have met the criteria for all ten safety actions outlined in the year six guidance. Approval was gained through the Quality and Safety committee on behalf of the Trust Board and the CEO signed the Board declaration form prior to submission to NHS resolution. The National Review of Maternity Services 2022-2024 Report was published September 2024 by the Care Quality Commission (CQC). This was a summary of findings including visits to 131 maternity services to see what care was like for pregnant women and babies. Of the locations inspected between August 2022-December 2023, almost half were rated as requires improvement (36%) or inadequate (12%). A summary of findings are discussed within this report.
Regulatory/legal requirement:	NHSE compliance requires the Board to review and approve this report
Business Plan Link:	Quality ☐ People ☐ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues had been taken into consideration
Resource Implication/VFM Statement:	Not applicable
Risk:	During quarter two, our main concern was surrounding staff raising concerns through the Speak Up Guardian regarding some aspects of poor culture and behaviours within maternity services. Considerable action was taken including listening events held by the senior and executive teams with staff and a commissioned external review. Support continues to be offered and accepted through our OD and OH services. The commissioned external independent investigation within Maternity has now reached its conclusion and a range of recommendations have been made. A robust and detailed action plan has been compiled to respond to the recommendations. This includes a strong commitment to investing in leadership at every level with HR and OD input. Significant work is currently underway to address all recommendations. Workforce can still prove a challenge within maternity services during high activity/acuity and increasing numbers of cases where medical and social complexities mean that despite staffing improvements the clinical floor can feel increasingly busy, a full midwifery workforce review (Birthrate+) is due to be completed by mid-December 2024.

No of Pages	5	**Appendixes**	MatNeo Overview Board Report

Name, position and contact details of author:	Brenda Lynes, Director of Maternity Services brenda.lynes@nhs.net

Report Sponsor	Vikki Carruth, Chief Nurse & Executive Maternity Safety Champion	**Presenter:**	Brenda Lynes

Governance and Engagement pathway to date:	Prior to this overview report being presented to the Board, this report and supporting informing reports were reviewed and approved via the Quality and Safety Committee on 27/11/24. Areas covered in this report were addressed in MatNeo Governance and Accountability monthly meetings, MatNeo Assurance Meetings and MatNeo Clinical Board.

What happens next?	This report is for assurance information. The subsequent quarter 3 2024/25 overview report is scheduled for presentation April 2025.

Publication	The report can be published.

Background

The Three-Year delivery plan for maternity and neonatal services sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women and birthing people, babies, and families.

There was clear agreement from all key stakeholders on what the plan's focus should be, services are asked to concentrate on four themes:

- Listening to and working with women and families, with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning, and support
- Standards and structures that underpin safer, more personalised, and more equitable care.

Delivering this plan requires the dedication of everyone working in NHS maternity and neonatal services in England who are working tirelessly to support women and families and improve care.

The National Review of Maternity Services 2022-2024 Report was published September 2024 by the Care Quality Commission (CQC). This was a summary of findings including visits to 131 maternity services to see what care was like for pregnant women and babies. Of the locations inspected between August 2022-December 2023, almost half were rated as requires improvement (36%) or inadequate (12%).

Key Themes/findings were:

1. Responding and learning from incidents
2. Risk assessment and triage
3. Recruitment and retention of staff
4. Estates and environment
5. Inequalities and racism
6. Communication with women and families

ESHT were rated as good during this process, however work continues to improve in all the areas identified.

Issues

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 full midwifery workforce review (Birthrate+) is due to be completed by the mid December 24.

The external independent investigation in Maternity has now reached its conclusion and a range of recommendations have been made. A robust and detailed action plan has been compiled to respond to the recommendations. This includes a strong commitment to investing in leadership at every level with HR and OD input. Significant work is currently underway to address all recommendations

Key actions include:

- Feedback to staff, which is progressing
- A commitment to investing in leadership development and training to secure psychological wellbeing and safety provided.
- Harnessing full engagement from colleagues at all levels
- Tighter controls for recruitment
- Review of Maternity Leadership structure and work to restore previous good culture and improve where there were areas of poor culture, regular use of pulse surveys (or similar).

- A Peer review of clinical practices

We are working with Human Resources and the Organisational Development team to provide a support program for staff.

Continued recruitment and retention work includes the provision of wellbeing services for staff and the training of a further 10 midwifery staff to provide Trauma Risk Management support to staff (TRIM), work is ongoing in-regards to flexible working and self-rostering.

A robust plan of action is underway to ensure Trust targets are met with regards to trust mandatory training with rates currently above 80% and a focus to reach our 90% target.

Finally the submission of evidence for the Year 6 Maternity Incentive scheme (MIS) concluded on 30 November 24. ESHT presented a written paper of evidence to the Quality and Safety Committee on 28/1/24, who confirm full compliance with all 10 Safety Actions, further, an audit was completed by External auditors RSM UK Risk Assurance Services LLP 13/11/24 who confirmed they found full compliance with all 10 Safety Actions.

Consequences for not taking action

Not applicable, this report is for information and assurance.

Conclusion

There is good evidence to support that our services are managed effectively on a day-to-day basis as confirmed following the CQC visit in October 2022, staff compliance in line with national requirement for maternity specific training has been maintained.

Robust governance process has been maintained in line with our Perinatal Quality Surveillance process during the reporting period. Any risks are escalated through robust Trust process to confirm that ESHT Maternity services are managed and monitored effectively and safety is maintained clinically.

Recommendations

This report is for information and assurance, the recommendation is to endorse the approval of full compliance to year 6 maternity Incentive Scheme.

East Sussex Healthcare NHS Trust

MatNeo Overview Board Report

Q2 2024/25 (July to September 2024)

Author: Brenda Lynes, Director of Maternity Services

Trust Board Meeting in Public 10/12/24

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East Sussex Healthcare NHS Trust

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- Service user voice
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- CQC national maternity survey 2023 (Q1 update)
- MNVP and ESHT annual coproduced action from S/U feedback (Q1 new A/P)
- Equity & Equality

Theme 2, Growing, retaining and supporting our workforce
- MatNeo quarterly/ biannual workforce report (includes Labour Ward Acuity Red Flag Incident Reporting Q1)
- Recruitment and Retention Report (Q1)
- TNA
- Culture
- MatNeo Staff Survey
- SCORE Survey perinatal Culture & Leadership Actions

Theme 3, Developing and sustaining a culture of safety, learning and support
- CNST Maternity Incentive Scheme (MIS) Year 6
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Theme 4, Standards and Structures that underpin safer, more personalised and more equitable care
- Claims, Complaints and Risks Scorecard
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- CQC Inspection A/P (re mandatory training and Appraisal compliance)
- Antenatal & Newborn Screening Report Public Health Report
- CNST MIS annual report and self-assessment

→ **Feature Reports**

Cover

East Sussex Healthcare NHS Trust

Theme 1 - Listening to and working with women & families with compassion

The Maternity and Neonatal department have substantial evidence demonstrating effective co-production and collaborative working to proactively and positively improve services for our women and birthing people. During Q2 we have continued to make progress in line with the National CQC Service User audit action plan, including continuous improvement of our maternity website, progress to support partners in line with our 24-hour visiting. Work continues to improve our Induction of labour pathway and align processes across Sussex. Service users commented on the range of good quality information available during the antenatal period.

We are working to improve Service User experience, specifically around communication as to a baby's wellbeing when straddling the postnatal ward and our Special Care Baby Unit. Breastfeeding support is another area where improvements are required to ensure consistent advice is given; we have recently recruited two support workers who offer increased consistent support on the ward area. Work continues to improve our discharge processes.

We are actively working to improve our Equity and Equality data and have resourced targeted services to support stopping smoking for pregnant people and their families, with robust surveillance services for those people at greater risk during pregnancy. Our continuity teams continue to provided targeted support for under 21's and for women and people where English is not their first spoken language. Complex homebirth requests from service users are also supported through our continuity teams.

Finally, staff and service users are delighted that we have reopened our Eastbourne Maternity Unit to intrapartum care (2/9/24), we have seen increasing numbers of births over the past two months

Cover

East Sussex Healthcare NHS Trust

Theme 2 - Growing, retaining and supporting our workforce

Quarter 2 has seen a reduction in vacancy rate (0.9%) with a slight decrease in fill rates due to the high levels of short-term sickness (average 7.5%). This is being actively managed by our Head of Midwifery and her leadership team. Red flags raised during Q2 are reflective of the sickness rates There is evidence of appropriate mitigation taking place through the effective use of the department's escalation process where additional clinical support is required.

Our budgeted establishment is in line with Birthrate+ (2022 analysis) and we have currently commissioned a further review (completion expected end November 24)

Neonatal nursing and medical services and Obstetric medical services are all commissioned and delivered in line with national requirements.

Our staff survey actions have included focussed work on improving PDR compliance, ensuring staff understand their roles and have clear annual KPI's.

The external independent investigation of Maternity has now reached its conclusion and a range of recommendations have been made. A robust and detailed action plan has been produced to respond to this which involves a strong commitment to investing in leadership at every level. We are working with the Organisational Development team to provide a support program for staff to work to improve areas where poor culture was identified and to support staff in rebuilding the best aspects of the department's culture in line with our trust values. This work is likely to be extensive and will require significant buy-in from some individuals and from the service as a whole.

We have an active Score Survey action plan and this will evolve to include actions from the external reviews including pulse surveys (or similar). Continued recruitment and retention work to provide wellbeing services for staff includes the training of a further 10 midwifery staff to provide Trauma Risk Management (TRIM) support to staff; work is ongoing in-regards to flexible working and self-rostering.

Cover

East Sussex Healthcare NHS Trust

Theme 3 - Developing and sustaining a culture of safety, learning and support

The overall perinatal mortality rate (PMR) for stillbirth & neonatal deaths (NND) and Hypoxic ischaemic encephalopathy (HIE) grade 2&3 are all showing significant improvement (continued low numbers).

The stillbirth rate has shown significant improvement since Jan 24, Neonatal death rate since April 23 and overall perinatal mortality rates since Jan 24 and HIE grades 2&3 since Sept 22. Improvements include maintaining high compliance in all areas of our Saving Babies Lives V3 care bundle; we continue to embed our regional preterm optimisation Quality Improvement initiative Prem 7; we are 99% compliant with the SBL toolkit (verified by the ICB and LMNS); and we have met CNST requirements for year 6. We continue to make good progress with the aim for full implementation.

We have identified an issue with insufficient scanning capacity for growth scans to meet the national required timeframes and uterine artery doppler compliance. The department is working to review provision of all scans to enable focussed work on essential scans.

Avoiding Term admissions to SCBU are below the national average for Q2 (3.87), a Quality Improvement project is underway to review admissions for respiratory distress syndrome. We continue to have an ongoing review of caesarean section rates which have risen (as is the case nationally).

Focussed work to reduce health inequalities includes targeted smoking cessation support, vaccine uptake and healthy weight management, whilst ESHT do not follow national trends for inequalities relating to Black and Asian women and birthing people (numbers are very small), focussed work continues in this area.

Assurance is confirmed through the LMNS quarterly assurance group and our annual internal audit that full CNST compliance across all 10 safety actions has been achieved for year 6, submission has been approved through the Quality and Safety committee on behalf of the Board.

Cover

East Sussex Healthcare NHS Trust

Theme 4 - Standards and Structures that underpin safer, more personalised and more equitable care

There has been significant improvement across our partnership Local Maternity and Neonatal System (LMNS) with improving oversight and assurance, driving significant joint working, data quality improvement, oversight of quality and safety and identifying areas to standardise and improve as a system through our Perinatal Quality Surveillance (PQS) Operating model, with significant work to improve our local dashboard.

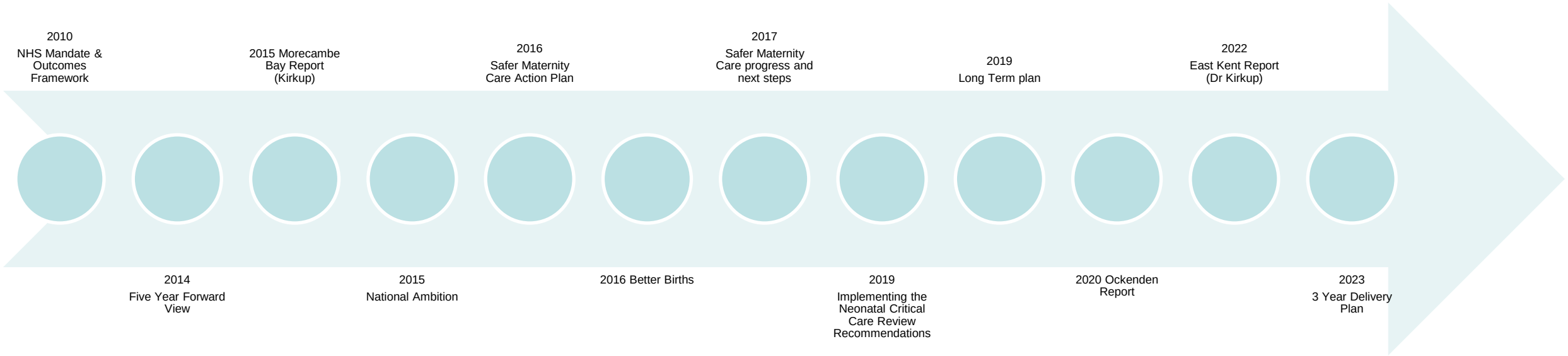
At a local level, with regards to our Claims, Complaints and Risk scorecard and Perinatal mortality reviews, our data is evidencing that we are a learning organisation and for Q2 there were no avoidable perinatal deaths.

5 multidisciplinary team (MDT) cases were closed during Q2 (2 over 1 year old) and learning identified included improving documentation and early recognition of pre-eclampsia. Transitional Care pathway work is progressing and reducing admissions to our Special Care Unit. Across the network the main reason for admissions are respiratory and ESHT is not an outlier in this regard. At ESHT a Quality Improvement project is underway which has been shared with the LMNS, who are keen for us to share any learning. In the last 10 months there were no avoidable term admissions to the neonatal unit which is positive.

A key action from the CQC action plan is to achieve 90% for Trust mandatory training; during Q2 the average was 75% compliance. The Quality and Safety Committee have discussed key actions that will be taken to improve compliance by the end of March 2025.

East Sussex Healthcare NHS Trust

The Journey to a national Maternity and Neonatal Safety Ambition



The 3 Year Delivery Plan

East Sussex Healthcare NHS Trust

Theme 1: Listening to and working with women and families with compassion

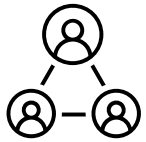
- Objective 1: Care that is personalised .....
- Objective 2: Improve equity for mothers and babies .....
- Objective 3: Work with service users to improve care.....

Theme 2: Growing, retaining, and supporting our workforce .....

- Objective 4: Grow our workforce.....
- Objective 5: Value and retain our workforce .....
- Objective 6: Invest in skills.....

Theme 3: Developing and sustaining a culture of safety, learning, and support.

- Objective 7: Develop a positive safety culture .....
- Objective 8: Learning and improving.....
- Objective 9: Support and oversight.....



Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care .....

- Objective 10: Standards to ensure best practice .....
- Objective 11: Data to inform learning.....
- Objective 12: Make better use of digital technology in maternity and neonatal services.....

Three Year Delivery Plan: Theme 1

Listening to and working with women & families with compassion (Q2)

East Sussex Healthcare NHS Trust

Work with Service Users to Improve Care

- Regular on-site walkabouts with our Maternity Voices partners
- Eastbourne Maternity Unit (EMU) –reopened to Intrapartum care 2/9/24
- Coproduced ESHT and MNVP action plan from service user themes
- Coproduced ESHT and MNVP action plan following the national CQC maternity survey – all actions progressing and to scheduled targets Agreed MNVP annual workplan (as shared in Q1)
- 33 individual members of staff thanked by service users for going above and beyond

Our Service User Voice

You Said	We Did
Improve breastfeeding support	• Infant feeding lead providing a training day for all staff • 2x feeding support workers available week-days on the acute unit for support • MSW support in community to provide consistent advice and support
Consider Mental Health Support offered	• Specialist support provides individualised care plans • Neuro divergence training introduced for all staff • Community nursery nurses noted by SU's to provide high quality care and knowledge • Discussion with HV teams in progress regarding recognition and provision of MH support postnatally

MatNeo CQC Survey

(Outstanding actions)

- Outstanding action to introduce our new Induction of Labour Pathway
- Current work ongoing to standardised care across the LMNS including information to service users

Listening to and working with women & families with compassion

East Sussex Healthcare NHS Trust

Improving Equity & Equality

- Improved data collection
- Monthly equity and equality group
- Robust Public Health services within maternity
- Compliant with Saving Babies Lives (SBL) v3
- Vaccination programme in progress (pertussis, seasonal flu.
- RSV program commenced 01/09/24
- Targeted work on Folic Acid
- Targeted smoking cessation activity
- Established Maternal Medicine service across Sussex
- Robust Pelvic Health and Perinatal Mental Health Services
- Targeted work following NND as an immediate action surrounding the management of raised Blood Pressure (skills drills and medical teaching session)

Equity & Equality	10% most deprived				20% most deprived			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BME stillbirth rate Rate per 1000 births	0	6.94 (1 baby)			0	0		
BME neonatal deaths Rate per 1000 births	0	0			0	0		
BME maternal death rate Rate per 1000 births	0	0			0	0		
BME Neonatal HIE diagnosis (brain injury) Rate per 1000 births	0	0			0 (1 cooled baby, normal MRI scan)	0		
Smoking at booking National average 9.9% (2023/24)	21.98	24.4			15.85	22.14		
Smoking at delivery National average 7.4% (2023/24)	14.83	18.69			11.65%	14.16		

Three Year Delivery Plan: Theme 2

Growing, retaining and supporting our workforce

Our workforce

East Sussex Healthcare NHS Trust

Maternity Workforce

	Q1	Q2	Q3	Q4
Birthrate Plus Acuity Compliance (National recommendation 85%)	83%	79.5%		
Data Source	**Q1**	**Q2**	Q3	Q4
Birth to midwife ratio (National recommendation 1:21)	1:28	1:32		
Sickness	1.9%	7.53%		
Maternity Leave	4.7%	4.23%		
Vacancy rate	1.6%	0.66%		
Midwifery total fill rates	89.2%	86.7%		

Maternity			
	Budgeted June 24	**Budgeted April 2022**	
Specialist	27.67	21.3	
Combined Screening	4.25	4.05	
Community Midwifery Conque	21.00	18.27	
Community Midwifery EDGH	19.30	18.2	
Frank Shaw	92.97	80.62	
EMU	15.46	18.78	
Maternity Day Unit	14.54	12.78	
Case Load Teams	14.60	24.6	
Total	209.79	198.60	
3.4% of April 22		**6.75**	
Apr-22		198.60	
BR+ 3.4% uplift		6.75	
Total inc uplift		205.35	
Jun-24		209.79	
variance to 22 + 3.4%		4.44	over suggested BR+ increase to budgeted staff

The BR+ workforce assessment was presented to the Board in June 2022. The Board agreed with the workforce assessment, with a headroom uplift of 26.4%. This is reflected in current midwifery workforce budgets as demonstrated in the extraction below.

	Q1	Q2	Q3	Q4
1-2-1 Care in Labour	100%	100%		
Supernumerary labour ward coordinator	100%	100%		

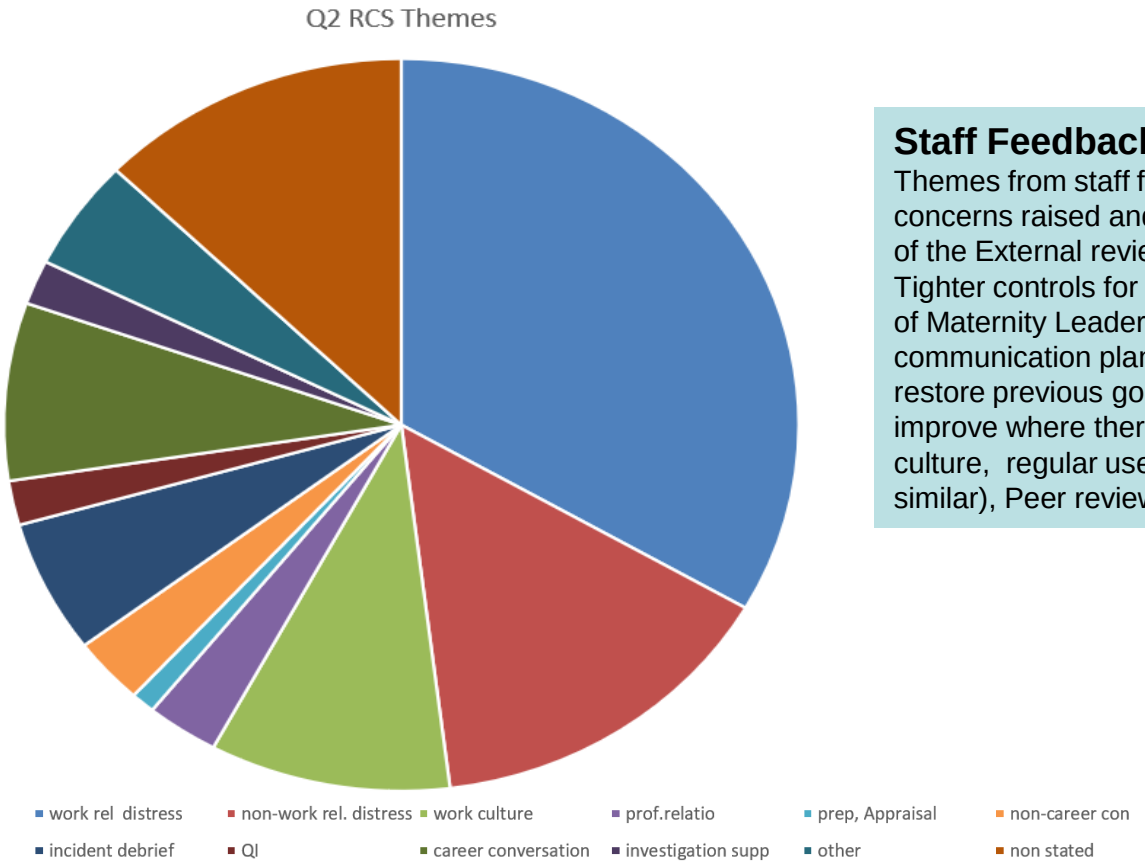
Three Year Delivery Plan: Theme 2

Growing, retaining and supporting our workforce

Our workforce

East Sussex Healthcare NHS Trust

Clinical Maternity Red Flags Q2	Action
• Unable to fill vacant shifts, unexpected absence/ sickness	Mitigated by use of escalation process and Bank usage
• Delayed commencement of Induction of labour	All cases are clinically risk-assessment by the medical team prior to agreeing a delay



Staff Feedback Themes Q2

Themes from staff feedback reflect the concerns raised and investigated as part of the External review. Actions include; Tighter controls for recruitment, Review of Maternity Leadership structure, communication plan for all staff, work to restore previous good culture and improve where there were areas of poor culture, regular use of pulse surveys (or similar), Peer review of clinical practices.

Medical workforce: Obstetrics

- Consultants: Full compliance with RCOG Roles and Responsibilities (audited quarterly)
- Consultants: Compensatory rest, fully compliant with RCOG guidance
- Middle grades: full compliance with RCOG guidance on employing short and long-term locums

Neonatal staffing: Medical

Meets the British Association of Prenatal Medicine (BAPM) national standards of neonatal medical staffing

Neonatal staffing: Nursing

Levels meet Operating Delivery network (ODN) requirement (ESHT has a 12 cot SCBU)

Qualified in Speciality (QIS)

Target 70%	Q1	Q2	Q3	Q4
	57.4%	50.2%		

Action Plan in place with staff currently on training programme, expect to achieve by Q2 2025
Over the past quarter 0 shifts fell short for QIS trained staff per shift

Vacancy rate	Q1	Q2	Q3	Q4
	7%	2.2%		

Recruitment progressing

Anaesthetic staffing

100% compliance Anaesthesia Clinical Services Accreditation (ACSA)

Three Year Delivery Plan: Theme 2

Growing, retaining and supporting our workforce

Our workforce

NHS East Sussex Healthcare NHS Trust

Training Needs Analysis (TNA)

Comprehensive annual review competed. All staff training needs are reflected in line with NHSE requirements (as shared in Q1)

Recruitment & Retention 3-year plan

Programme Aims

- Retention
- Psychological wellbeing and safety
- Recruitment
- Career mapping

Key risks & mitigations

- Maternity Review into leadership and culture concluded. Key actions include: feedback to staff (in progress)
- A commitment to investing in leadership development and training to secure psychological wellbeing and safety provided. To be informed by outcomes of independent review
- Harnessing full engagement from colleagues at all levels
- Tighter controls for recruitment, Review of Maternity Leadership structure, communication plan for all staff, work to restore previous good culture and improve where there were areas of poor culture, regular use of pulse surveys (or similar), Peer review of clinical practices,
- Alignment of Professional Midwifery Advocates (PMA) with Trust Restorative Supervision approach to improve the quality of monitoring and evaluation

MatNeo Staff Survey Score report

Positives

- Good focus on Incidents
- Increased PDR compliance (and increased career conversations)
- Less people considering leaving the division
- Noted increased focus on wellbeing(trust –wide)
- Ongoing engagement sessions
- Vacancy rate is low

Learning Points

- Staff want to really know and understand their individual responsibilities
- Increasing MSK problems at work
- Staff feel worn out at the end of their shift
- Increased work-related stress (related to specific issues)

Actions

- Staff listening events in place and ongoing
- Results discussed with staff, who have been asked for their ideas for improvement
- Additional OH support to allow earlier return to work where possible
- OD work to be confirmed following external review

Three Year Delivery Plan: Theme 3

Developing and sustaining a culture of safety, learning and support

East Sussex Healthcare NHS Trust

Avoiding term admissions into neonatal units (ATAIN)
National average 5%

	Q1	Q2	Q3	Q4
Rate	5.27	3.87		

Key action:
- Quality Improvement project for Respiratory Distress Syndrome(RDS) in progress
- Ongoing review of caesarean section rates – noted decrease in LSCS at 37 weeks

(below the national average rate for Q2)
Quality Improvement project in progress to aim to reduce admissions for RDS

Transitional Care (TC)

	Q1	Q2	Q3	Q4
No	73	47		
Main treatments	• IV antibiotics • Treatment for Hypoglycaemia	• IV antibiotics • Temperature support		
Actions	*Nil – 0 inappropriate admissions to SCBU*	*1– 1 inappropriate admissions to SCBU – could have been managed through transitional care*		

Saving Babies Lives (SBL) V3 Q2 2023/24

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	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	99%	Partially implemented	99%	CNST Met

MDT Training target >90% at year end

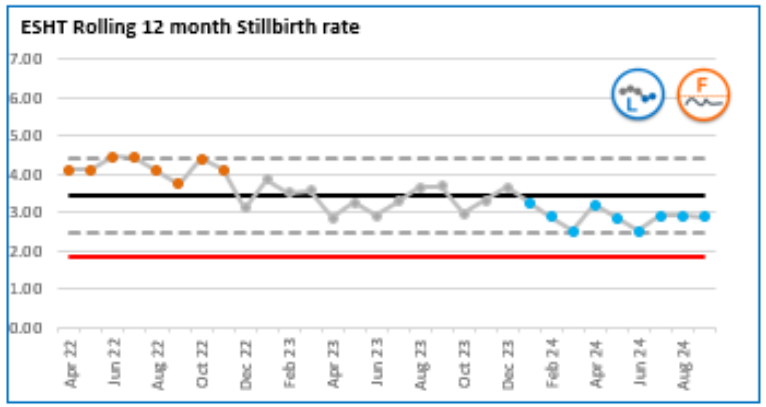
CTG & fetal monitoring training competency	**Q1**	**Q2**	Q3	Q4
Combined Medic & Midwives	98%	94%		
PROMPT compliance	**Q1**	**Q2**	Q3	Q4
Combined Medic & Midwives	90%	97%		

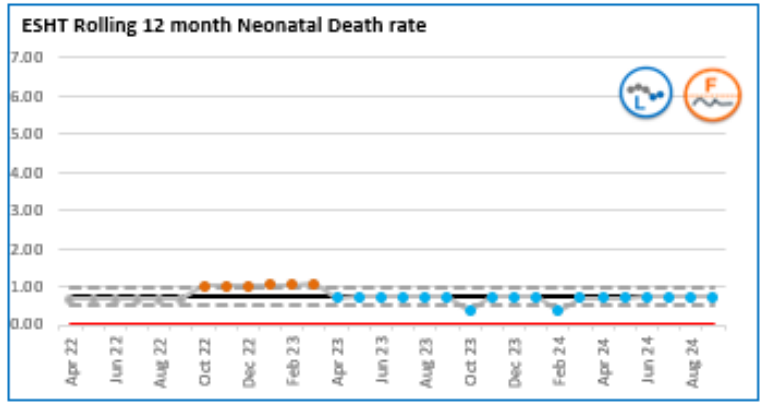
Three Year Delivery Plan: Theme 3

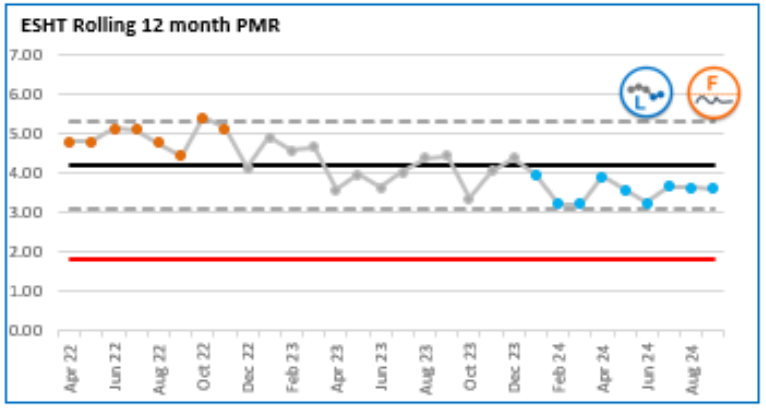
Developing and sustaining a culture of safety, learning and support

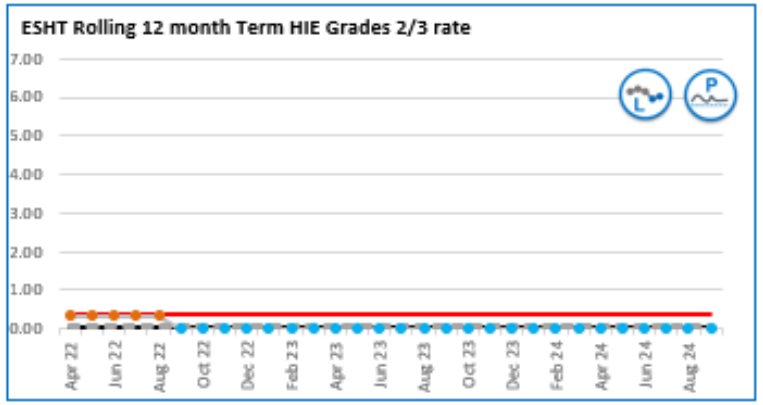
East Sussex Healthcare NHS Trust

Perinatal Quality & Safety









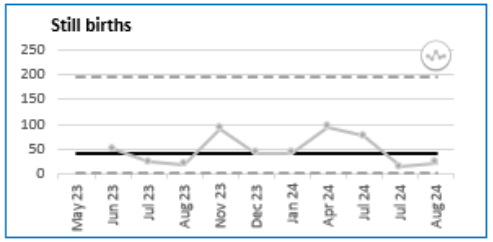
Why are some SPC charts missing targets?
There is no national or regional benchmark data for stillbirths or neonatal deaths. As per the technical annex to the 3-year delivery plan, the England level data used a different data source, so it is not appropriate to present side by side.

Rare event charts: are updated in real time and show the average days between stillbirths, neonatal deaths, and HIE (all diagnosis)

Date of last stillbirth 20/08/24

Average days between stillbirths 47.7

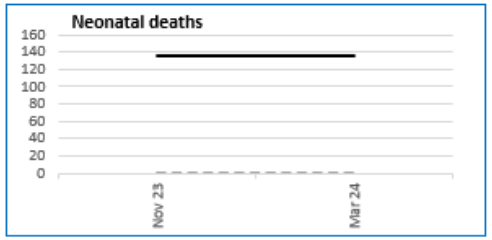
No significant change



Date of last neonatal death 18/03/24

Average days between deaths 136.0

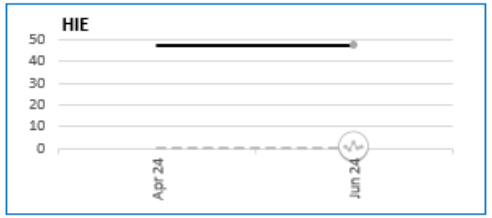
No significant change



Date of last HIE 08/06/24

Average days between HIE 47.0

No significant change



Significant improvements
Stillbirths, neonatal deaths, overall PMR and HIE grade 2 & 3 all show significant improvement due to continued shift of low numbers.
Stillbirth rates have shown a significant improvement since Jan 24, Neonatal deaths since April 23, overall PMR since Jan 24 & HIE grades 2/3 since Sept 22.

Perinatal Mortality Rate (PMR): stillbirths and neonatal deaths combined
Hypoxic-ischaemic encephalopathy (HIE) (when baby's brain does not receive enough oxygen and/or blood flow around the time of birth)

Developing and sustaining a culture of safety, learning and support

Perinatal Quality & Safety

Closed Incidents	
Incident type	**Recommendations/ actions**
Closed MDT Cases web160395	• Work completed with MDT regarding early recognition of signs of pre-eclampsia • Reinstated skills drills on the clinical floor (from March 24) • Consider the use of MEWS in A&E (action currently under review)
web 158381 web 156463	• Work completed with the triage team to ensure consistent advice in line with national/local guidance is provided • Audit to confirm effective documenting of pre-eclampsia symptoms within electronic records • Discussion with LWC to ensure all staff escalate to coordinator in a timely manner
Web 148564 (Feb 23 case)	• Work completed with community staff to ensure a 4hrly (min) update to Labour ward coordinator regarding progress at a Homebirth (now standard practice) • Discussion with community midwives regarding the use of Entonox at a homebirth • Purchase of community suction equipment (all community staff trained in its usage)
Closed MNSI/PSII Nil closed	

East Sussex Healthcare NHS Trust

Three Year Delivery Plan: Theme 4

Standards and Structures that underpin safer, more personalised and more equitable care

MatNeo Claims, Complaints, Incident Scorecard

- Provides volume value and cause of claims over 10 years
- April 2013- March 2023 = 51 claims made to value of £86,127,373

No closed claims
Learning from closed complaints & Severity 3,4 & 5 Incidents

- *no avoidable deaths*
- Improve verbal communication with service users and between staff
- Work to empower all midwifery staff to escalate concerns
- Ongoing work to improve the quality of documentation within our electronic patient record system

PMRT

- 100% compliant with all standards

Key actions:

- Implementation of MDT meetings for complex cases to include Mental Health and Safeguarding services
- Service users reminded about reporting reduced fetal movements (with signposting to written guidance)
- New electronic system to be introduced for booking ultrasound scans in pregnancy

CQC Inspection action plan

Outstanding action: Mandatory training

- Achieve 90% for Trust mandatory training as listed in report (currently average 83%)
- Plan to improve overall percentages discussed with Q&S committee

Three Year Delivery Plan: Theme 3

Developing and sustaining a culture of safety, learning and support

East Sussex Healthcare NHS Trust

CNST MIS annual report and self-assessment

CNST Maternity Incentive Scheme (MIS) year 6 Safety Actions	
SA1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?
SA2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
SA3	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?
SA4	Can you demonstrate an effective system of clinical workforce planning to the required standard? a) Obstetric medical workforce b) Anaesthetic medical workforce c) Neonatal medical workforce d) Neonatal nursing workforce
SA5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?
SA6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?
SA7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.
SA8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
SA9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?
SA10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Fully Compliant against all areas

Year 6 submission (timeframe closed 30/11/24)

- **Audit: Fully compliant 30/11/24**
- **Board Declaration form**

National review of maternity services in England 2022 to 2024

East Sussex Healthcare NHS Trust

- Report published September 2024 by the Care Quality Commission (CQC). Summary of findings from previous 2 years and visits to 131 maternity services to see what care is like for pregnant women and babies
- Of the locations inspected between August 2022-December 2023, almost half were rated as requires improvement (36%) or inadequate (12%).
- Key Themes/findings:
    1. Responding and learning from incidents
    2. Risk assessment and triage
    3. Recruitment and retention of staff
    4. Estates and environment
    5. Inequalities and racism
    6. Communication with women and families

Recommendations for NHS trusts

Ensure all women leave hospital with the information they need to be able to process their experience and have an opportunity to make arrangements to speak to a member of the multidisciplinary team about their birth within a realistic timeline. Women whose cases are referred to a review panel should have the right to attend the panel and the opportunity to co-produce improvements for future reviews.

At ESHT

- Established Debriefing service
- Daily walkabout to manage immediate concerns from women and birthing people
- Working to improve discharge process (to include daily discharge group discussion)
- PSIRF and MNSI process includes close working with women and birthing people

Recommendations for NHS trusts and integrated care boards (ICBs)

- Improve their collection of demographic data, including information on ethnicity and levels of deprivation, to improve outcomes for women.
- Ensure that demographic data, including ethnicity data, is always considered when reviewing patient safety incidents and action is taken where risks are identified.
- Ensure that there are clear policies and procedures on the collection of demographic information and staff understand the importance of how this data can be used to improve outcomes for women.

At ESHT

- Currently collect demographic data, work ongoing to improve this data and usage
- Demographic data is used within maternity services when reviewing high risk cases
- ESHT are fully compliant (in line with MIS/ CNST safety actions requirement) in the data collection and submission to NHSE monthly
- Quarterly analysis of all data ongoing

East Sussex Healthcare NHS Trust

Agenda Item: [12.1]

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	**Trust Board**	**Date of Meeting**	10 December 2024

Report Title:	Freedom to Speak Up Guardians report
Purpose of the Report/Outcome/ action requested:	This report provides an overview of the activity of the Freedom to Speak Up Guardians (FTSUGs) for Quarter 1 and 2 in 2024. It gives the recorded concerns raised by staff groups and the key categories of concerns. In line with reporting requirements, we last reported to the People and Organisational Development Committee (POD) in November 2024. The FTSUGs are required to report to Trust Board twice a year. This report seeks to provide assurance on the proactive and supportive activities of the FTSUGs and insight into the themes raised from cases. Recognition of the learning opportunities from staff who speak up can only improve patient safety, staff wellbeing and culture. It also provides key national updates and development news. The Guardians have been compliant with submitting anonymised quarterly data to the National Guardians Office, which is a mandatory requirement.
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☒
Authority for Decision:	Trust Board
Executive Summary	• Review of Quarter 1 and Quarter 2 within ESHT to provide assurance that staff can speak up and utilise the FTSUG route. • Key concerns staff at ESHT are raising include inappropriate attitudes and behaviours and impact on staff wellbeing. • One Anonymous concern in each quarter and assurance that they are supported in line with good practice but recognising limitations to feedback. • Improvement in mandatory training figures but further support is required to give assurance. • Highlights of Speak up October 2024
Regulatory/legal requirement:	In line with National Guardian Office requirements, the FTSUGs are required to report to the Trust Board twice a year.
Business Plan Link:	Quality ☐ People ☒ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues had been taken into consideration
Resource Implication/VFM Statement:	None

Risk:	None to be added to the risk register		
No of Pages	12	**Appendixes**	None
Name, position and contact details of author:	Ruth Agg and Dominique Holliman FTSUG's		
Report Sponsor	Steve Aumayer Chief of People and Deputy CEO	**Presenter:**	Ruth Agg and Dominique Holliman FTSUG's
Governance and Engagement pathway to date:	Presented to POD 21.11.2024		
What happens next?	Update of paper for any points raised and presentation to Board		
Publication	Can be published		

Data and trends

The table below shows the number of concerns that were raised with the ESHT FTSUGs during quarters 1 and 2 of 2024. Inappropriate attitudes and behaviours remain the leading reason for people speaking up and registered nurses and midwives are the professional group that speak up the most, followed by administrative and clerical colleagues.

The table identifies the reasons for speaking up according to the categories set by the National Guardians Office. We also collect data on any other reasons for speaking up at ESHT and additional concerns were raised from colleagues citing poor leadership and systems and processes as contributing to a negative workplace experience.

Nationally, quarter 1 saw 8,872 cases raised with guardians, a 30% increase in the number of cases compared to the same quarter last year. 40% of those included an element of inappropriate attitudes and behaviours and the category of worker safety or wellbeing also showed the continuation of an upwards trend. Whilst our quarter 1 data did not reflect a significant increase in either inappropriate attitude and behaviours or worker safety and wellbeing, our numbers have remained roughly static in these categories and did account for more than 75% of the total cases for colleagues speaking up in ESHT last year.

In quarter 1 of this year, 40% of concerns were raised within the women and children's division, citing concerns around leadership, inappropriate behaviours and attitudes and systems and processes. The volume of concerns necessitated oversight at senior level and an external review of maternity services was commissioned. The findings of the review have been shared with the divisional leads and we thank colleagues for their contributions to the review and await further communication regarding any actions and organisational learning that can be applied from the findings. By quarter 2, the concerns from this division had reduced to 10% of the overall Guardian caseload, suggesting that the review afforded a suitable channel for concerns to be explored, and colleagues engaged with this route.

There is a keenness to look at any learning and improvement and further guidance for managers and leads when a significant number of concerns are raised. Previously, in other areas with high numbers of concerns these also eventually led to an external review. Staff feedback included the time scales and ongoing impact when concerns were escalating on wellbeing and attendance at work. This is an opportunity to consider proportionate actions and time scales when responding to increasing concerns in Divisions. Timely psychologically safe spaces to share concerns with senior leads are welcomed by staff, but regular communication and record of meetings was also sighted as a concern by staff perceiving nothing was happening.

The National Guardian office published its Annual report in July. Over 30,000 cases have been brought to Freedom to Speak Up guardians throughout 2023/24 - the highest ever recorded, a 27.6% increase on the previous year.

The National Guardian's Office latest annual report from July 2024 summarises the themes and learning from the speaking up data shared by Freedom to Speak Up guardians. FTSU-Case-Data-Annual-Report-23-24-1.pdf

Nearly two in every five cases (38.5%) involved an element of inappropriate behaviours and attitudes. This matters because we know that working environments affect quality and safety, impacting on staffing, retention, and ways of working.

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

"Culture is a patient safety issue. Every interaction – whether patient, family member, colleague, or consultant – makes a difference to lives and outcomes.

We know it can take courage to speak up. These case numbers represent 30,000 opportunities for learning and improvement for the benefit of patients and colleagues, yet too many voices still go unheard.

This year Freedom to Speak Up guardians have handled more cases than ever before. This is credit to the efforts made by guardians to foster trust and break down barriers to speaking up within their organisations. Four fifths of those who gave feedback to their guardian about their speaking up experience, said that they would speak up again. There remains a persistent number of cases where guardians indicate that the person speaking up to them may be experiencing detriment for speaking up. As a percentage, this remains at 4 per cent, but given the increase in numbers, this equates to 1,285 cases. Freedom to Speak Up guardians are often the last opportunity for an organisation to put something right. Recent high-profile cases highlight the negative reputational impact which mistreating people for speaking up can have on organisations. And yet these stories persist, that the organisation was more interested in its reputation than in listening to the concerns or acting on them. And there is no more chilling example than the crimes of Lucy Letby which are the focus of the current Thirlwall Inquiry. I am hearing increasingly of instances of guardians facing detriment themselves for doing the very job that they have been employed to do speaking truth to power and having the courage to have difficult conversations. While I hope that these are outliers, mistreating a guardian for raising concerns cannot be tolerated. A priority for me is to see how we might seek further protection of Freedom to Speak Up guardians from detriment for doing their role."

SpeakUp - National Report Metrics

FYYear	FYQuarter	Anonymous	Detriment	Bullying	Patient Safety	Worker Safety	Attitude Behaviour	Total Issues Logged
2024/25	1	1	0	1	9	10	10	53
	2	1	0	11	4	18	25	72
	Total	2	0	12	13	28	35	125
Total	**Total**	**2**	**0**	**12**	**13**	**28**	**35**	**125**

SpeakUp - Professions Report Metrics

FYYear	Quarter	Profession	Anonymous	Detriment	Bullying	Patient Safety	Worker Safety	Attitude Behaviour	Total Issues Logged
2024/25	1	Additional Clinical Services	0	0	0	1	1	2	9
		Administrative and clerical	0	0	0	0	2	1	6
		Allied Health Professionals	0	0	0	0	0	1	1
		Medical and Dental	0	0	0	1	0	0	2
		Not Known	0	0	0	0	0	0	3
		Nursing and midwifery registered	1	0	1	7	7	6	32
		Total	1	0	1	9	10	10	53
	2	Additional Clinical Services	0	0	3	3	3	4	10
		Additional Professional Scientific and Technical	0	0	3	0	2	2	5
		Administrative and Clerical	0	0	0	0	3	7	22
		Allied Health Professionals	0	0	0	0	0	1	3
		Estates and Ancillary	0	0	0	0	1	2	2
		Medical and Dental	0	0	2	0	2	1	3
		Not Known	1	0	2	0	0	1	3
		Nursing and midwifery registered	0	0	1	1	5	5	21
		Other	0	0	0	0	1	2	2
		Social Care	0	0	0	0	1	0	1
		Total	1	0	11	4	18	25	72
	Total	Total	2	0	12	13	28	35	125
Total			**2**	**0**	**12**	**13**	**28**	**35**	**125**

SpeakUp - Divisional Report Metrics

FYYear	Quarter	Division	Anonymous	Detriment	Bullying	Patient Safety	Worker Safety	Attitude Behaviour	Total Issues Logged
2024/25	1	CHIC	0	0	0	0	2	1	4
		Core Services	0	0	0	0	0	0	1
		Corporate	0	0	0	0	1	0	2
		DAS	0	0	0	1	0	1	6
		Estates and Facilities	0	0	0	0	0	1	1
		Littlington medical	0	0	0	0	1	0	1
		Not specified	0	0	0	0	1	0	2
		Other	0	0	0	0	0	0	1
		TWS	0	0	0	1	0	0	1
		Urgent Care & Medicine	0	0	0	1	3	4	12
		Urgent care medicine Devonshire ward	0	0	0	1	1	0	1
		Women, Children & Sexual Health	1	0	1	5	1	3	21
		Total	1	0	1	9	10	10	53
	2	Administrative/Secretarial	0	0	0	0	0	0	1
		CHIC	0	0	1	1	1	3	7
		Core Services	0	0	3	0	2	1	5
		Corporate	0	0	1	0	2	2	9
		DAS	0	0	0	3	3	6	10
		DIGITAL AND IT	0	0	0	0	0	2	3
		Estates and Facilities	0	0	0	0	0	1	2
		Finance	0	0	0	0	0	3	3
		Not specified	0	0	1	0	3	1	7
		TWS	0	0	0	0	1	1	2

		Urgent Care & Medicine	1	0	4	0	6	5	15
		Women, Children & Sexual Health	0	0	1	0	0	0	8
		Total	1	0	11	4	18	25	72
	Total	Total	2	0	12	13	28	35	125
Total			**2**	**0**	**12**	**13**	**28**	**35**	**125**

Thirlwall Inquiry

The Thirlwall inquiry has been set up to examine events at the Countess of Chester Hospital and their implications following the trial and subsequent conviction of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital. The oral evidence hearings began on 10th September and look at three general areas:

1. The experiences of parents of the babies named in the criminal charges faced by Letby
2. The conduct of hospital staff and how Letby was able to repeatedly harm babies on the neonatal unit
3. The wider NHS including the culture within hospitals, and how it affects the safety of newborns in neonatal units.

The terms of reference also identified a list of 30 key questions the inquiry will seek to answer and included general questions such as "what happened to those who raised concerns?" and questions about wider NHS culture, including the conduct of board members, managers, and medical staff. The inquiry is expected to last until at least the end of the year and we will provide further updates and comment from the National Office in due course.

Speak Up Month

In October we celebrated National Speak Up month at ESHT with Guardian walkabouts, team meetings, bespoke training and promotion of the online speak up, listen up modules and the launch of our new poster.

Speak up badges, promotional pens and cupcakes were well received to support our discussions as we met with as many colleagues as possible. Steve Aumayer kindly recorded a video on the extranet to support our messaging and he accompanied a walkabout at both SPH and the Conquest site with Dominique. We were delighted that our staff side Union representatives also joined Dominique and Steve at the Conquest site to promote routes for speaking up. Ruth and Dominique attended several team meetings to share the new poster and discuss how to speak up and what to expect when we speak up. Leads were also sent the Freedom to Speak Up: A guide for leaders in the NHS & organisations delivering NHS services.

Attendance at the Head of Nursing Teams meetings and Matrons meetings were well received. Face to face visits to the community are also planned.

The Communications team developed regular pieces to promote the availability of training and shared a specific article on the value of speaking up and the role of the ESHT Guardians. This was accompanied by frequent tweets sharing photos and stories of our journeys around the Trust over the course of the month. A Schwarz round on the value of feeling heard was planned to coincide with the campaign month but we felt that the proposal to hold this online was deterring participants from feeling safe to contribute as storytellers. We are working with the Schwarz round facilitators to deliver this as a face-to-face session as soon as possible.

It is pertinent that the theme for this year's national speak up month was the power of listening, as many colleagues report that they attempted to raise concerns through their normal reporting route but felt that their feedback was diminished or trivialised. These comments were supported with examples that some

line managers were not receiving concerns with compassion or were perceived to make judgements and lacked impartiality when addressing a workplace issue. For example, not having a concern robustly addressed as it was assumed that the issue being raised was indicative of the individual's lack of resilience or, in the case of one colleague who was made to feel that their concern was not something that needed to be explored in detail, as it was suggested that their neurodivergence inhibited their understanding of processes.

We are pleased to learn that the Southeast Staff Experience, Engagement and EDI team in NHS England is offering sessions throughout November on neuroinclusive people management. There is also neurodiversity training on MyLearn alongside guidance for managers and allies on the extranet and we keenly promote both these and the A-typical network for neurodivergent staff. Identifying barriers to speaking up and advocating for compassionate, sensitive handling of concerns remains a priority.

Speak up training

Several managers were still unaware that the 'listen up' training is mandatory and, as yet, we have still not reconciled how to identify all staff at ESHT who manage or support staff who require the training. There has been an improvement in the training figures (568 for listen up in May 2024)

ESHT Freedom to speak up Training figures

October 2024	Running Total
Speak up - 19	**587**
Listen up - 23	**705**
Follow up - 0	**43**

National Updates

The National Guardians office has published their 3–5-year strategy which outlines plans for those they support, their organisation and their staff.

The Dash Review, carried out by Penny Dash, will assess whether six organisations deliver effective leadership, listening, learning, and regulation to the health and care systems in relation to patient and user safety. It is anticipated that the review will examine how patient safety organisations work together and explore how the speaking up culture in healthcare can have more impact.

Those included in the review are:

- CQC, including the Maternity and Newborn Safety Investigations programme (MNSI)
- National Guardian's Office (NGO)
- Healthwatch England (HWE) and the Local Healthwatch (LHW) network
- Health Services Safety Investigations Body (HSSIB)
- Patient Safety Commissioner (PSC)
- NHS Resolution (quality and safety functions only)

Further details are available at: https://www.gov.uk/government/publications/review-into-the-operational-effectiveness-of-the-care-quality-commission-full-report

The Health Services Safety Investigation Body (HSSIB) have just published their investigation report. In the report, HSSIB make a safety recommendation that the National Guardian's Office will work with stakeholders to identify the barriers that prevent temporary staff from speaking up and develop mechanisms to address those barriers.

This builds upon our work exploring the barriers to speaking up to improve workplace cultures so that all workers – no matter what their contract terms – are confident to speak up. The report can be found here: Workforce and patient safety: temporary staff – integration into healthcare providers

Supporting managers and making information accessible

The FTSUGs often meet with newly recruited line managers, and we recognise that they can be inexperienced in receiving and handling concerns. Many colleagues in new leadership roles encounter dysfunctional team behaviours that they are keen to address at the outset of their appointment, both to revisit Trust values and to set the tone for the culture of their work environment.

Guardians contributed to the development of the proposed dignity at work pages on the extranet, with an expanded section of scenario-based examples from practice, frequently asked questions and suggestions. We have asked that these pages also include the FTSUG guidance on how to receive concerns. This should support managers to feel equipped to manage speak up conversations and to offer a consistent and supportive response to those approaching them.

FTSUGs can help to develop restorative practice, de-escalating cases which otherwise become adversarial. Working with staff representatives, managers and individual workers, innovative solutions have been developed which help support staff and build better relationships. We feel that this is so important at a time of huge pressure on the NHS where civility and respect are vital to working effectively together to keep our patients safe.

Supporting overseas-trained colleagues

On behalf of the National Guardians Office, we have promoted an opportunity for our overseas-trained colleagues to be involved in a national study which is seeking to understand their experiences of speaking up. This speak up review is intended to enhance the understanding and improvement of the Speak Up culture among overseas-trained workers in the NHS and to develop actionable recommendations to foster a more inclusive and supportive environment for these workers. Participation in the study has included an online survey and 1:1 interviews alongside focus groups for doctors, nurses and midwives, radiographers, biomedical scientists, physiotherapists and occupational therapists. We look forward to sharing the findings when they are published and will keenly await any recommendations from that review.

Dominique attends the ESHT task and finish group which seeks to ensure that our internationally recruited colleagues have robust feedback mechanisms to feel safe and confident to share experiences and are encouraged to report any incidents of incivility towards them with assurance of appropriate feedback and action taken where indicated. Posters outlining how and where to raise concerns are now in all welcome packs and are shared as part of the induction programme. The executive welcome at inductions also includes the importance of speaking up and reinforces how we welcome feedback and commit to listen. The FTSUGs have historically raised concerns from overseas staff, and this has been welcomed to address the concerns they have raised. Attendance on induction days for overseas staff is supported face to face by the FTSUGs.

Listening events feedback

In August, Dominique and Mel Adams, People Experience Manager, facilitated a listening event to explore colleague experiences of reporting bullying and harassment in ESHT. The event generated lots of discussion and suggestions and plans are underway to implement actions based on the feedback and intelligence gathered at the events. Dominique, Sarah Feather and Mel Adams have already met with the network leads to give initial feedback.

As a result of some of the ideas proposed at the event, Dominique has asked for speaking up to be included as one of the topics discussed in the wellbeing conversations that are offered annually to all staff. Wellbeing conversation paperwork and the list of topics to discuss has now been updated to reflect this addition. This should ensure that managers check with individuals that they are aware of who they can speak up to if they develop a concern, and that the topic is used as a prompt for discussion around the value of speaking up.

New database development

The new guardian database for documenting and monitoring cases is now being trialled. This revised system will give much more detailed data regarding the progression of individual cases. It will enable us to extract the essential data for national reporting requirements as well as much richer intelligence around what makes colleagues approach the guardians, whether they have raised their concerns elsewhere, outcome measures and routes to resolution. The new system will also report upon whether colleagues would use the service again and help us to monitor average caseload handling times. We have worked with the systems analyst team over several months to refine the database and an accompanying reporting dashboard and we look forward to sharing the new data format in future reports.

Ongoing workstreams

- Further explore how to improve training of listen up and identifying managers and supervisors.
- Continue proactive and supportive work across the Trust, ensuring reach to staff who may experience barriers to speaking up.

Management Response to Speak Up Guardian Report

Purpose of the paper	To provide a Trust response to the Freedom to speak up Guardian's report.					
	For decision		For assurance	X	For information	
Sponsor/Author	Jenny Darwood Acting Chief People Officer					
Governance overview	The Freedom to speak up National Guidelines require a twice-yearly update to Board by a Guardian. POD reviews these papers.					

Strategic objectives	Quality	People	Sustainability
	x	x	x

Our values	Kindness	Inclusivity	Integrity
	x	x	x

Recommendation	The Board is asked to receive the report noting the updates provided
Executive summary	This paper welcomes the Freedom to Speak up Guardians six monthly report to Board and discusses actions that align with the report contents. It recognises that, whilst our speak up arrangements are good, there is a key focus on managers training.
Next steps	Promotion and access to managers training

This paper provides a brief response to the Freedom to speak up Guardian's report.

The report from the Freedom to Speak Up Guardians is welcomed and its contents accepted. As stated in the report, our speak up processes remain fully compliant with the guidance from the National Guardians Office. This report continues to demonstrate both the willingness of colleagues to speak up and the value our guardians have in promoting and supporting this process.

It should be noted that nationally speak up cases have increased in quarter 1, but that this increase has not been demonstrated within our Trust where numbers have remained stable. However, reports of poor behaviours remain the highest reason for speak up cases, which mirrors the national trend.

The guardians maintain an overview of cases and trending data for 'hotspots', escalated to managers and senior leaders. This is evidenced within the report where, following an increase in cases within a division, an independent review was commissioned and listening events for colleagues in the affected area. These staff engagement and listening events have contributed to a reduction of reporting within this area.

The report continues to evidence that FTSU is embedded within the organisation. However work continues to promote the importance of speak up, including Executive-led Trust inductions and marketing and events.

Supporting the education and skill of our managers is integral to the embedding of speak up in the culture of our Trust, giving managers and leaders confidence in listening and responding to speak up themes. A managers' essential toolkit has been developed, located on MyLearn, which provides a single area for managers to access training and resources to equip them with necessary skills and to locate and access support through the People Engagement Teams.

The Trust Violence and Aggression Reduction group is actively working to tackle issues relating to attitudes and behaviour and worker safety. This includes looking at the Trust's estate along with other broader issues which may contribute to people feeling frustrated and behaving in an inappropriate manner.

The development of the database is well underway, and we eagerly await the richness of data that this will produce enabling further improvements to the FTSU service further.

The next FTSU report will be presented in 6 months which will include workstream and training updates.

Agenda Item: [13.1]

Report To/Meeting	Trust Board	**Date of Meeting**	10th December 2024
Report Title:	Infection Prevention and Control Annual Report 2023/24		
Purpose of the Report/Outcome/ action requested:	The Board is asked to note the content of the report.		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐		
Authority for Decision:	Trust Board		
Executive Summary	The annual report outlines the infection prevention and control (IPC) activities of East Sussex Healthcare NHS Trust (ESHT) for the financial year 2023/24. It sets out arrangements made by ESHT to allow the early identification of patients with infections and measures taken to reduce the spread of infections to others. It also reports on audit, surveillance, achievements, and challenges faced by the IPC team.		
Regulatory/legal requirement:	The Trust Board is required to review the Infection Prevention and Control annual report to receive assurance about the effectiveness of IPC activities in the organisation.		
Business Plan Link:	Quality ☒ People ☐ Sustainability ☐		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into account.		
Resource Implication/VFM Statement:	No implication.		
Risk:	Key IPC risks are set out within the full annual report.		
No of Pages	4	**Appendixes**	Yes
Name, position and contact details of author:	Vikki Carruth, Chief Nurse and Director of Infection Prevention and Control/ Lisa Redmond, Head of Infection Prevention and Control.		
Report Sponsor	Vikki Carruth, Chief Nurse	**Presenter:**	Vikki Carruth, Chief Nurse
Governance and Engagement pathway to date:	Trust Infection Prevention and Control Group (internal members only) Quality and Safety Committee		
What happens next?	Focus on IPC as fundamental to all care activity; recognising that supporting reconditioning, nutrition and hydration, mouthcare and early discharge strategies all contribute to reducing the most common healthcare associated infections (pneumonia, UTI and CDI) in older patients. Support the antimicrobial strategy to prevent CDI and multidrug resistant organisms: adherence to antimicrobial guidelines and use of Microguide		

	and increased clinician attendance at the antimicrobial steering group. Support for Trust wide ANTT strategy. Reducing the risk of cross infection through support to establish decant areas to facilitate timely high level decontamination of the healthcare equipment and environment.

Publication	This report is appropriate for publication

Introduction

Standard contract limits for healthcare associate infection were exceeded. There were eight MRSA bacteraemia reported which is the highest number reported since 2009/10. Six of the patients were known MRSA carriers. Two cases were considered possibly avoidable and provided opportunities for learning. One was likely to be due to contaminated blood culture rather than true infection (but avoidable for reporting), the other was a patient diagnosed with MRSA from a hip wound in the community where the MRSA status had not been alerted.

The CDI limit was exceeded with 68 infections (41 hospital onset and 27 community onset) against a low limit of 57. The 41 hospital onset infections represent a 41% reduction in hospital onset cases from the previous year. The overall number of CDI has returned to levels reported since 2018 when criteria changed. Nationally ESHT is ranked 67 out of 135 Trusts for rate of CDI infection. The risk of CDI increases with age and antibiotic use. 71% of hospital onset infections occurred in patients over 75years who had received antibiotics. The national rate of CDI is also increasing. One case of cross infection of CDI occurred in a patient, when the deep cleaning that is normally undertaken was not carried out at a time of COVID outbreak and operational challenge. Duty of candour was undertaken.

Excellent clinical engagement with hand hygiene events and over 8,000 audits undertaken in acute and community services, showing high trust wide compliance. COVID continued to circulate with over 1300 cases which caused outbreaks throughout the year. Flu had lower impact and was well managed. The IPC winter escalation plans for patient pathways put in place worked well.

ESHT reported a higher-than-average rate for hip replacement surgery (n=2) under the mandatory surgical site infection surveillance scheme but was not a high outlier (in the highest 10% of all hospitals). The infections were reviewed at the quarterly meeting and are considered to relate to patient derived risk factors.

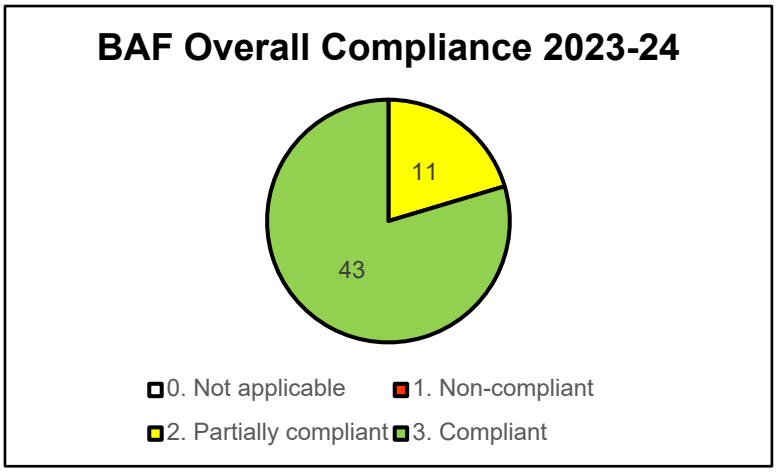
A serious incident investigation was undertaken in response to a rare incident of cross infection of listeria to a baby in the maternity setting. Those involved recovered from the infection.

Respiratory mask fit testing is now part of the IPC service and 89% of required staff are fitted to a mask which supports workforce resilience to safely respond to emerging infectious disease risks.

Background

Healthcare associated infections have increased significantly at a National level since the COVID pandemic. The reason is not fully understood but it is believed that frailty and deconditioning and high demand on services is contributing.

The Infection Prevention and 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.



Progress with the CDI recovery and antimicrobial strategy was hampered by difficulty recruiting to pharmacy and technical difficulties with EPMA resource to support antimicrobial stewardship. Recruitment has since taken place in Pharmacy, and it is hoped we can realise benefits to AMS by Spring 25. Antimicrobial steering group aims to revise EPMA to gain greater impact on antimicrobial stewardship.

There were delays isolating patients with infections because of high bed occupancy and low percentage of single rooms. This has particularly impacted on COVID and CDI transmission.

There is a robust IPC reporting, surveillance and governance processes in place, supported by divisional ADNs at TICPG and IPC representation at divisional Matrons and Governance meetings.

Water safety, decontamination, NSC, ventilation and food safety groups appropriately report into TICPG.

The IPC service is fully established and responsive to infection challenges.

Next steps…

Focus on IPC as fundamental to all care activity; recognising that supporting reconditioning, nutrition and hydration, mouthcare and early discharge strategies all contribute to reducing the most common healthcare associated infections (pneumonia, UTI and CDI) in older patients.

Support the antimicrobial strategy to prevent CDI and multidrug resistant organisms: adherence to antimicrobial guidelines and use of Microguide and increased clinician attendance at the antimicrobial steering group. Support for Trust wide ANTT strategy.

Reducing the risk of cross infection through support to establish decant areas to facilitate timely high level decontamination of the healthcare equipment and environment.

East Sussex Healthcare NHS Trust

Infection Prevention & Control

Annual Report

2023 - 2024

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1. Executive Summary

This report outlines the infection prevention and control (IPC) activities of East Sussex Healthcare NHS Trust (ESHT) for the financial year 2023/24. 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 2023/24:
A year of high numbers of healthcare associated infection rates in the context of increasing incidence nationally during a period of high occupancy and operational demand for services. The annual epidemiology for HCAI in England shows that since the onset of the pandemic reportable HCAIs have increased considerably.

Eight MRSA bacteraemia were reported which is highest number reported since 2009/10. Six of the patients were previously MRSA carriers. Two cases were considered possibly avoidable and provided opportunities for learning. One was likely to be due to contamination as blood cultures had been taken via a newly inserted cannula by a member of staff who had not received ESHT training for blood cultures so therefore not per policy. The remaining case was complex as the patient was diagnosed with MRSA from a hip wound in the community having had hip replacement due to pathological fractures. The MRSA status had not been alerted on the patient record which may have delayed change of antimicrobial treatment although the patient was chronically colonised with MRSA.

The *Clostridioides difficile* infection (CDI limit was exceeded with 69 infections (41 hospital onset and 27 community onset) against a low limit of 57. The 41 hospital onset infections represents a 41% reduction in hospital onset cases from the previous year. The overall number of CDI has returned to levels reported since 2018 when criteria changed. Nationally ESHT is ranked 67 out of 135 Trusts for rate of infection. The risk of CDI increases with age and antibiotic use. 71% of hospital onset infections occurred in patients over 75years who had received antibiotics. The national rate of CDI is also increasing. One case of cross infection of CDI occurred in a patient, when the deep cleaning that is normally undertaken was not carried out at a time of COVID outbreak and operational challenge. Duty of candour was undertaken. A CDI and antimicrobial strategy has been presented to TIPCG. Progress is hampered by difficulty recruiting to pharmacy resource to support antimicrobial stewardship. There continues to be delays isolating patients with diarrhoea because of high bed occupancy and unavailability of single rooms.

Excellent clinical engagement with hand hygiene events and over 8,000 audits undertaken show 98% trustwide compliance.

COVID continued to circulate with over 1300 cases diagnosed, which caused outbreaks throughout the year. Flu had lower impact. The winter plans for patient pathways put in place worked well.

Two infections following hip replacement surgery were reported under the mandatory surgical site infection surveillance scheme (SSISS). They occurred in 2022 (the scheme reporting period covers 12months post-surgery), the infections were reviewed at the multidisciplinary trust SSISS meeting and considered to relate to patient derived risk factors. The infections were not common to a particular surgeon or theatre and not shown to be related to an outbreak.

Respiratory mask fit testing is now part of the IPC service and 89% of required staff are fitted to a mask. The IPC service is fully established and responsive to infection challenges.

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.

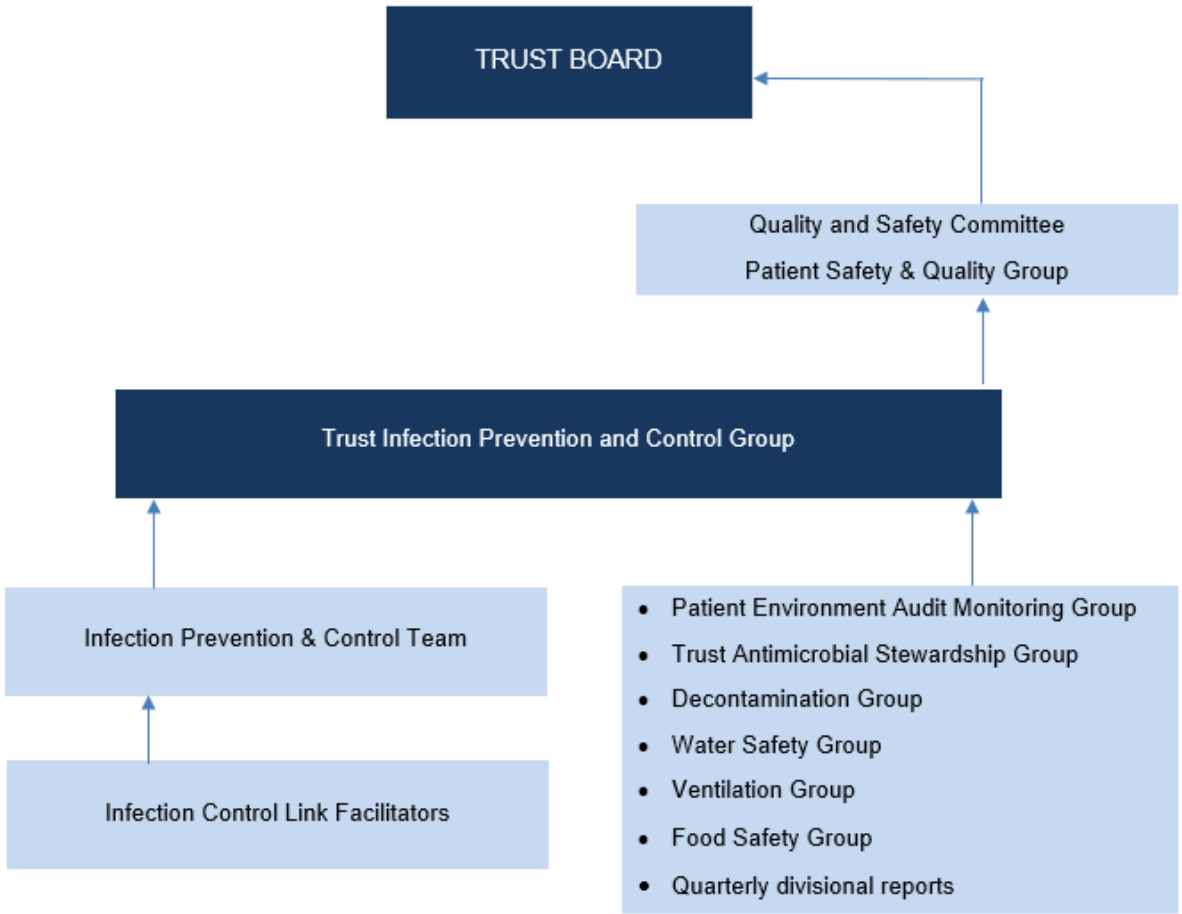
2.1 Infection Prevention & Control Team Structure

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). There is also a dedicated Surgical Site Infection Surveillance Nurse to undertake mandatory surveillance of orthopaedic surgery.

In addition to the IPCT, the Trust also funds four (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.

During 2023/24 the mask fit testing team became a substantive service and forms part of the IPC service management.

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). IPC contributes to the Clinical Advisory Group which was established to support the COVID pandemic response and has been agreed as a 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

A weekly status report of mandatory reportable infections at ESHT is shared with IPC colleagues at NHS Sussex and ESCC. The DIPC and Head of IPC discuss any significant IPC issues with the ICB UKHSA, and ESCC as required. ESHT reports outbreaks and seasonal flu data via data capture systems as required. Significant outbreaks and incidents are escalated to NHS Sussex Head of Quality and Nursing and the Southeast Lead for NHS England as required. 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 that is classroom based and via MS Teams has been established for 2023/24.

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.

Mandatory surveillance of community acquired *Clostridioides difficile* infections and Gram-negative bacteraemias and *Staphylococcus aureus* has continued to be undertaken by the ESHT IPC team on behalf of the local ICB.

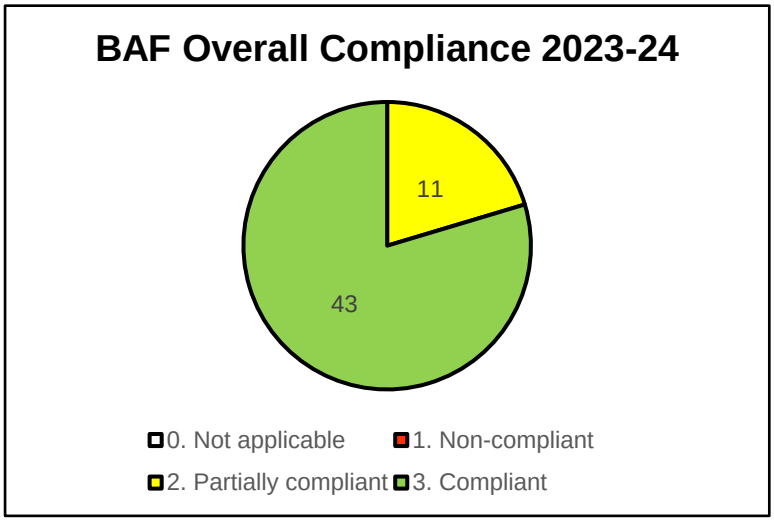
3. Compliance with Outcome 8 Regulation 12 “Cleanliness and Infection Control” Health & Social Care Act 2008 and the new NHS IPC Board Assurance Framework.

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 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.

Overall, in March 2024 there was evidence of compliance with 43 of the 54 key lines of enquiry.



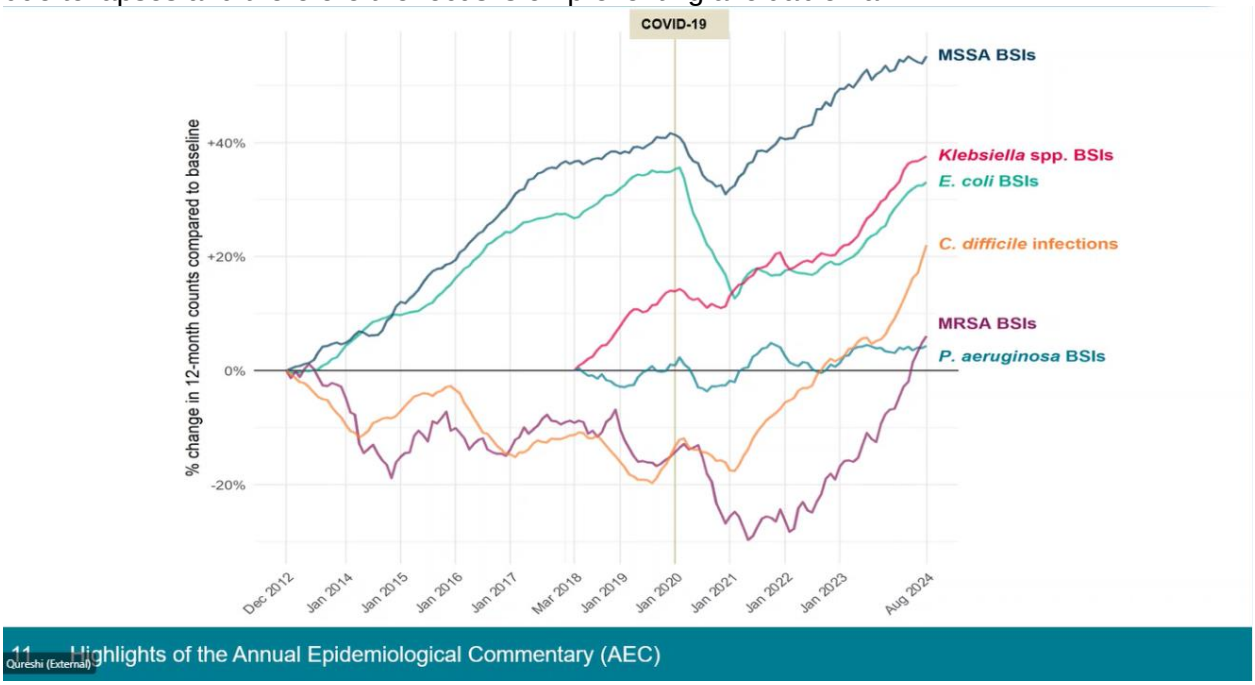
BAF - Key Lines of Enquiry Criteria
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them Compliance 6/8. Auditing is limited to hand hygiene and personal protective equipment on InPhase as we need to build each IPC audit onto this system. Mandatory training compliance was below 85% in Urgent Care and Medicine divisions. Less than 70% of junior doctors have completed IPC mandatory training which has been escalated to medical education to see what support can be given to address this.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections Compliance 8/9 High level of assurance regarding cleanliness, self-assessed partial compliance with staff training on food safety which is being addressed.
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance Compliance 2/6 This is currently the most challenging criteria for ESHT, assessed as such due to difficulty recruiting suitable pharmacy resource to support improvements in antimicrobial use/stewardship.
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion Compliance 4/5 Partial compliance was given to this criteria due to out of date patient information leaflets (a consequence of increased work of COVID), there was improvement during the year but more work needed.

5. Ensure early identification of individuals 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 others Compliance 4/5 We assessed one criteria as partially compliant due to seeking assurance around signage for directing people with respiratory infections on arrival which has been requested of comms team.
6. Systems are in place 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 Compliance 5/6 Mandatory training and respiratory protection compliance is above 85%. We have assessed ourselves as partially compliant on establishing if staff are competent in IPC as we don't currently have a resource to audit this sufficiently. Hand hygiene competence has been introduced since 1st of June 2023 which is a positive step to achieving this.
7. Provide or secure adequate isolation precautions and facilities Compliance 4/4 – Fully compliant. BAF criteria for isolation changed in 2023 with a greater emphasis on risk assessment and prioritisation of patients for isolation rather than ability to isolate all those with transmissible infection. To this end, ESHT is compliant as the IPC and clinical site management teams work closely to prioritise patients for single rooms although this remains challenging.
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate Compliance 7/7 - Fully Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections Compliance 0/1 Several IPC policies are overdue for review. Solutions are being sought to support audit of compliance.
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection Compliant 3/3 - Fully compliant

4. Mandatory Surveillance

The Department of Health (DH) requires NHS Trusts to take part in a national mandatory and voluntary surveillance programme. The mandatory HCAI Data Capture System is a web-based data collection system managed by UKHSA for specific infections (*Escherichia coli*, *Klebsiella* spp., *Pseudomonas aeruginosa*, *Staphylococcus aureus* (MRSA and MSSA) and *Clostridioides difficile*).

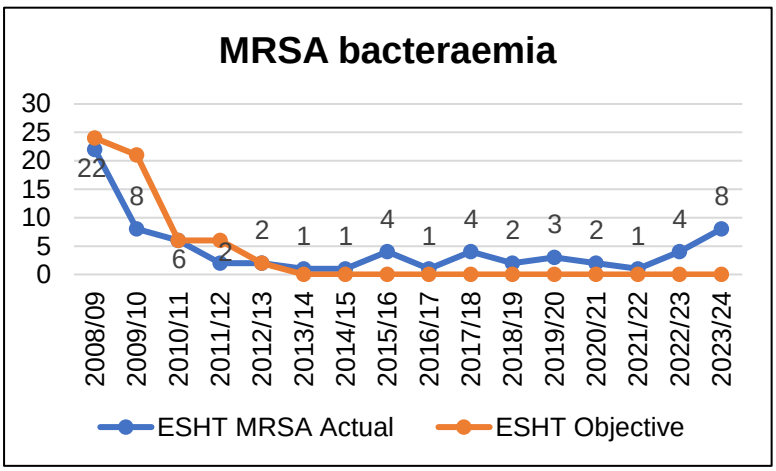
Each Trust is set an annual objective. Not all cases of CDI or bacteraemias are avoidable or due to lapses and therefore the focus is on preventing avoidable harm.



The annual epidemiology shows that since the onset of the pandemic reportable HCAIs have increased with most significant increase in MRSA bactereamia from the previously very low baseline. The reasons for this national increase is not yet fully understood but is thought to be a consequence of the pandemic.

4.1 MRSA bacteraemia

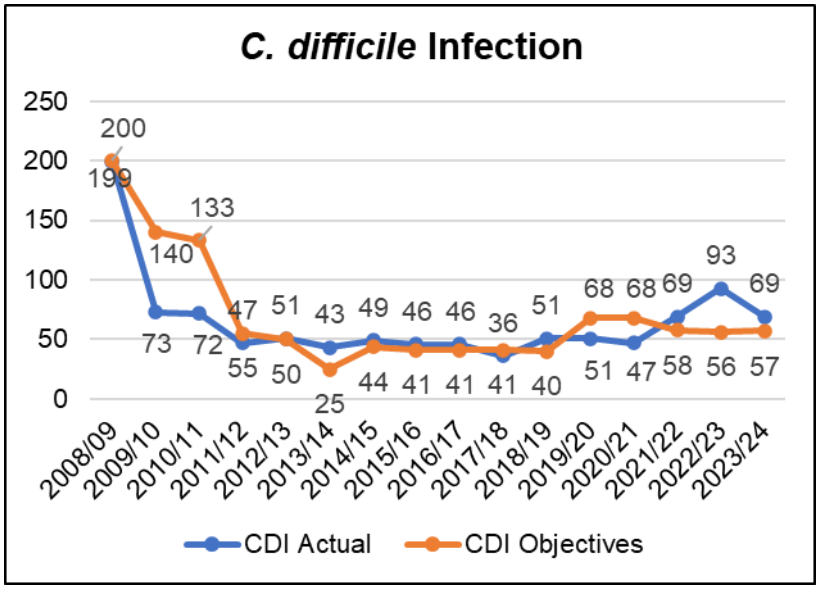
ESHT continues to have a zero tolerance to cases of MRSA bacteraemia which could potentially be avoidable. ESHT reported 8 cases of healthcare associated MRSA bacteraemia in 2023/24 compared to 4 cases in 2022/23.



Multi-disciplinary post infection review of each case identified the following: Six of the patients had a prior history of MRSA carriage. Four cases were assessed as unavoidable. For two cases the source of infection could not be ascertained and therefore considered probably unavoidable. Two cases were considered possibly avoidable and providing opportunities for learning. One was likely to be due to contamination as blood cultures had been taken via a newly inserted cannula by a member of staff who had not received ESHT training for blood cultures so therefore not per policy. The remaining case was complex as the patient was diagnosed with MRSA from a hip wound in the community having had hip replacement due to pathological fractures. The MRSA status had not been alerted on the patient record which may have delayed change of antimicrobial treatment although the patient was chronically colonised with MRSA.

4.2 *C. difficile* infection (CDI)

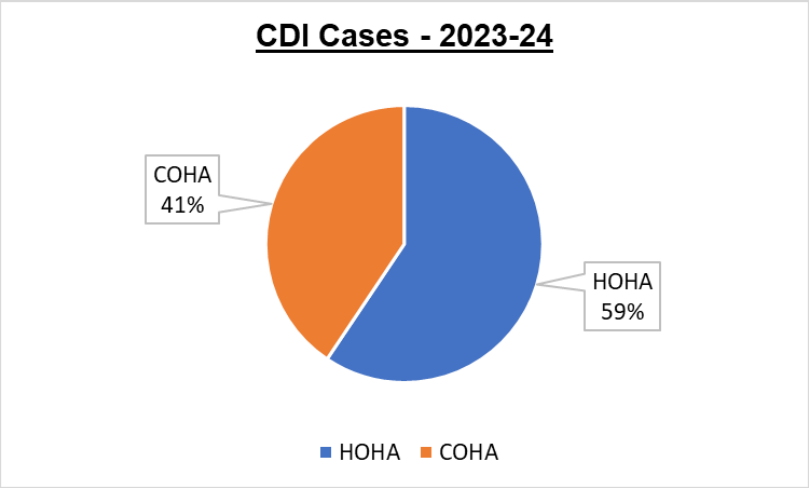
The annual limit set for 2023/24 was 57 cases for ESHT to take account of prior healthcare exposure within 28 days.



In total 69 cases were attributed to ESHT for 2022/23. 28 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 table below.

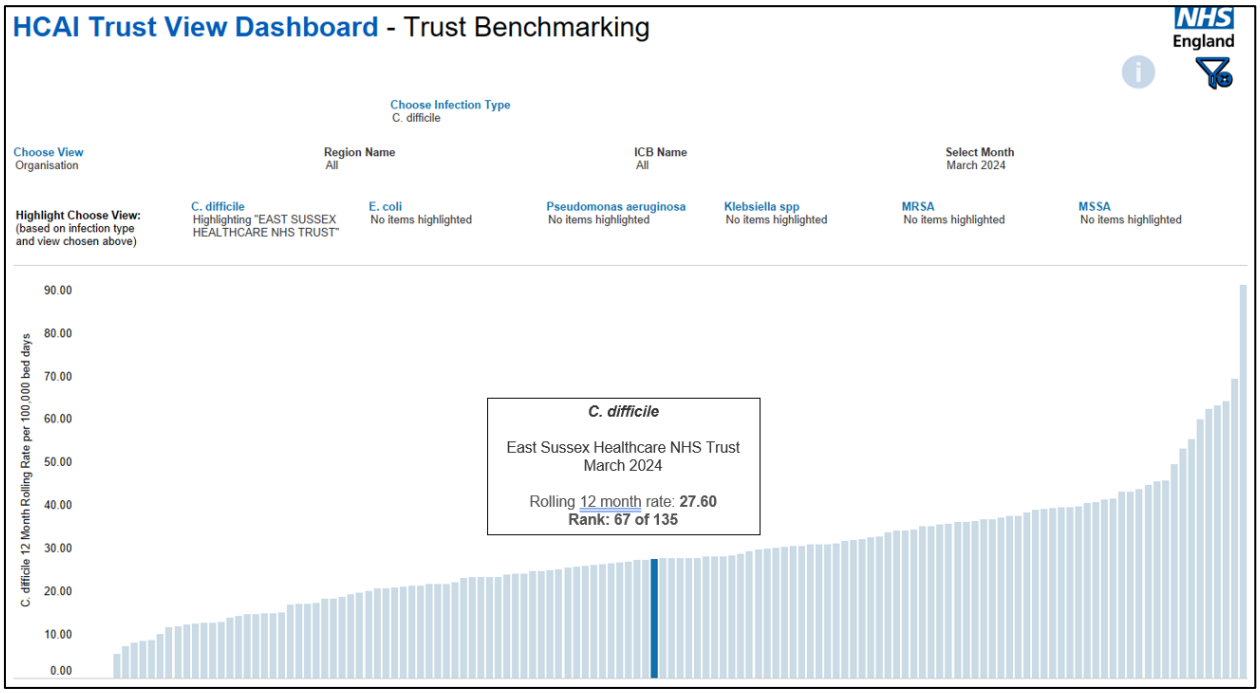
C. difficile toxin Infection 2023/24					
Month		ESHT		ICB	Combined
	Limit	HOHA	COHA	Actual	Total
April	5	5	1	0	6
May	5	5	3	2	10
June	5	3	3	4	10
Q1	**15**	**13**	**7**	**6**	**26**
July	4	3	2	9	14
August	5	5	4	5	14
September	5	3	1	1	5
Q2	**14**	**11**	**7**	**15**	**33**
October	4	4	5	4	13
November	5	3	3	6	12
December	5	2	3	5	10
Q3	**14**	**9**	**11**	**15**	**35**
January	4	3	2	5	10
February	5	4	0	4	8
March	5	1	1	1	3
Q4	**14**	**8**	**3**	**10**	**21**
TOTAL for 23/24	**57**	**41**	**28**	**46**	**115**

The 2023/24 incidence of CDI returned to levels reported since the criteria for reporting changed in 2018: with the addition of community onset cases with prior healthcare being attributed to acute Trusts. 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.

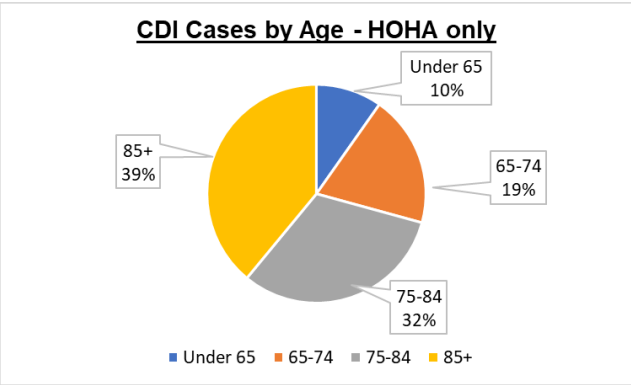


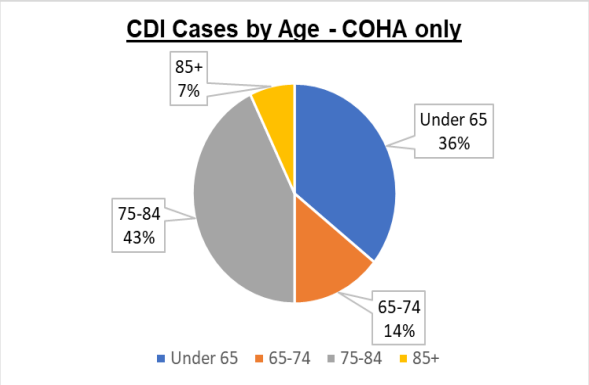
There is no significant difference in the number of infections diagnosed on each acute site, Conquest 33 and EDGH 36 with equal distribution of hospital onset infections. Cases have occurred on a broad range of wards, higher numbers associated with MacDonald ward (5), Frailty (4) and Benson trauma orthopaedic ward (4) which care for frailty patients.

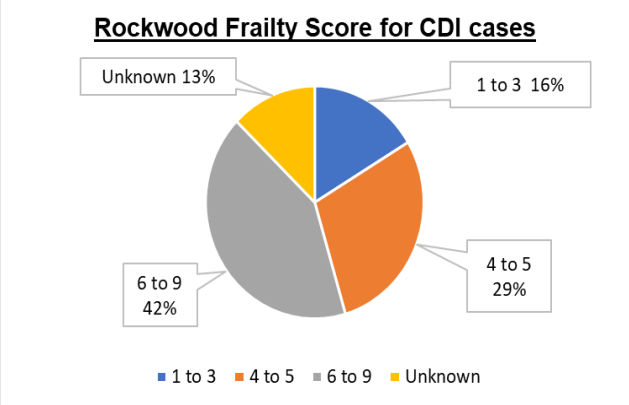
18% of community onset infections had not had an overnight stay for treatment but still met the criteria for attributing to ESHT because they were coded as admissions.



For 2023/24 the trust was ranked 67 of 135 for *C. difficile* in England and regionally in the SE at 12 of 18. It is likely that our integrated Trust function contributes to the number of COHA infections that we report as patients acute and community care are attributed to ESHT and as Trusts do not code patients in the same way it can be difficult to directly compare Trusts in relation to COHA infections. The risk of CDI increases exponentially with age which also means we are more likely to have cases than organisations treating a younger population.







71% of hospital onset infection and 51% of community onset infection, occurred in patients over the age of 75. In addition to advancing age, 42% of patients were very frail. Further work is being undertaken with the antimicrobial steering group to adjust prescribing policies for older patients to try to reduce their CDI risk.

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).

HOHA PIRs	2023/24
No Lapse in Care	24 (59%)
Lapse in Care likely to have contributed to outcome	3 (7%)
Lapse in Care unlikely to have contributed to outcome	14 (34%)
TOTAL cases	**41**

41 infections occurred in 41 patients. 24 patients were assessed as having CDI despite adherence to the *C. difficile* and antimicrobial prescribing policies. Themes from the 14 non-contributory lapses are delays in isolation, delays in sending stool samples and/or incomplete documentation, which were unlikely to have negatively impacted on the patient and contributed to their CDI.

To gain further insight into community onset infection, PIR was undertaken on COHA cases between October 2023 and March 2024 – a total of 14 cases were reviewed, assistance from ICB was sought to gather primary care data. However, it proved very difficult to gain worthwhile information about any care the patient had received outside ESHT due to absence of data sharing agreements.

Lapses in Care

The year ended with 3 cases thought to have been lapses in care. Significant discussion with IPC and ICD as unclear if this case could have been prevented in view of long standing history

of CDI, but it is considered that treatment escalation should have occurred earlier and this was felt to warrant a lapse in care.

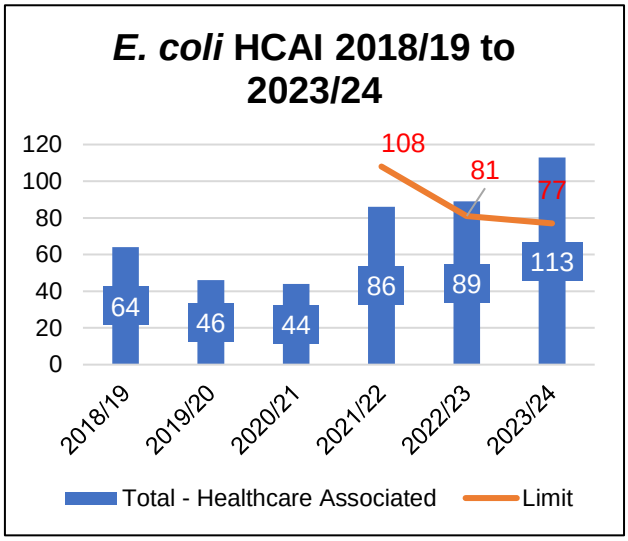
Outbreaks and Periods of Increased Incidence (PIIs)
The IPC team record the location of CDI cases and if two positive results are received from the same ward this is treated as a period of increased incidence and as per guidance, additional actions are taken such as additional training and audit on that 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 2023-24 that is due to probable cross infection. This occurred on Frailty ward when the index case was wandering and the bay was not deep cleaned or treated with HPV as there was extreme operational pressures and the ward was closed due to COVID at the time. 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 (GNB) is mandatory for all provider Trusts.

4.3.1 *E. Coli*

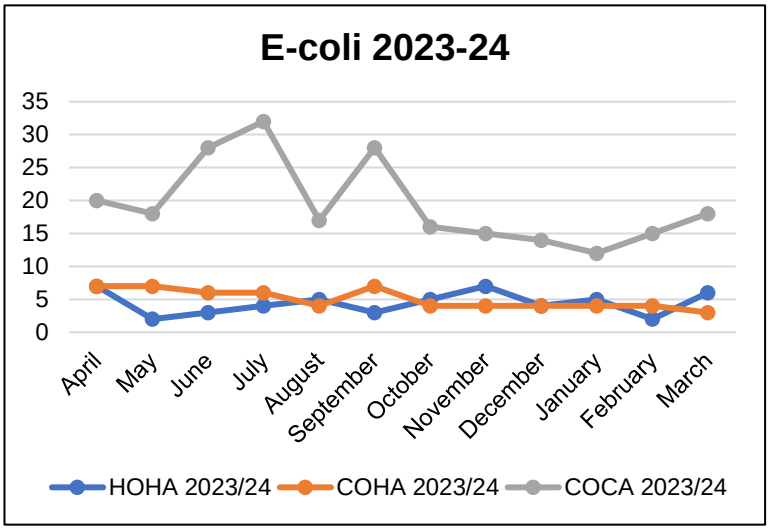
E. coli 2023/24 – limit 77				
Month	**ESHT**		**ICB**	**Combined**
	HOHA	**COHA**	**Actual**	**Total**
April	7	7	20	34
May	2	7	18	27
June	3	6	28	37
Q1	**12**	**20**	**66**	**98**
July	4	6	32	42
August	5	4	17	26
September	3	7	28	38
Q2	**12**	**17**	**77**	**106**
October	5	4	16	25
November	7	4	15	26
December	4	4	14	22
Q3	**16**	**12**	**45**	**73**
January	5	4	12	21
February	2	4	15	21
March	6	3	18	27
Q4	**13**	**11**	**45**	**69**
TOTAL for 23/24	**53**	**60**	**233**	**346**

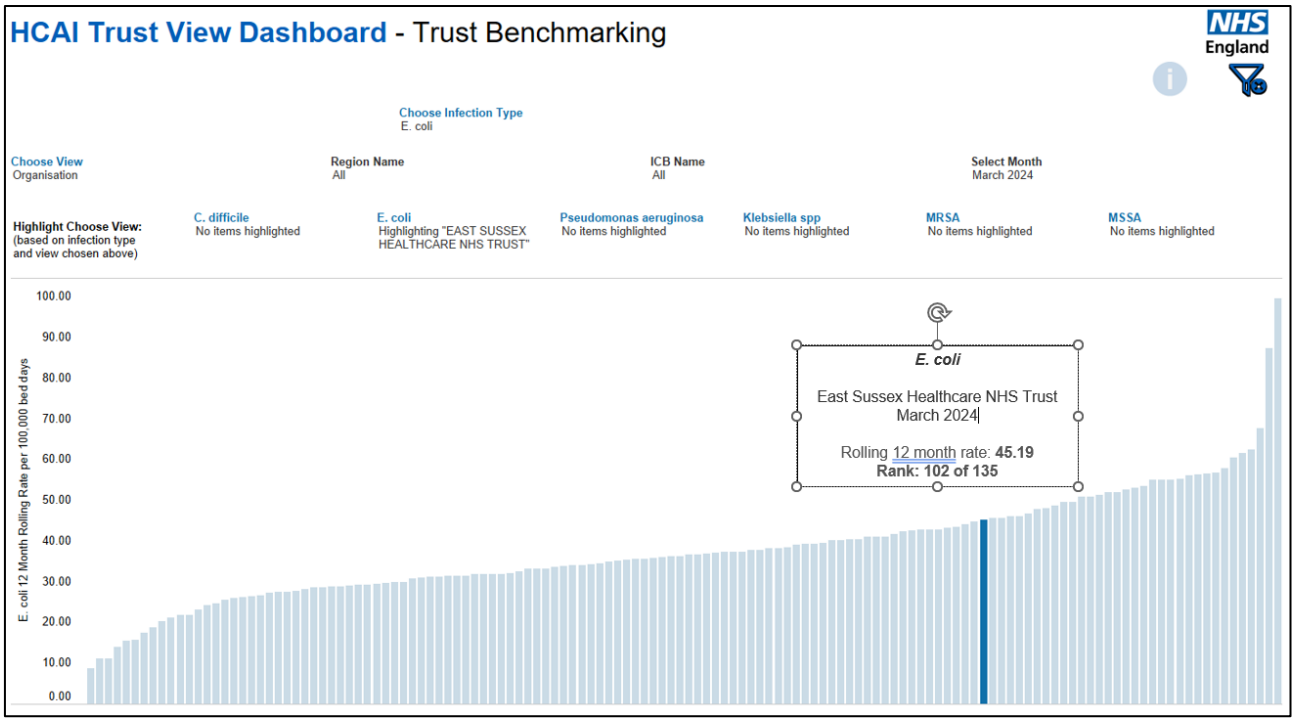


We have reported 113 cases of E.coli bacteraemia, against a limit of 77. There were 53 cases of Hospital Onset Healthcare Associated (HOHA) *E. coli* bacteraemia, of which three were considered possibly avoidable - 2 PICC line associated related to a bariatric patient and a patient with significant skin condition that may have increased the risk of line infection) and 1 CAUTI considered possibly avoidable if antibiotic cover had been given for catheter change which was traumatic. Other common causes were UTI (15), hepatobiliary (9) and 7 respiratory with 11 cases source unknown.

A further 60 cases were 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.





For 2023/24 we were ranked 102 of 135 for *E. coli* in England and regionally in the SE at 11 of 18.

4.3.2 *Klebsiella sp.*

ESHT reported 49 cases of *Klebsiella* bloodstream infection against a limit of 35.

Klebsiella sp. 2023/24 – limit 35				
Month	ESHT		ICB	Combined
	HOHA	COHA	Actual	Total
April	2	3	5	10
May	1	2	5	8
June	1	0	2	3
Q1	**4**	**5**	**12**	**21**
July	3	3	5	11
August	2	1	4	7
September	3	4	7	14
Q2	**8**	**8**	**16**	**32**
October	1	3	8	12
November	2	4	6	12
December	3	1	5	9
Q3	**6**	**8**	**19**	**33**
January	1	3	2	6
February	2	1	3	6
March	2	1	6	9
Q4	**5**	**5**	**11**	**21**
TOTAL for 23/24	**23**	**26**	**58**	**107**

Most common source was urinary tract infection (37) of which 15 were related to urinary catheters of which 8 were long term catheters. 19 patients had hepatobiliary source not related to healthcare.

4.3.3 *Pseudomonas*

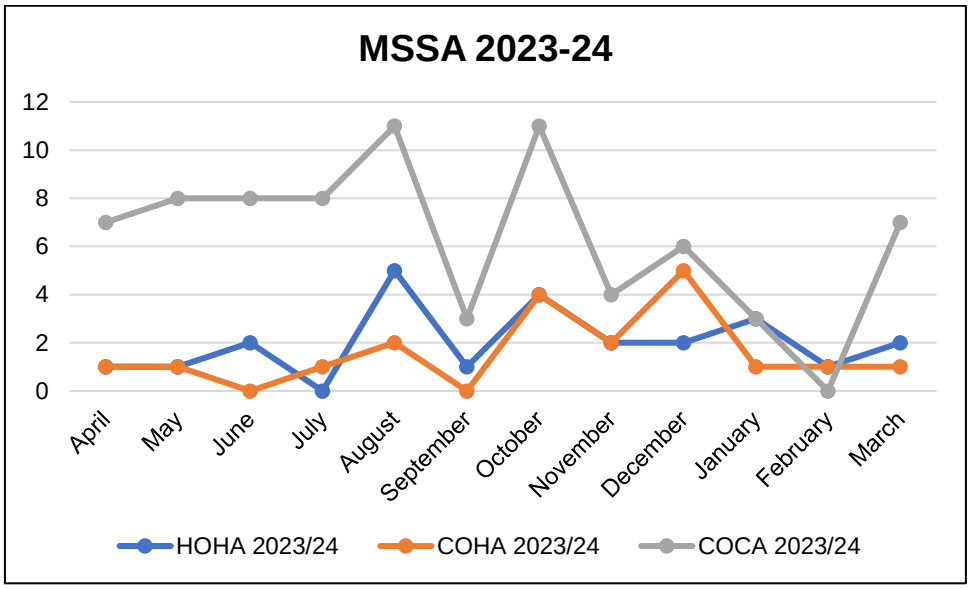
ESHT reported 19 cases of *Pseudomonas* bloodstream infection against a limit of 12.

Pseudomonas 2023/24 – limit 12				
Month	ESHT		ICB	Combined
	HOHA	COHA	Actual	Total
April	0	0	1	1
May	2	2	2	6
June	0	1	1	2
Q1	**2**	**3**	**4**	**9**
July	0	1	1	2
August	2	1	1	4
September	1	0	0	1
Q2	**3**	**2**	**2**	**7**
October	0	0	2	2
November	3	1	1	5
December	0	0	2	2
Q3	**3**	**1**	**5**	**9**
January	3	0	1	4
February	1	1	2	4
March	0	0	0	0
Q4	**4**	**1**	**3**	**8**
TOTAL for 23/24	**12**	**7**	**14**	**33**

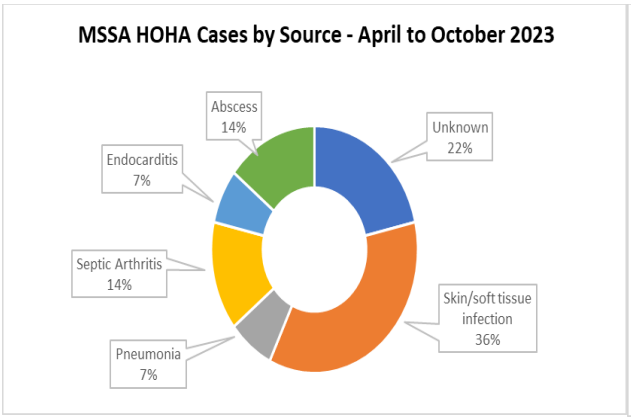
Most common sources of Pseudomonas bacteraemia was respiratory tract infection (10) and urinary tract infection (9). One case was considered potentially avoidable as likely not a true infection but representing contamination of the specimen.

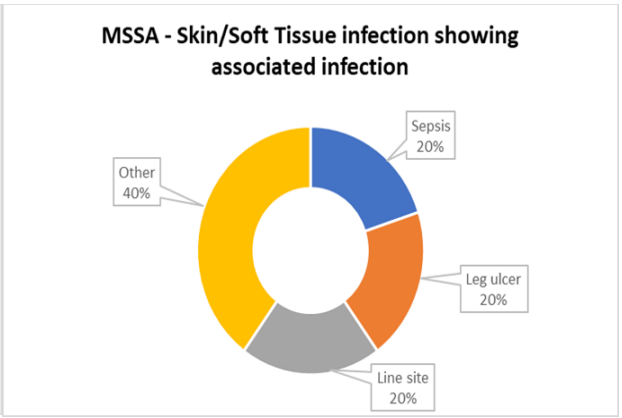
4.4 Mandatory reporting of Methicillin Sensitive *Staphylococcus Aureus* (MSSA)

No limit has been set for MSSA blood stream infections for Trusts. As the bacteria is commonly found on the skin of >20% of the general population.

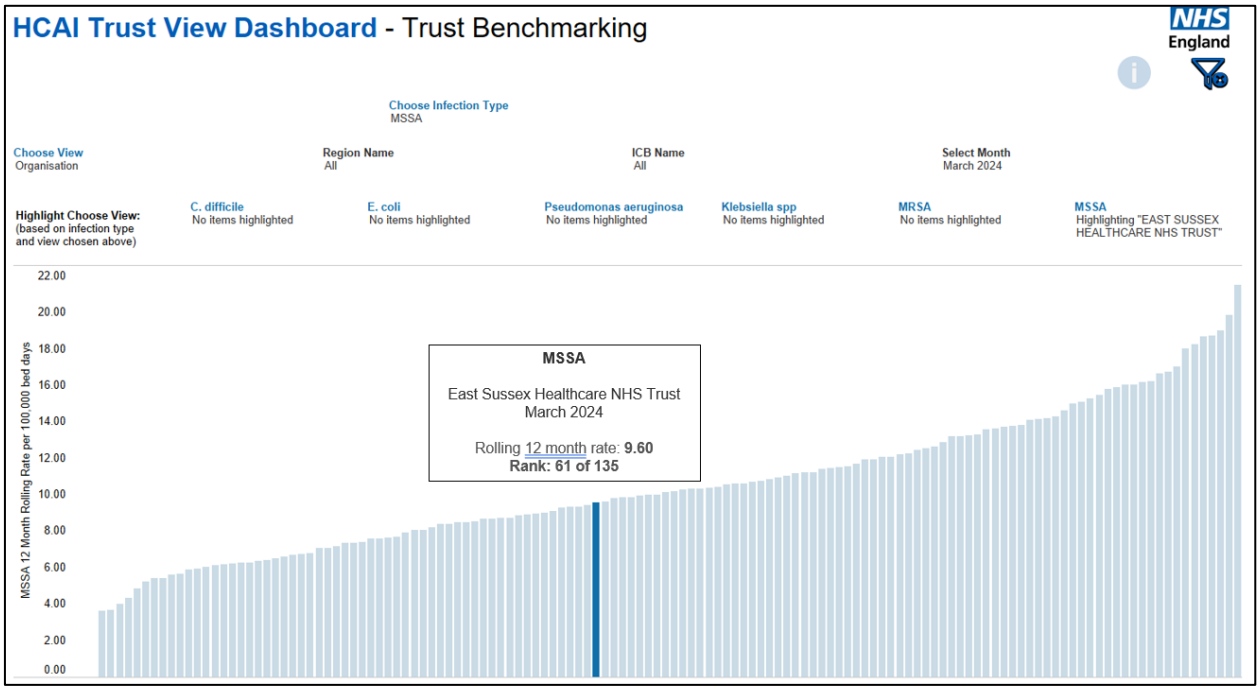


43 MSSA bacteraemia were reported which is higher than usual. Significant increase was noted by October at which point a deep dive into possible causes was undertaken.





Skin and soft tissue most common source of infection. Three infections were assessed as possibly avoidable, one was a UTI in a patient who had bladder surgery, another related to hip prosthesis and another was a contaminated sample.



The rolling rate for MSSA bacteraemia takes account bed occupancy and we were ranked 61 of 135 for MSSA in England and regionally in the Southeast at 8 of 18 Trusts.

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). The patients are actively monitored during their hospital stay and post discharge through patient questionnaires, outpatient appointments and readmission information for a period of 365 days.

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 has met the reporting requirement having completed surveillance for two of the four categories and completed three periods of surveillance.

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 2023. The results from both hospitals are combined to give a final figure to compare against national benchmark. However quarterly reports are generated for each site.

Since SSIs reported by patients cannot be verified in the same way as those detected by active surveillance in hospital, rates based on patient reported SSI will be calculated separately to those based on SSI detected in inpatients. Two rates of SSI will be reported:

1. Cumulative incidence of SSIs detected during the inpatient stay and in patients readmitted with SSI.
2. Cumulative incidence of SSI based on all SSIs detected by inpatient and post-discharge surveillance including those reported by the patient at 30 days post-operation.

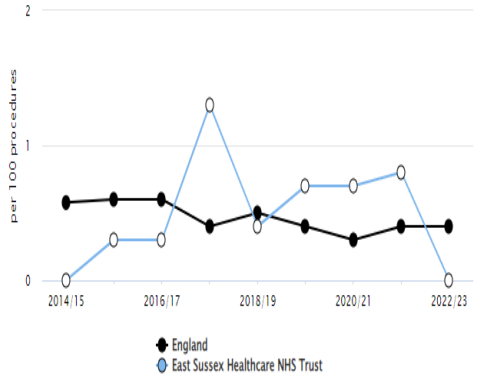
When comparing SSI incidence based on patient reported SSI or other post-discharge methods, it is important to consider the proportion of patients who have been followed up post discharge as this will affect the number of SSI reported. The return of patient questionnaires has been low over this period. however the reported data for patient reported includes any patient reported or post discharge infections and there has been 90% attendance at outpatient review. The post discharge questionnaire is now also available on patient knows best and there is the facility to send reminders to patients which should increase the return rates. Although post-discharge data can be collected using various follow-up methods, the main outcome measure for national surveillance purposes will be the SSI rate based on inpatient and readmission SSI.

Table one - Surgical Site Infection Knees for ESHT 2014/15-2022/

Surgical Site Infection Knee Prosthesis by acute NHS trust and financial year

Crude rate - per 100 procedures

Show confidence intervals Show 99.8% CI values More options



Recent trend: No significant change

Period		East Sussex Healthcare NHS Trust Count	Value	95% Lower CI	95% Upper CI	England
2014/15		0	0.0	0.0	0.9	0.6
2015/16		1	0.3	0.0	1.6	0.6
2016/17		1	0.3	0.0	1.6	0.6
2017/18		6	1.3	0.5	2.7	0.4
2018/19		2	0.4	0.0	1.4	0.5
2019/20		3	0.7	0.1	1.9	0.4
2020/21		1	0.7	0.0	4.0	0.3
2021/22		2	0.8	0.1	2.9	0.4
2022/23		0	0.0	0.0	1.9	0.4

Source: PHE Surgical Site Infection Surveillance Service (SSISS)

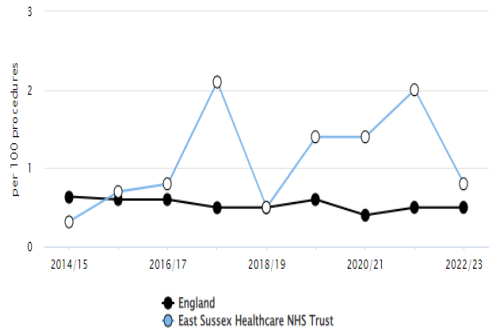
Indicator Definitions and Supporting Information

Table two - Surgical Site infection Hips for ESHT 2014/15-2022/23

Surgical Site Infection Hip Prosthesis by acute NHS trust and financial year

Crude rate - per 100 procedures

Show confidence intervals Show 99.8% CI values More options



Recent trend: No significant change

Period		East Sussex Healthcare NHS Trust Count	Value	95% Lower CI	95% Upper CI	England
2014/15		1	0.3	0.0	1.8	0.6
2015/16		2	0.7	0.1	2.3	0.6
2016/17		2	0.8	0.1	2.8	0.6
2017/18		9	2.1	1.0	4.0	0.5
2018/19		2	0.5	0.1	1.8	0.5
2019/20		5	1.4	0.5	3.2	0.6
2020/21		2	1.4	0.2	4.9	0.4
2021/22		6	2.0	0.8	4.4	0.5
2022/23		2	0.8	0.1	2.8	0.5

Source: PHE Surgical Site Infection Surveillance Service (SSISS)

Core Data 1st April 2022 – 31st March 2023

Category of surgery	Number of procedures	Number of infections	Infection rate	Mean infection rate for all participating Trusts (data April 2022 -March 2023)
Total knee replacement	195	0	0	0.4
Total hip replacement	259	2	0.8	0.5

Microorganisms isolated include Enterococcus faecalis, Staphylococcus epidermidis and S. aureus, methicillin - sensitive (MSSA). There is no evidence to suggest cross infection.

ESHT reported two infections related to hip replacement surgery during quarter 2 of 2022 which resulted in a higher than average rate for hip replacements but not a high outlier (in the highest 10% of all hospitals). The infections were reviewed at the quarterly meeting and were considered to relate to patient derived risk factors and deconditioning as surgical provision was re-established from the pandemic.

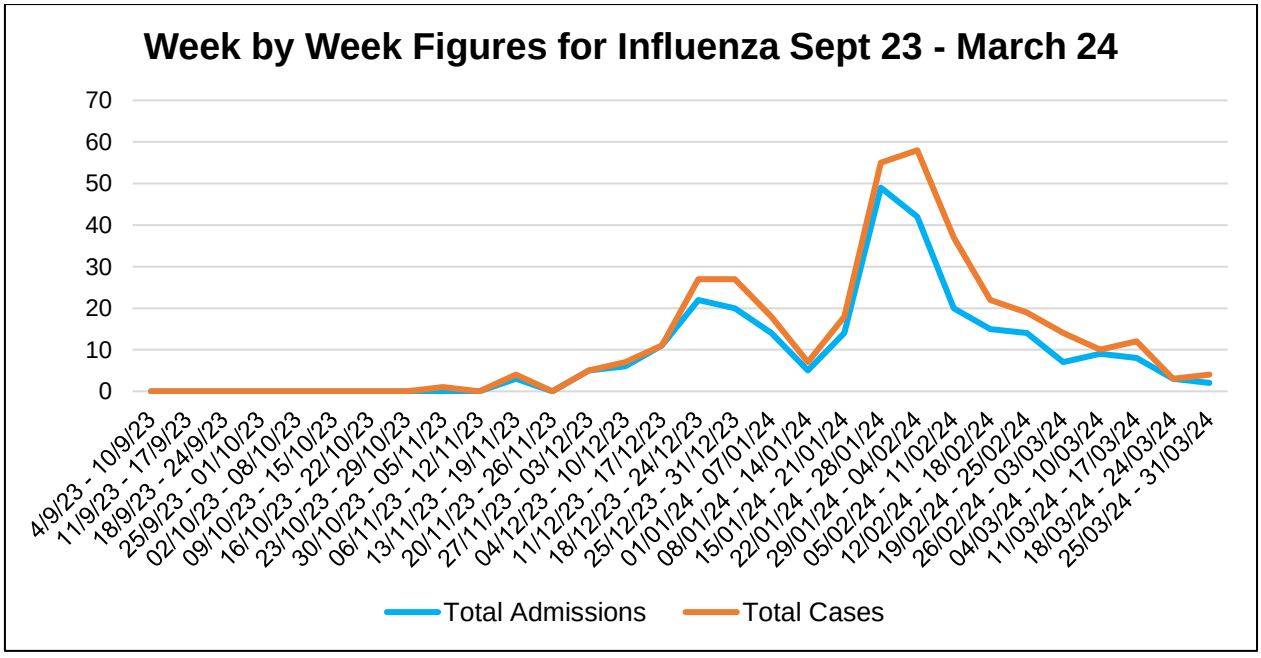
During the last year the following quality improvements have been identified:

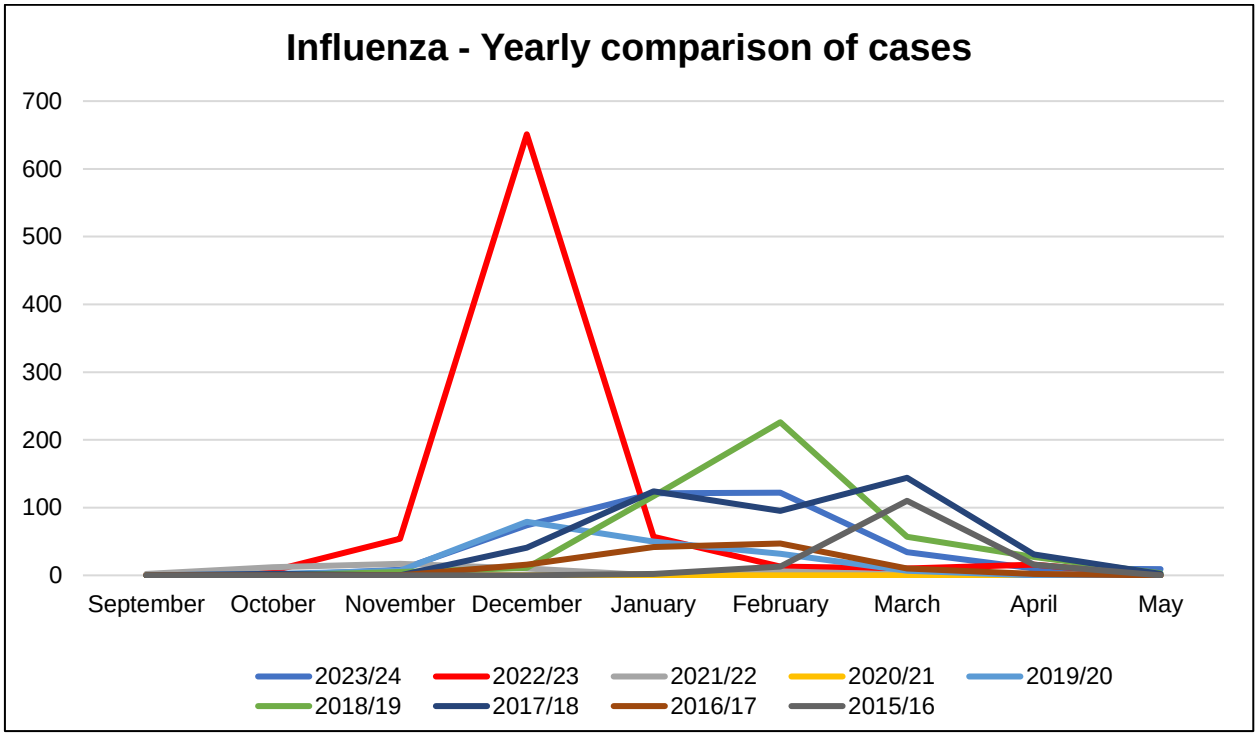
- Changes to the patient information leaflet to include information advising patients not to shave near the operation site prior to surgery, and to bring slippers and dressing gown to keep warm prior to surgery. This leaflet is awaiting ratification
- A new wound information leaflet is in the process of being designed which will be given to patients on discharge.
- Additional fluid cabinets have been purchased and irrigation fluids will be warmed

These improvements were identified from the One together audit and are in line with 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 and additionally the number of cases admitted to intensive care to determine the national “burden” on critical care units.





There was a lengthy flu season during the year commencing in November with patients diagnosed until March. Overall, 359 cases of infection were diagnosed of which 271 were admitted to hospital. 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. The impact of flu was moderate, only twenty five infections were assessed as hospital onset, with outbreaks mainly confined to bays that were well managed inline with the winter IPC plan.

Vaccination of ESHT frontline clinical staff for flu was managed by Occupational Health.

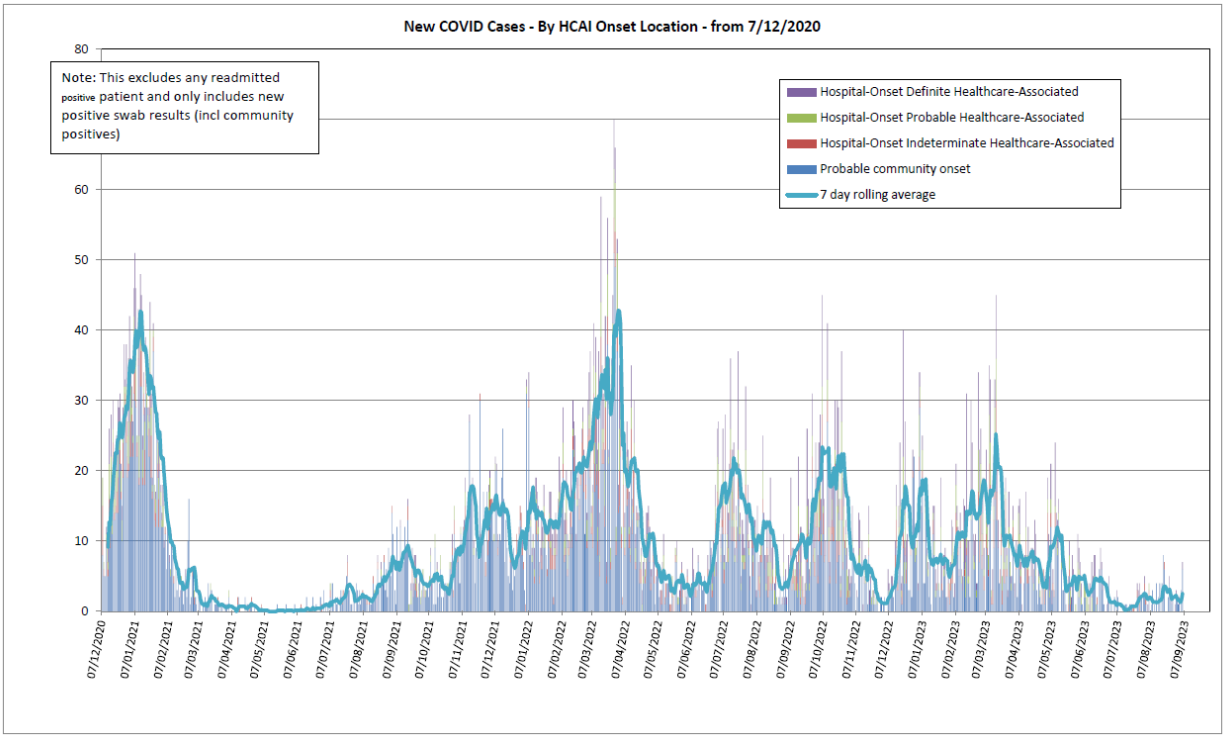
4.7 Norovirus

Impact of Norovirus was low. Two wards were affected by outbreak in February 2024. Glynde ward had 17 patients and 5 staff affected with 9 lost bed days and Littlington ward had 13 patients and 1 staff affected with 4 lost bed days. Outbreaks were of low consequence and managed as per trust policy.

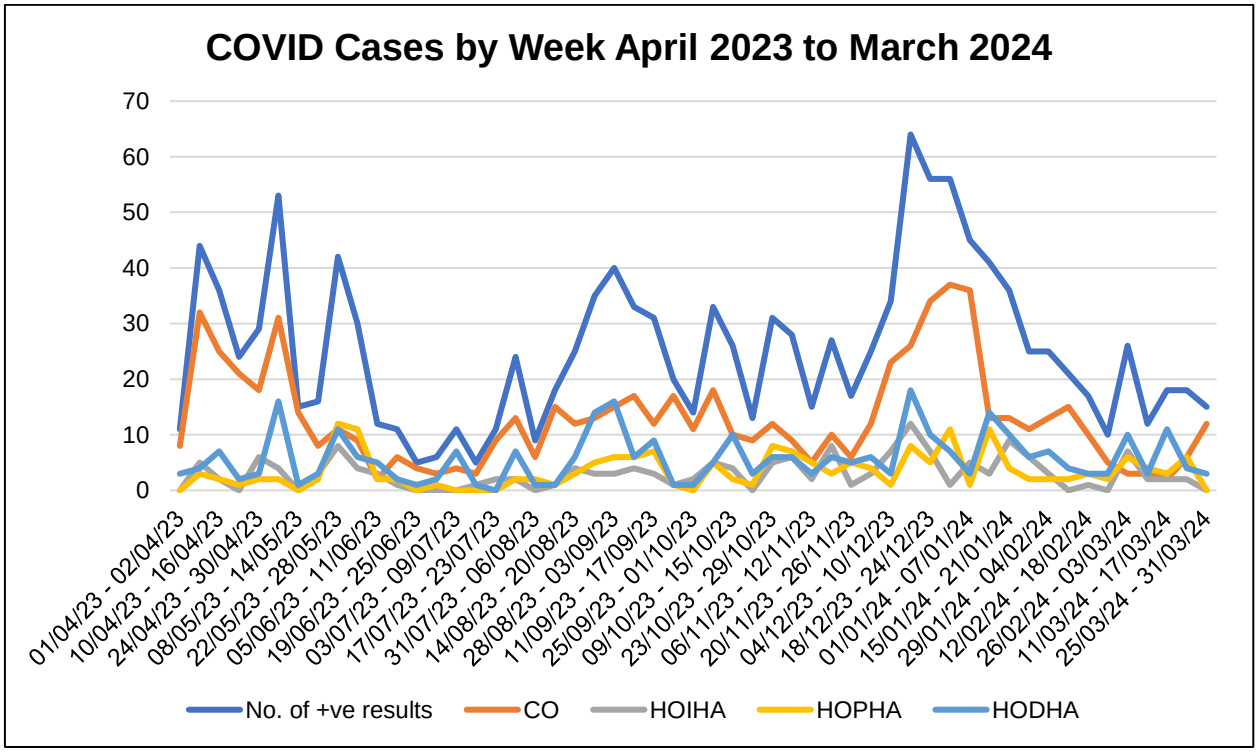
5. Emerging Threats and Operational Preparedness

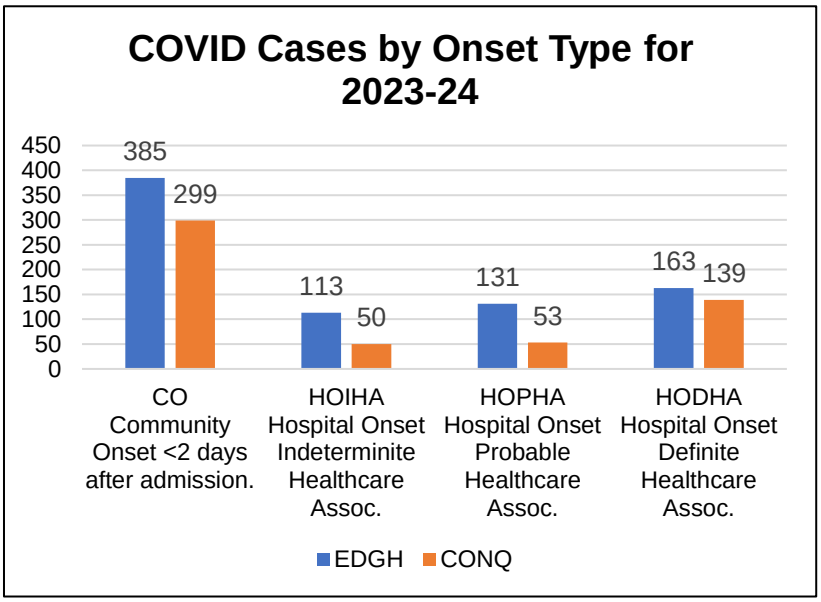
5.1 SARS-CoV-2, COVID-19

The chart below shows the prevalence of COVID since December 2020. Please note this chart stopped being produced from September 2023. Since this date the IPC team have compiled the data and during 2023/24 over 1,300 patients were diagnosed.



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





There were periods of high transmission within bays and 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

Anyone wearing an FFP3 mask is legally required by the H&S executive, to be fit tested by an accredited mask fitter. It remains mandatory for all patient facing staff at ESHT to be fitted to a minimum of two FFP3 masks so that there is low reliance on a specific product. Staff need to be retested as part of the requirement and to be retested within two years.

This year the fit testing team has been made a substantive service and recruitment has been undertaken to appoint a team leader and three other members of staff to deliver the trustwide service. Fit testers have undertaken training and are accredited.

Of the 4288 eligible for fit testing. 89% of these staff have either passed at least one mask fit test and/or have a personal air purifying powered respirator (PAPR). Data is presented quarterly for assurance to TICPG.

MASK APPOINTMENTS (CROSS SITE)	2023/24
Appointments booked over the year	**4497**
Staff who did not attend (DNAs) or cancelled	**1565**
Masks have been successfully fitted to current staff	**5177**
Unsuccessful mask fits to current staff	**5332**
Staff yet to attend a fit test	**1885**

During the year, appointment activity fell from 12300 to 4497. The rate of non-attendance is high at 35%, which is likely to reflect the clinical activity limiting staff time to attend.

The fit test policy has been updated and now incorporates the SOP for mask fitting. Power hood training has now been added to Mylearn online training platform.

The mask fit team lead is currently creating new flyers/signposting to highlight the importance as to why we still need to wear a FFP3 mask as other infectious threats increase such as measles and TB.

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.

A serious incident investigation was undertaken relating to three people with Listeria infection within women's health at Conquest hospital during May and June of 2023. The three confirmed cases are identical on sequencing, an unusual sequence, not seen elsewhere on the national database. Two of the infections were community onset. The investigation concluded that there was probable transmission of Listeria monocytogenes via direct or indirect contact during a time when the risk of infection was not known. Duty of candour was undertaken and the infection was successfully treated.

7. Promoting Standard Infection Prevention Precautions

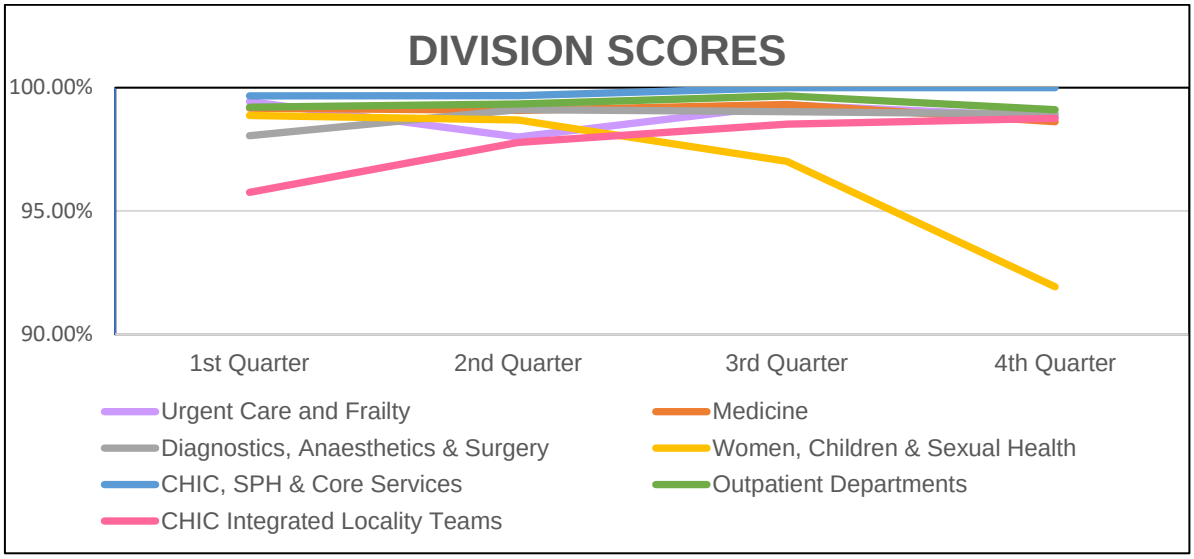
7.1 Hand Hygiene Promotion

The Trust's Infection Prevention and Control Team (IPCT) co-ordinates an annual programme to promote hand hygiene throughout the Trust. This includes staff training and monthly audits for in-patient areas, outpatients, CHIC, and Integrated locality teams. We emphasise the importance of hand hygiene to our staff, visitors, and patients. Our staff participated in World Hand Hygiene Day activities in May 2023, promoting the '5 Moments of Hand Hygiene' and correct hand hygiene technique through posters, slogans, and games.

7.2 Hand Hygiene Compliance

Infection Control Link Facilitators (ICLFs) conduct monthly hand hygiene audits, observing healthcare staff and providing immediate feedback. Audit results are analysed, reported to relevant groups, and actions are taken in cases of non-compliance. Observations are documented on InPhase, or on a printed hand hygiene audit tool if InPhase is unavailable, with data inputted by the end of the month.

OVERALL HAND HYGIENE SCORES PER QUARTER: 2023 - 2024			
1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
98.59%	98.81%	98.98%	98.02%
98.59%	98.81%	98.98%	98.02%



A total of 8448 audits were submitted for the period of 2023 – 2024. Each department in In-patient areas are required to submit 10 audits per month, while the non-in-patient areas must submit 5 audits per month. The ICLFs were reminded to ensure that they submit the required number of audits. A slight decrease was noted in November and December, likely due to operational pressures during the winter season.

ESHT reported high compliance score for hand hygiene every quarter. There were some divisions who had increased compliance, particularly the CHIC Integrated locality teams followed by the Urgent Care and Frailty areas. However, there is a slight decline of compliance in the Women, children & sexual health as shown in the chart above.

The most common non-compliances involved staff failing to perform Hand Hygiene before patient contact. This was closely followed by staff who did not adhere to the Trust's 'bare below the elbows' policy. These issues were also identified during the IPCT triangulation audits. It was further observed that some staff members did not perform hand hygiene between patient contacts and after the removal of their Personal Protective Equipment (PPE). With regards to the CHIC and outpatient areas, the staff failed to enumerate their 5 moments of hand hygiene and need to improve their hand hygiene techniques.

During the year, the IPCT conducted triangulation audits to observe healthcare staff compliance across different departments in an unbiased manner. Non-compliance issues are discussed with line managers. The triangulation audits provided a more accurate picture of hand hygiene practices, helping to identify underlying issues and implement more effective interventions. The triangulation audits are then analysed together with the audits submitted by the ICLF.

The IPCT and the ICLF collaborated closely to train the staff using the glow box. Some training sessions were conducted to include the donning and doffing of PPE and doing hand hygiene especially after removing their PPE.

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.

During 2023/24 compliance with MRSA screening, triangulation of hand hygiene audits, sharps safety, universal precautions, PPE, Commode cleanliness and safe food storage was assessed and results fed back to clinical teams to effect timely action.

Audit of Pseudomonas risk at clinical handwash basins was undertaken in augmented care as part of the water safety programme.

Weekly A&E Walkabouts were extended to other areas of EDGH further to improvements works in the Trust. These included the Discharge Lounge, Friston Ward, CCU, the new A&E ENP suite and the Endoscopy Department.

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.

Face to face training has recommenced and updates are provided at divisional matrons meetings and governance meetings on request.

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 at national conference centres and online in the past year. The team is represented at the monthly NHSE IPC network events and has participated in national CDI collaborative and sustainability events.

The team have presented at the Sussex wide IPC link conference and the ESCC IPC champions event. Another member of the team has successfully completed an IPC leadership course under the auspices of the Florence Nightingale Foundation.

7.6 IPC Governance

Key Achievements for 2023-24:

- We were compliant with reporting our monthly HCAI data and Quarterly Mandatory Laboratory Return by the deadline to UKHSA via the DCS.
- The number of policies in date increased from 33% to 59% and two new policies are currently being written.
- Patient Information Leaflets – the number in date increased from 36% to 50% and included two new leaflets on food poisoning and antibiotics.
- Two audits were completed and presented at TIPCG.
- IPC team mandatory training compliance increased, ending the year at 96.6%.
- Appraisals were at 84.2%.
- 5 complaints and 7 FOI requests were received and responded to by the deadline.
- The number of IPC related incidents open on Datix reduced during 2023/24 and ended the year at 59.
- 101 IPC related incidents were reported on Datix during 2023/24. Four of these were categorised as Severity 3 or above. One relating to a PII for *C. difficile* was downgraded to severity 2. One relating to three listeria cases at Conquest remained at Severity 4. The two remaining cases reported at severity 3 and related to tuberculosis are still ongoing as further tests are required.

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.

The Trust NSC target score for Clinical, Housekeeping and Estates was assessed as 89.36%, overall, this was achieved. Where an area has consistently scored low, they are asked to attend the Patient Environmental Audit Meeting (PEAM) and provide an Action Plan to address the low compliance, and this is discussed at the TIPCG which is chaired by the DIPC.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
House Keeping	95.57%	96.14%	97.00%	96.49%	96.61%	95.76%	96.48%	96.62%	96.88%	97.00%	98.00%	97.13%
Clinical Staffing	98.89%	98.88%	98.98%	98.64%	98.58%	98.22%	94.13%	98.09%	98.50%	98.50%	98.00%	98.46%
Estates	98.69%	98.46%	98.47%	98.18%	98.30%	97.91%	97.23%	98.31%	98.34%	98.00%	98.00%	97.82%

The Estates chalenges are considered as a cleanliness concern. Cleanliness is reported and discussed at PEAM. Maintenance issues are directed straight to the Estates department. The "Building for Our Future" project work has commenced and will make a significant improvement to the standards of the estate and will be ongoing.

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. Both acute sites have invested in new equipment to provide a more productive cleaning service.

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.

Years	**21/22**	**22/23**	**23/24**
Av. No. of Deep cleans carried out on the Acute Sites	855	977	1164

23/24 – Highest month in this year was September 2023 with 1480 cleans and the lowest month was March 2024 with 461 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
- 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 (September 2023).

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 2017 Baseline) by 10% by 31 March 2024.

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 levels this was not always possible.

10. Water Safety

The well-established Trust Water Safety Group, in line with the Health Technical Memorandum (HTM) 04, meet 3 times per year. Its aims to ensure Strategic Water Safety Management for patients, visitors, and staff. Reporting to the Trust's Infection Prevention and Control Group.

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 2023.

Water Safety Plan (WSP) and Legionella Written Schemes of Control (WSoC)

The Legionella Written Schemes for Eastbourne, Conquest and Bexhill have been updated as a Water Safety Plan (WSP).

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. The Hospital Risk Reassessments have been deferred for a year to 2025, to focus on completing the remedial tasks. Schedules of the remedial works, from the risk assessments, have 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 2 years. Work to upgrade the EDGH HSDU industrial building water services has now been completed.

Pseudomonas Risk Assessments
Pseudomonas Risk Assessments have been completed by external consultants and an action plan prepared. Elevated counts in Pevensey Ward at Eastbourne are yet to be resolved. Temporary Point Off Use (POU) are in place.

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 Year to Date: 82%
Follow Up Maintenance Year to Date: 88%

Legionella & Pseudomonas Sampling
Legionella sampling is carried out each month for the Trust Healthcare Facilities. The results are reviewed, and corrective measures taken, or escalated. Samples for *Pseudomonas aeruginosa* sampling are carried out every 6 months. The results are reviewed, and corrective measures taken.

11. Ventilation Group
The Trust attaches the greatest importance to the health, safety and welfare of staff, patients and visitors. It is accepted that it is for management and staff to do all that is reasonably practicable to achieve compliance with the HSE, NHS and other guidance regarding ensuring the safe management, design, installation, operation and maintenance of the Trust's Specialist Ventilation systems.

Trust Ventilation Safety Group (VSG)
The Trust Ventilation Safety Group, in line with the Health Technical Memorandum (HTM) 03-01, meets 3 times per year. Its aims to ensure Strategic Ventilation Safety Management for patients, visitors, and staff. Reporting to the Trust's Infection Prevention and Control Group. The Trust VSG is supported by and Estates and Facilities Sub-group.

Trust Policy
The Trust has in place a Ventilation Safety Policy to confirm responsibilities and arrangements for Ventilation Systems Management. The Policy is currently being updated for approval by VSG and TIPCG.

Risk Assessment
Condition Surveys are carried out by the Independent Authorising Engineer to arrive at Risk Assessments for each system. The Trust continues to upgrade ventilation systems where achievable during major refurbishment projects. New builds are designed and commissioned to meet the requirements HTM 04-01.

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 Year to Date: 74%
Follow Up Maintenance Year to Date: 81%

Microbiological Sampling
Microbiological sampling is carried out regularly for the Critical Ventilation Systems. The results are reviewed, and corrective measures taken, or escalated.

12. Food Safety Group
The Food Safety Group was established in 2023 in line with the National Healthcare Food and Drink Standards. It aims to ensure rigorous food safety management for patients, visitors, and staff. Reporting to the Trust's Infection Prevention and Control Group, it focuses on the safe handling, preparation, and storage of food.

Key achievements for 2023/24:

- Thoroughly revised and enhanced the Food Safety Management System to meet the latest standards and best practices.
- Successfully appointed a highly qualified Independent Food Safety Specialist to provide expert guidance and oversight.
- Developed comprehensive guidelines for visitors bringing food into hospitals, ensuring safety and compliance.
- Implemented detailed local ward procedures for managing food in ward kitchens, promoting consistency and safety across all units.

The Food Safety Group's dedication to enhancing food safety protocols has led to significant advancements in 2023/24. With a strengthened management system, expert oversight, and improved guidelines and procedures, the group is committed to ensuring the highest standards of food safety for all patients, visitors, and staff. These efforts reflect our unwavering commitment to health and safety within the healthcare environment.

13. Decontamination Group

The Decontamination Group ensures the Trust adheres to decontamination standards, regulations, and guidelines, improving patient outcomes. Reporting to the Trust Infection Prevention and Control Group (TIPCG), the group oversees decontamination practices, audits compliance, advises on equipment purchases, and ensures staff training.

Key achievements for 2023/24:

- The group successfully advocated for capital funding to replace six outdated sterilisers in the HSDU and Pathology departments. With the funds secured, installation is now underway in the designated areas.
- The HSDU team achieved another milestone by maintaining their SGS accreditation with only three minor non-conformances, showcasing their commitment to excellence.
- The group facilitated significant ventilation improvements in the Endoscopy decontamination unit at Conquest, aligning with IHEEM audit recommendations, and introduced a state-of-the-art peracetic monitoring tool to enhance decontamination processes.

The Decontamination Group's achievements in 2023/24 highlight their dedication to enhancing decontamination practices and ensuring compliance with regulatory standards. Through securing vital funding, maintaining high accreditation standards, and implementing critical improvements, the group has significantly bolstered patient safety and care quality. These accomplishments reflect our ongoing commitment to excellence in healthcare.

14. Risk Register

A risk relating to the limited use of specific kits to facilitate complex orthopaedic surgery was raised in 2022/23 and has continued to be 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 and it is anticipated that the risk will be closed.

Ongoing risks include lack of isolation facilities, inability to carry out planned deep cleaning due to lack of decant facilities.

Acknowledgements

The report includes contributions from the Antimicrobial Lead Pharmacist and Directors of Estates and Facilities.

Appendix 1 – TIPCG Reporting Schedule for 2023-24

Reporting Item	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
HCAI Update Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	Cancelled	✓	✓
IPC BAF	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
PEAM minutes and NSC Audit Report	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Annual Programme of Work and Regulation 12			✓									
Emergency Preparedness 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	✓			✓			✓				✓	
Water Safety Group Report					✓			✓				✓
Estates & Facilities Report Quarterly Report		✓			✓			✓			✓	
Ventilation Group Report					✓			✓				✓
Decontamination Group Progress Report		✓					✓		✓			✓
Food Safety Group Report								✓			✓	
CEF Report			✓			✓			✓			✓
SSISS Quarterly Report			✓			✓			✓			✓
Risk Register (all Trust risks linked to IPC)			✓	✓	✓	✓	✓	✓	✓			✓
Mask Fit Report			✓			✓						✓
IPC Governance Report			✓			✓			✓			✓
Flu Planning						✓			✓			
Infection Prevention & Control Annual Report							✓					
Policies	✓	✓	✓		✓	✓	✓	✓	✓			✓

East Sussex Healthcare NHS Trust

Agenda Item: [13.2]

Report To/Meeting	Trust Board	**Date of Meeting**	10th December 2024
Report Title:	Safeguarding Annual Report 2023 - 2024		
Purpose of the Report/Outcome/ action requested:	The Board are asked to note the work in the last year and take assurance form the detail within as well as note the challenges as described.		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐		
Authority for Decision:	Trust Board		
Executive Summary	The report provides oversight of ESHT Safeguarding activity 2023-2024 noting positive practice, achievements and the challenges going forward.		
Regulatory/legal requirement:	The Trust Board is required to review the Safeguarding annual report to receive assurance about the effectiveness of Safeguarding activities in the organisation.		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☐		
Equality, Diversity, and Inclusion Impact Assessment/Comment	No impact.		
Resource Implication/VFM Statement:	No implications.		
Risk:	Key risks are set out within the full annual report.		
No of Pages	3	**Appendixes**	Yes
Name, position and contact details of author:	Author: Gail Gowland, Head of Safeguarding		
Report Sponsor	Vikki Carruth, Chief Nurse	**Presenter:**	Vikki Carruth, Chief Nurse
Governance and Engagement pathway to date:	Quality & Safeguarding Committee Safeguarding Strategic group, virtually.		
What happens next?	Safeguarding work and any enquiries raised about the trust continues to be tracked through databases and reviewed on a weekly basis.		
Publication	This report is appropriate for publication.		

Introduction

Safeguarding enquiries have continued to demonstrate a year-on-year increase across all demographics, alongside complexity of presentations. Safeguarding enquiries that reference concern about the trust have continued to be monitored on a weekly basis, members of the Safeguarding team participated in the discharge events that were facilitated in 2023 which addressed some of the themes about the trust.

Work to embed a process for the routine enquiry of domestic abuse as developed in 2023-2024 with several strands of work progressing to support the identification of victims of abuse. A joint piece of work with urgent care and digital colleagues enabled the rapid assessment screening tool, first developed in 2021-2022, to be embedded in Nerve Centre in March 2024 as a mandatory assessment for patients attending the Emergency setting over the age of 16. The advancement of this was also supported by daily safeguarding huddles within the Emergency Department and training provided by the Specialist Domestic Abuse worker.

ESHT have been trail blazers for work regarding transitional safeguarding and participated in county wide work to develop a transitional safeguarding pledge. A theme that has been a feature over the last few years is that of young people experiencing a mental health crisis, with young people requiring mental health support receiving care in acute in-patient beds. The lack of appropriate inpatient mental health beds and of emergency foster placements continues to be both a regional and national issue, exacerbated by the pandemic and the economic situation.

This is further highlighted within Safeguarding Children's activity in the last year, which has seen the impact of child completed suicide, with two in the period 2023/2024. Whilst the particular circumstances are always scrutinised within the Child Death Overview Panel (CDOP) process, additional multi-agency analysis has considered whether any other children known to the victim could be at increased risk.

Work to develop understanding across with organisation regarding the application of the Mental Capacity Act has been progressed and is also a quality account priority.

A deep dive and cleanse of the data pertaining to Children in Care health assessments occurred, the outcome of which was revised data results for Q1, 2 and 3 reflecting accurate data and clear processes for Specialist Nurses and Administrators to follow. Furthermore, the data cleanse highlighted that 94.3% of Initial Health Assessments (IHAs) were completed within timescale when considering exception reporting not within ESHT's control, with most breaches due to external factors

specifically, missing data, late notification, cancellations by Social Worker/Foster Carer and batched requests.

Additionally, 94.5% of own Local Authority review health assessments in over 5s and 92% under 5s completed within timescale when considering exception reporting not within ESHT's control. The majority of breaches were due to external factors specifically missing data and late notification. Preparatory work commenced to establish UASC and IHA clinics within the acute settings on a one stop basis re agreed location, blood sampling and medication. Recruitment of Doctors completed with a provisional start date of July 2024.

Background

During the period 2023-2024, the Safeguarding team experienced some staffing challenges with long term sickness within the children's speciality and a vacancy for a Named professional for 4 months in the adult's service. Furthermore, there were also staffing challenges within Maternity Safeguarding. The Children in Care nursing team have seen a change of line management and moved to the CNO portfolio under the Safeguarding umbrella, replicating the structure within the ICB Safeguarding team.

A second cohort of Domestic Abuse champions was facilitated by the Specialist Domestic Abuse worker and work was undertaken with Nervecentre and the digital teams to embed the Domestic Abuse Rapid Assessment Tool (DART) within the Emergency Department.

The interactive Think Family level 3 training programme was updated and refreshed with the eLearning component linked to learning briefings published by the respective safeguarding boards and the facilitated session with updated case studies.

Assessment

During the period 2023-2024 more robust data collection tools were developed across the team which has allowed deeper analysis of themes and trends.

Analysis of cases identified the risk of patients with weapons in the community and a learning event with Police involvement was facilitated with the CHIC division in response.

An audit of the conclusion reports received in respect of Safeguarding Adults enquires was undertaken and identified some key themes for the trust that were shared within the Patient Safety Team and the Professional Advisory Group. Patients presenting with Significant Mental Illness (SMI) across all ages and sectors continues to be a feature of some safeguarding enquiries.

East Sussex Healthcare
NHS Trust

Safeguarding and Children in Care Annual Report 2023/24

esht.nhs.uk

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Message from our Chief Nursing Officer, Vikki Carruth

As Executive Lead for Safeguarding Children and Adults, it is my responsibility to ensure the board and the public that East Sussex Healthcare NHS Trust (ESHT) meets the statutory requirements required and is assured and updated via this report.

This work ensures that there are robust governance processes for recruitment, reviewing policies and local and Sussex wide procedural documents, relevant learning and development and multiagency working, including representation on both local safeguarding boards. The Chief Nurse also works closely with the Chief Operating Officer and others to ensure systems and processes are in place to safeguard patients presenting with mental ill-health who also need ESHT services or are awaiting transfer of care for assessment and treatment.

This past year, the Safeguarding Team have worked hard to develop robust data collection systems. Staff have continued to have the appropriate access to safeguarding support and advice, which has been a blended offer of virtual and face to face support and training.

There has been continued focus to ensure that safeguarding policies, procedures, and practices remain up to date, are reviewed regularly and are fit for purpose. All policies and procedures are accessible to staff via the Safeguarding pages on the Trust Extranet and advice and support is provided by our Safeguarding team.

The last year has once again seen an increase in the numbers and complexity of cases of abuse and neglect across the whole population of East Sussex. Cases referred to respective child or adult social care teams have continued to see a year-on-year increase.

A continued theme has been that people across all ages experiencing a mental health crisis and requiring mental health support are receiving care in acute in-patient beds. This lack of in-patient mental health expertise and availability and of emergency foster placements is both a regional and national issue, exacerbated by the pandemic and the economic situation.

A focus of work in 2023-2024 has been to develop a process that ensures patients attending the Emergency Departments are routinely asked about Domestic Abuse, this process has also been supported by the development of safeguarding huddles in gateway areas.

A key area of work for this year has been to further embed a culture of understanding pertaining to the Mental Capacity Act 2005 across the organisation.

The Trust is involved in both local Safeguarding Partnerships; (ESSCP for children and young people and the SAB for adults) and is committed to interagency working and positively supports opportunities to work with other agencies.

I would like to thank all staff for their continued support with this complex agenda and recognise the challenges it presents personally and professionally.

1. Introduction

The 2023/2024 Annual Safeguarding Report provides the East Sussex Healthcare NHS Trust (ESHT) Board with an overview of the safeguarding work undertaken during the year, and assurance regarding the Trust's compliance with the legislative and regulatory framework. This includes;

- Working Together to Safeguard Children (2018), (2023)
- The Children's Act (2004) - ESHT must be able to demonstrate that it safeguards children who access our care under section 11 of the act
- Safeguarding Vulnerable Adults in line with the Care Act (2014)
- Department of Health Care & Support Statutory Guidance under the Care Act (2014)
- The Mental Capacity Act (2005)
- Deprivation of Liberty Safeguards (2007), Mental Capacity amendment (2019)
- The Modern Slavery Act (2015)
- Safeguarding Children & Young People: Roles & Competences for Health Care Staff (2019)
- Safeguarding Adults: Roles & Competences for Health Care Staff (2018) The Female Genital Mutilation Act (2003)
- Promoting the Health and well-being of Looked After Children (2015)
- Domestic Abuse Bill (2021)
- Safeguarding Accountability and Assurance Framework (2022)

This year the report, comprises a part 2 that incorporates the work of the Children in Care (CIC) team. It aims to demonstrate and give assurance as to how East Sussex Healthcare Trust (ESHT) is committed to ensuring that all children in care receive the highest quality and effective medical and nursing health care that reflects statutory regulations and the intercollegiate guidance.

2. Safeguarding Governance

2.1 East Sussex Healthcare NHS Trust Safeguarding

Providers of NHS funded healthcare are required by NHS England to comply with the "Safeguarding Vulnerable People in the NHS Accountability Framework" (2022). ESHT must demonstrate that it is has effective arrangements to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators, and commissioners that these arrangements are working.

The Intercollegiate Document (2019) requires NHS organisations to have structured safeguarding leadership with clinical and safeguarding expertise. The Chief Nurse is the Executive Lead and has responsibility for ensuring effective trust wide safeguarding governance, available advice and expertise, and that robust arrangements and reporting are in place. The Chief Nurse and Deputy Chief Nurses support the Head of Safeguarding and the Safeguarding team, and co-ordinates with the Divisional Assistant Directors of Nursing who are responsible for ensuring robust safeguarding arrangements and practice in each of their clinical areas.

The Trust governance and reporting arrangements are based on legislative changes and statutory requirements. Safeguarding Leads are required to provide support, advice, scrutiny, and assurance. ESHT safeguarding policies for adults and children set out the key arrangements for safeguarding practice, roles, and responsibilities. These are monitored through the Safeguarding Operational and Strategic meetings.

2.2 System Safeguarding

The legislative and regulatory safeguarding requirements set out duties for ESHT to co-operate with and support the wider system safeguarding practice and statutory partners including the Local Authority and the Police. The Chief Nurse, Deputy Chief Nurse and Head of Safeguarding are members of both the Local Safeguarding Adults and the Local Safeguarding Children's Boards in East Sussex. The Head of Safeguarding and Named Professionals fully support the sub-committees, groups and processes of both safeguarding boards enabling ESHT to drive forward both the national and local safeguarding agenda in partnership with others.

2.3 Care Quality Commission (CQC) Inspection

The CQC inspection of the Trust in 2019/2020 found outstanding practice in relation to Safeguarding.
There has not been an inspection in the year 2023/2024, however, the Head of safeguarding responds to any CQC request for information as required.

3. Key Achievements in Safeguarding 2023 - 2024

The Safeguarding Team have continued to support the Divisions with Safeguarding issues throughout 2023-2024, some key pieces of work during this period include,

- ESHT have been trail blazers in the work of transitional safeguarding. As part of this, the Transitional Safeguarding Specialist practitioner and Named Nurse for Safeguarding Children have participated in Sussex Wide work regarding the transitional protocol and to develop a Transitional Pledge. The work focuses on the key priority which is 'ensure that vulnerable young people are supported in their transition to adulthood, which enables them to make a difference in their world and reach their full potential'.

- The ESHT Safeguarding Children Team contributed significantly to the multi-agency redevelopment of the East Sussex Neglect toolkit through participation at task and finish groups throughout 2023/24 and engagement with front line staff to support with a practical and effective toolkit for practice.
- The weekly risk meeting led by the Safeguarding Children Team has continued throughout 2023-2024 with consistently positive attendance from core professionals. A total of 790 children and people under the age of 18, who attended via ESHT Emergency Departments were reviewed in this multi-disciplinary forum throughout 2023/24.
- The safeguarding practitioners across the adult and children's speciality have introduced and developed daily safeguarding huddles with the Emergency

Departments across both acute sites. This has been incredibly well received with feedback that staff feel more supported in their safeguarding practice, knowledge and decision making.

- The ESHT Safeguarding Children Team have supported the National Referral Mechanism pilot scheme providing regular health intelligence to support robust and responsive planning for children and young people at risk of exploitation and trafficking.
- A screening tool to support staff to enquire about Domestic Abuse was updated and simplified; A collaborative piece of work undertaken with Emergency Department staff, Digital Nurse and the Nerve centre configuration team to embed the tool as a mandatory field in the Emergency Department for all patients over the age of sixteen. This went live on the 18th of March providing assurance that the Emergency Departments are proactively undertaking the routine enquiry of Domestic Abuse.
- The Safeguarding Adults Speciality have participated in the face-to-face discharge event summits in response to the themes of Safeguarding alerts raised about the organisation. The forums held with senior staff raised and consolidated awareness to reinforce robust discharge and transfer of care pathways.

4. Strategic Context

4.1 Child Safeguarding Arrangements

The East Sussex Safeguarding Children's Partnership board (ESSCP) brings together several key agencies as well as voluntary organisations and lay members, across the county, to ensure a collaborative approach to safeguarding children. Three key agencies, Local Authorities, Health, and Police are integral to the forum and jointly oversee the multi-agency arrangements to safeguard children. The Chief Nurse and Head of Safeguarding are members of the board, the Head of Safeguarding participates in several sub-groups.

4.2 Adult Safeguarding Arrangements

The Chief Nurse, Deputy Chief Nurse and Head of Safeguarding are members of the East Sussex Safeguarding Adults Board (SAB). The Head of Safeguarding also participates in sub-groups of the SAB.

'*The requirement of the SAB is to lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies'* www.scie.org.uk.

4.3 Domestic Abuse

The Head of Safeguarding is a member of the East Sussex wide Domestic Homicide Review Oversight Board.

Change Grow Live who are providers of Domestic Abuse services within East Sussex employ the Health Independent Domestic Violence Advocate (HIDVA) who is commissioned to undertake Specialist work within the trust.

5. Response to national themes and trends

Over the last year the national focus has changed in accordance with legislative frameworks. The Head of Safeguarding participates in national networks for both adults and children to ensure that the trust has oversight of key messages.

5.1 Mental Capacity Act Amendment Bill

Whilst this remains a national workstream, the planned changes are currently on hold. The trust has recognised that there needs to be a focus on the Mental Capacity Act (MCA) and as such there are programmes of work led by the Mental Capacity Lead.

5.2 Domestic Abuse

At a national level there has been a focus on tackling domestic abuse which has been mirrored within the trust. As an organisation we are developing systems for the routine enquiry of Domestic Abuse which has been positively acknowledged by local groups such as Safer Communities. Moreover, the Trust hosts the post of Health Independent Domestic Violence Advocate (HIDVA). The role was re-commissioned in 2020 with Change Grow Live for five years.

There continues to be a high percentage of acceptance to HIDVA support and feedback forms completed with patients receiving support has been positive.
120 referrals have been made to HIDVA in the last year (figure 1).

Of the 120 referrals managed by the HIDVA, 40 of the clients were pregnant and 96 children were also identified.

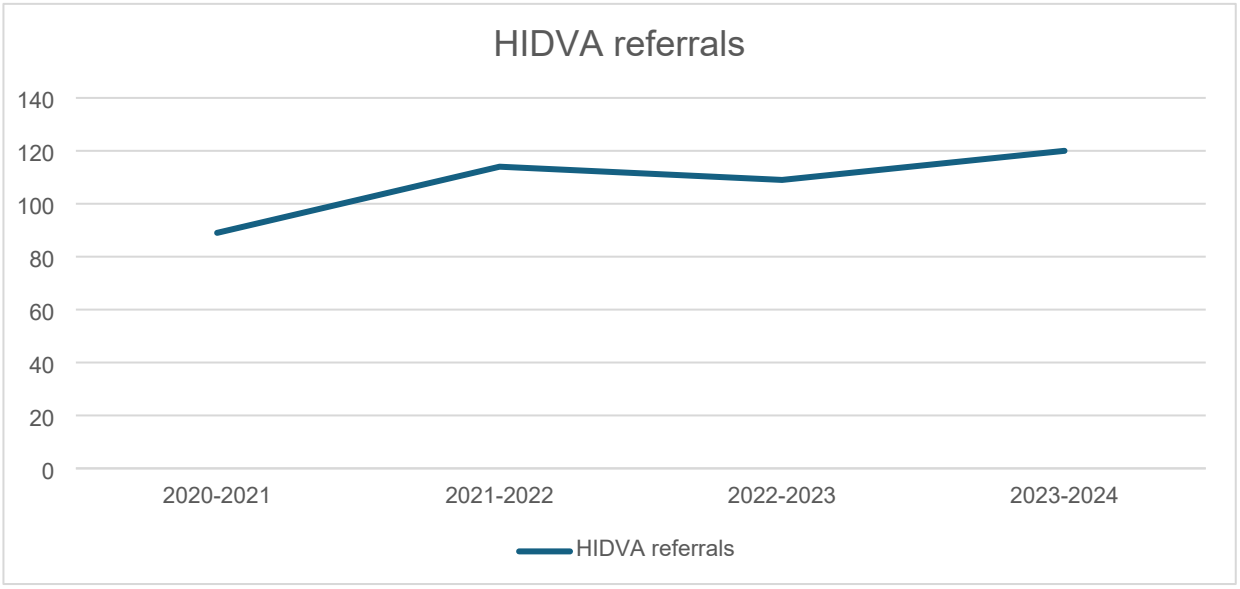


Figure 1

5.2.1 Domestic abuse training

The HIDVA has delivered Domestic abuse and the Impact on Health training to 222 staff members. This has included domestic abuse awareness and routine enquiry training to the Community Health and Integrated Care Division (CHIC). The HIDVA has co-delivered a joint training session with ASC on Domestic Abuse in Older Age-Learning from Adult Safeguarding Audits to the ESHT children and adults safeguarding team. The HIDVA co presented a session with the Head of Safeguarding to the ESHT Women's Network, to support 16 Days of Action Against Gender Based Violence and Abuse. The presentation highlighted safeguarding against domestic abuse within ESHT for staff and patients, with guidance on signposting, ESHT procedures, and HIDVA service
In addition to raising awareness, these sessions provide an opportunity to discuss challenges to practice.

10 ESHT staff members completed the second cohort of Domestic Abuse Champions Training.

5.3 Female Genital Mutilation (FGM)

FGM information sharing, known as FGM-IS, is a national IT system linked to the NHS spine that supports the early intervention and ongoing safeguarding of females, under the age of 18, who have a family history of Female Genital Mutilation (FGM). We have implemented the system which is led by the Named and Deputy Named Midwife for Safeguarding. Seven female infants born at ESHT had an FGM-IS alert added to their summary care record.

During 2023-2024 additional connections were made with other areas in the trust where patients who have experienced FGM may present, such as the genito-urinary specialist. Information about FGM is included in the 'Think Family' training.

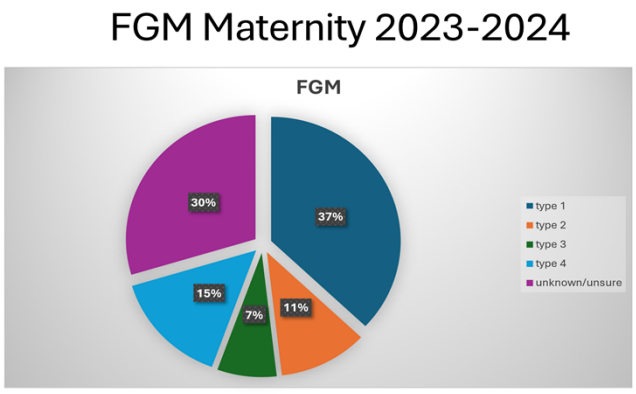


Figure 2

5.4 Contextual Safeguarding

Contextual safeguarding considers potential safeguarding risks that exist but are external to a child's family. The approach considers the differing relationships that children may have such as peers, school and their community. The Named Nurse for Children in Care participates in 'safer' meetings that consider risks to children through exploitation.
The team have participated in Sussex wide work that considers transitional safeguarding this focuses on potential risks between 13 and 25.

5.5 PREVENT

The Head of Safeguarding is the Trust lead for the PREVENT programme, which supports the local and national counter terrorism strategy, and is a requirement under the Counter Terrorism and Security Act, 2015. Locally the Trust is active on the PREVENT Board and submits numbers of PREVENT (Channel) referrals and training data quarterly to the ICB and NHSE. The trust Prevent policy was updated in 2023 to reflect current legislation and guidance.

PREVENT training is accessed via e-learning format, the training requirement changed from a standalone session to 3 yearly updates. Compliance is set at 85%, ESHT are close to compliance with both BPAT & WRAP training. The Trust have not made any referrals to Prevent in the last year but engages with Channel when required. (Figure 3)

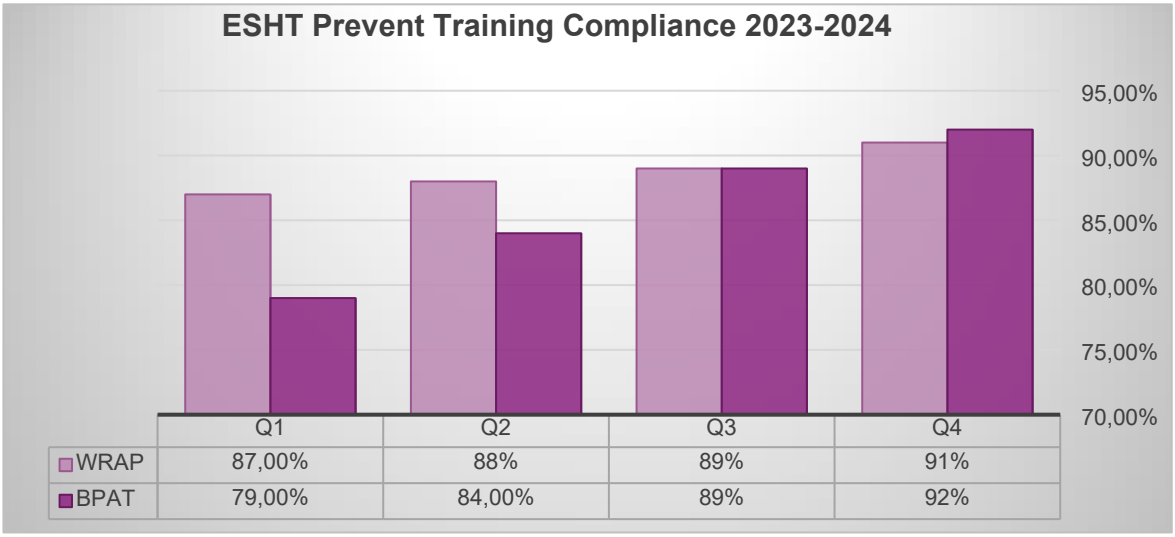


Figure 3

The Prevent lead works closely with the Head of Security to align work between PREVENT and Counter terrorism. Quarter 2 and quarter 3 demonstrated an increase in Prevent training compliance.

6. Local Serious Case Reviews and referrals

Domestic Homicide Reviews, Safeguarding Practice Review (child) or Serious Adult Review are independently chaired processes that draws on multi-agency analysis. The process is undertaken when it is considered that abuse has contributed to the death or serious injury, the purpose of which is to identify whether there is learning. As part of any serious review ESHT alongside other partner agencies submit detailed reports and

participate in panel meetings and practitioner learning events. The final reports, identifying lessons to be learned, and recommendations are compiled by an independent reviewer or author and may be published.

6.1 Domestic Homicide reviews

- Within this timeframe ESHT have contributed Independent Management Reports (IMR) to two cases, both which remain ongoing.
- Two historic domestic homicide reviews were published by Safe in East Sussex in 2023-2024 with a further case published as an executive summary. The learning from these reviews is disseminated through learning briefings shared at divisional governance meetings. and a further four cases are awaiting sign off by the Home Office.
- There remain a further five historic cases that have yet to be published, however with these sensitive issues at times, decisions are made not to openly publish to protect the family.

7. Safeguarding; Cradle to Grave

7.1 Maternity Safeguarding

In 2023/2024 there was a total of 3,227 maternity bookings. 26% (n=838) of the maternity bookings had a cause for concern/social report reviewed by the Maternity Safeguarding Team. This is an increase from 2022/2023 when there was a total of 3,160 maternity bookings, 22% (n=707) of which had a cause for concern/social report. Maternal mental health, domestic abuse and families open to Child Social Care being the main categories of concern at booking.

There were 351 referrals to child social care by the Maternity Team in 2023/2024.

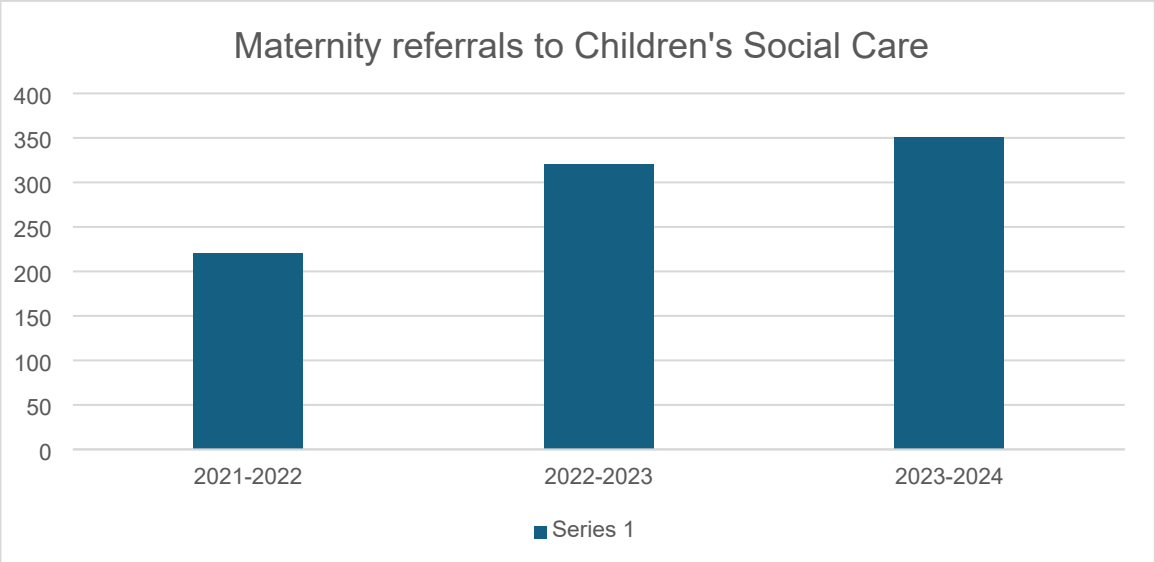


Figure 4

43 infants had a child protection (CP) plan in place prior to birth and 11 infants were supported with a child in need plan. The graph below shows the category of harm of the child protection plans in place at birth. Neglect remains the highest category of abuse. There were 68 maternity action plans (MAPS) for birth.

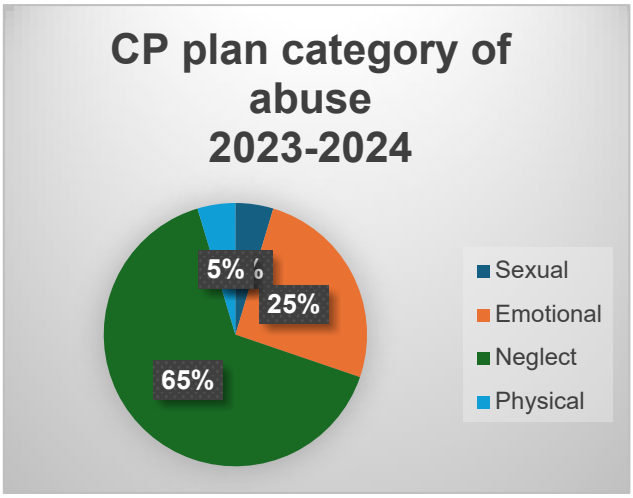


Figure 5

7.2 Children's Safeguarding

7.2.1 Overview

- In the period April 2023 - April 2024, ESHT referred two cases to the ESSCP case review panel. ESHT Safeguarding contributed research in the form of four rapid review serious cases, one of the cases is progressing to a child practice review.
- An Individual Management Report (IMR) was completed jointly by Named Professionals for both Safeguarding Adults and Children, the case remains ongoing.
- Two cases were published by East Sussex Safeguarding Children Partnership this year, one of which was an historic case delayed due to the associated criminal proceedings.
- A further case that involved children's services was published by the Safeguarding Adults Board.
- There remains an historic case where publication has been delayed by judicial proceedings.
- A further facet of Safeguarding Children's activity in the last year has been the impact of child completed suicide, with two in the period 2022/2024. Whilst the particular circumstances are always scrutinised within the Child Death Overview Panel (CDOP) process, additional multi-agency analysis has considered whether any other children known to the victim could be at increased risk.

7.2.2 Activity

The Safeguarding Children's Specialists within the team scrutinises child presentations within ESHT, to ensure that safeguarding pathways are recognised and followed. Safeguarding data is collated, such as the numbers of statements of referrals (SOR forms) submitted by the Trust to Children's Social Care. Furthermore, any relevant information shared with colleagues, such as the Health Visiting service is also collated.

The team participate in strategy meetings and host a weekly multi-agency forum that reviews attendances and admissions where there is a potential safeguarding risk.

During the pandemic, there was an increase in safeguarding children's referrals, and whilst referrals in 2023/2024 are marginally less than the preceding year this has not returned to pre-pandemic rates (figure 6). The majority of which are submitted by the Emergency Departments, which is a pattern that has been sustained. Data collection for Children's Safeguarding has improved in 2024 which will allow robust analysis of themes and trends going forward.

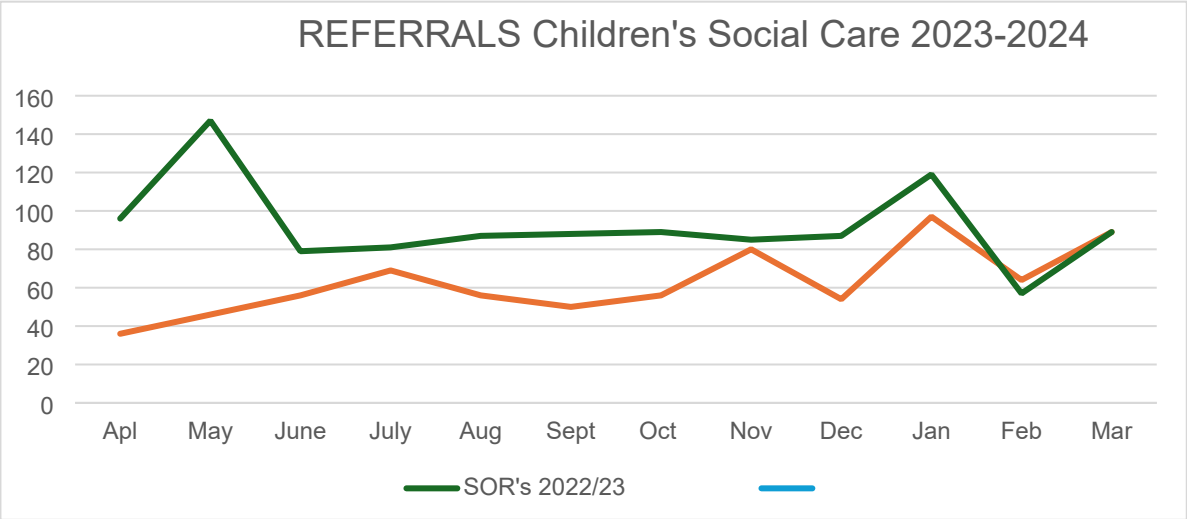


Figure 6

Quarter 4, themes

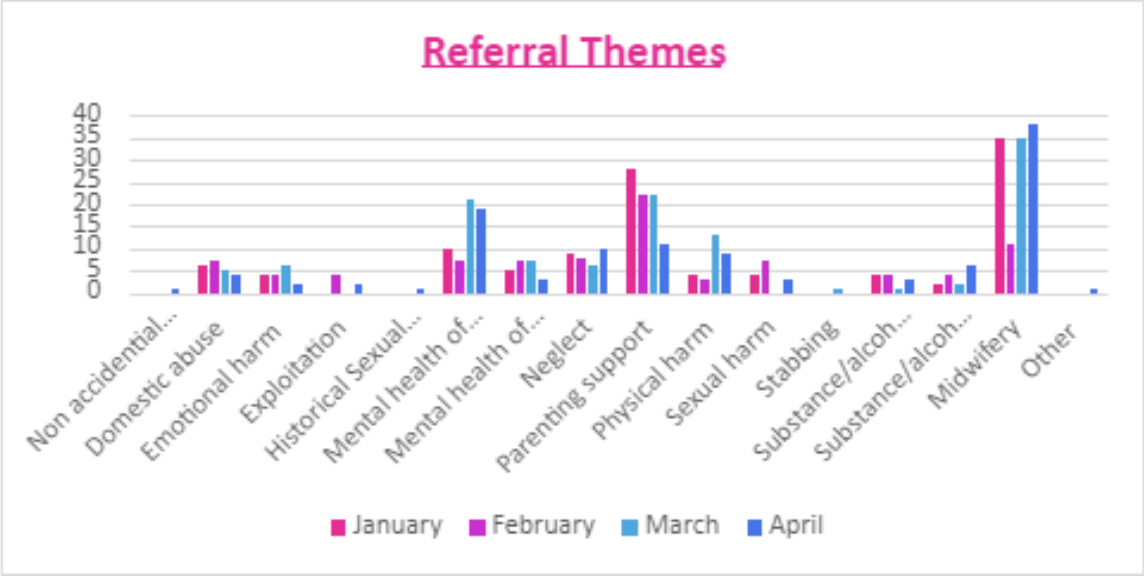
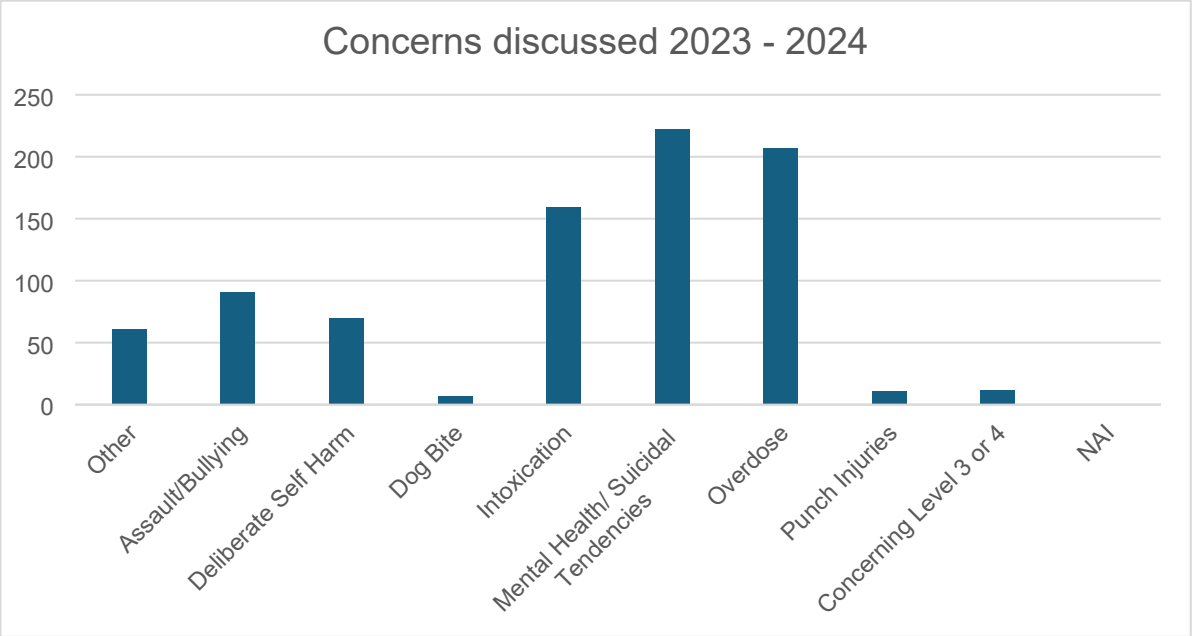


Figure 7

Figure 8, Themes discussed within the weekly Children's Risk Meeting



7.2.3 Actions

- The Safeguarding team continue to host a weekly multi-agency risk meeting in which child presentations of concern are scrutinised.
- The ESHT Transitional Safeguarding Lead and Named Nurse are part of the core membership of a multi-agency task and finish group which aims to develop a strategic approach to Transitional Safeguarding across East Sussex.

7.2.4 Named Doctors for Safeguarding Children

There are currently two Named Doctors for Safeguarding Children alongside a further post for Children in Care. The Named Doctor's work closely with the Head of Safeguarding and the Specialists Nurses for Safeguarding Children and provide clinical advice guidance and support. The Named Doctors have continued to develop safeguarding work within Paediatrics including,

.

- Providing support for liaison nurses in considering referrals for possible child protection medical examinations and safeguarding direction for medical colleagues following the assessment of a child.
- Support of colleagues at strategy meetings and case conferences, and in provision of written safeguarding medical reports.
- Facilitating monthly consultant peer review of safeguarding reports to ensure high quality and accurate reports from ESHT to Children's Services and enable a forum which provides an opportunity to scrutinise complex cases.
- Leading and facilitating bi-monthly peer support meetings to consider "Children with Perplexing Presentations".

- Support for medical and nursing colleagues in dealing with the huge increase in patients with mental ill health and complex psycho-social problems admitted to the children's ward, many of whom have no physical health needs.
- Liaising with partner agencies e.g. SPFT and Children's Services to ensure that discharge planning for young people on the ward with mental health crises, emotional dysregulation or additional social needs, happens in a timely way.
- Providing safeguarding induction to paediatric and ED physicians.
- Development of regular paediatric and ED safeguarding teaching programme.

As part of a child protection investigation, Paediatricians may be asked to conduct an urgent child protection medical or welfare medical. The process for medical examinations has been more clearly defined and is constantly reviewed and refined as necessary, for example with provision of rapid feedback to social workers of initial opinions, and ensuring data is collated as to how many medicals occur during a monthly period. Work is ongoing at a Sussex wide level to align the processes for medicals.

7.3 Safeguarding Adults

7.3.1 Overview

East Sussex Healthcare Trust contributed to two Safeguarding Adults Reviews (SARs) published by the Safeguarding Adult Board in 2023-2024 and a further case that continues to await publication. An additional case did not involve ESHT directly, but the adult lived in the East Sussex area. All published reports are available on the Safeguarding Adult Board website.

Key themes emerging from the serious cases includes, mental capacity, making safeguarding personal, application of safeguarding processes, and multi-agency information sharing and communication.

The ESHT safeguarding team continued to progress a combined tracker that monitors the progress of actions generated through Safeguarding Adult Reviews, Child Practice Reviews and Domestic Homicide Reviews.

7.3.2 Safeguarding Adult Referrals

Safeguarding alerts/referrals can be raised by staff, patients, family members or the public and are received by Adult Social Care (ASC), who apply three key tests to decide if the concern raised meets the threshold for a Section 42 Adult Safeguarding concern. Of the referrals ASC receive, not all, result in a Section 42 Enquiry, and may not progress after information gathering. The work undertaken within the safeguarding team for section 42 enquires and information gathering is however similar, and it should be noted that not all enquiries meet the threshold following investigation for section 42.

Often the referrals received by Adult Social Care may pertain to historic information. The annual report for 2022-2023 identified 722 cases but exception reporting, extracting historic data has reduced this figure. Improved data collection systems for 2023-2024 has

reinforced the picture of a year-on-year increase in the number of Safeguarding Adults enquiries (figure 13). This covers both acute and community services and includes enquiries raised by ESHT and those about ESHT.

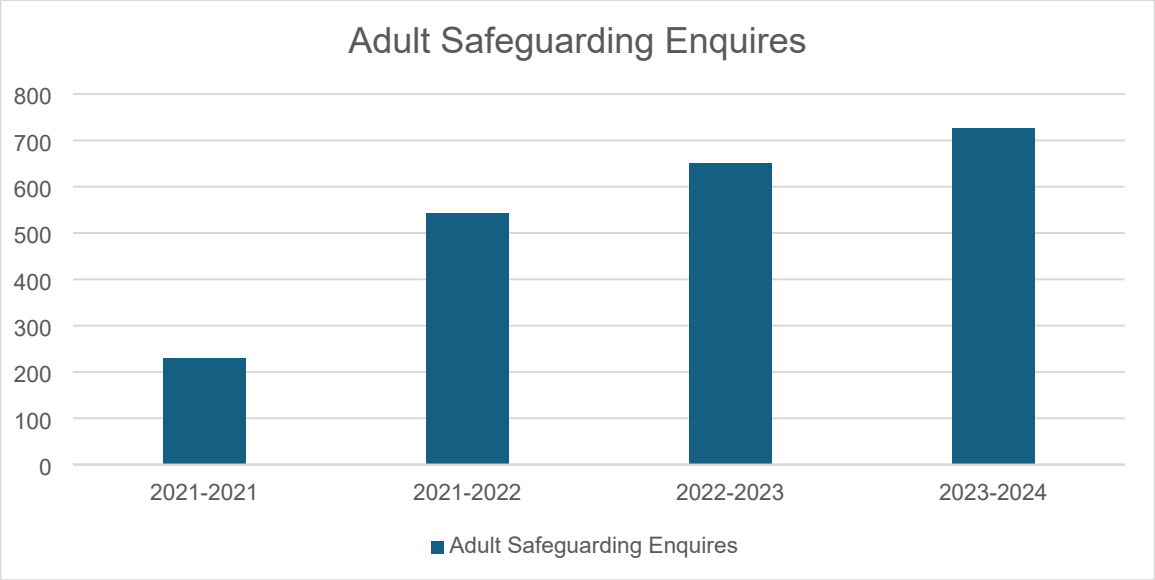


Figure 9

A quality improvement aspect of work was the development of a weekly tracker (Figure 10) which has continued throughout 2023-2024, to monitor the themes which are reviewed alongside the Heads of Divisions and Matrons and led by the Chief Nurse. The tracker for 2023-2024 demonstrate an increase in safeguarding about the trust during quarter 4. A deep dive was undertaken in response to scrutinise data and information.

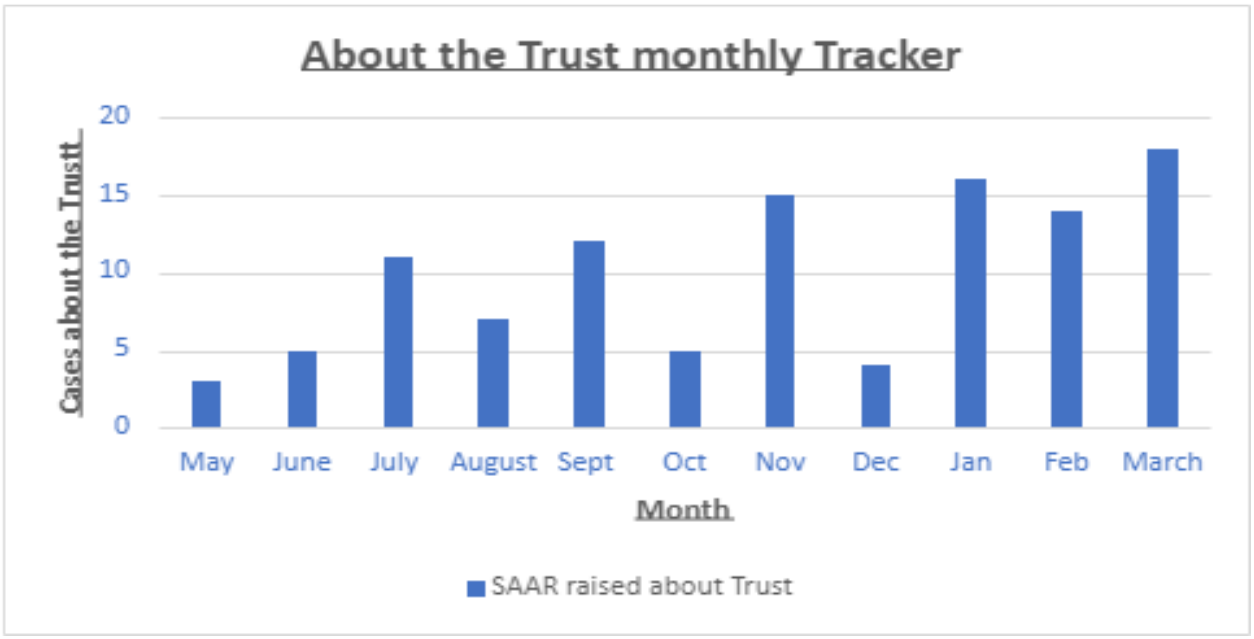


Figure 10

Number of Safeguarding Adults enquiries by comparison with previous year.

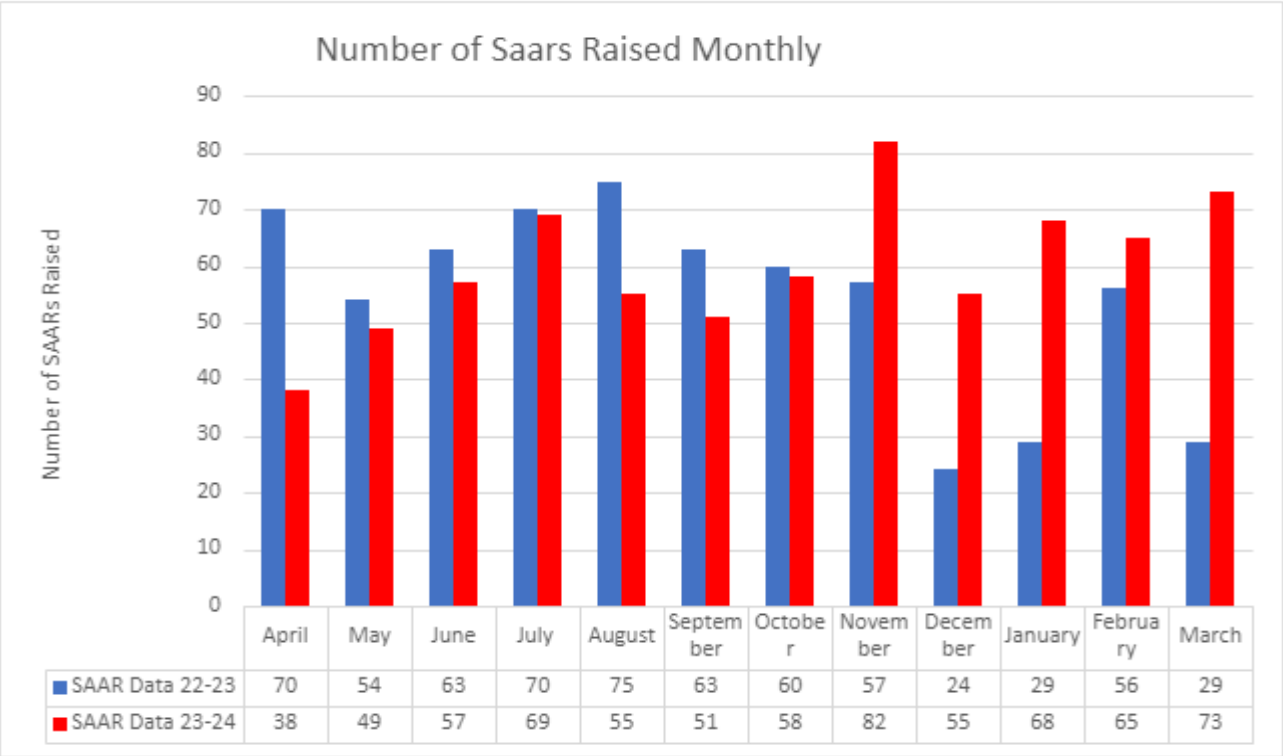


Figure 11

The progress of completion of the provider reports is also monitored through a database and discussion within Divisional governance forums to ensure robust and timely responses.

Neglect, self-neglect, and domestic abuse continue to be identified as key themes raised as safeguarding enquiries (figure 12). The presentation of safeguarding issues has continued to demonstrate complexity of cases.

Safeguarding Supervision within adult facing areas of the trust has, been facilitated on an ad hoc basis since the pandemic. A pilot process for the establishment of safeguarding supervision forums across the organisation was launched in quarter 4. The sessions have been offered virtually on a Divisional basis for staff to book onto via the My Learn platform.

In addition to this, daily safeguarding huddles commenced within the Emergency Departments Monday to Friday.

Safeguarding Adult Enquiry Themes 2023-2024

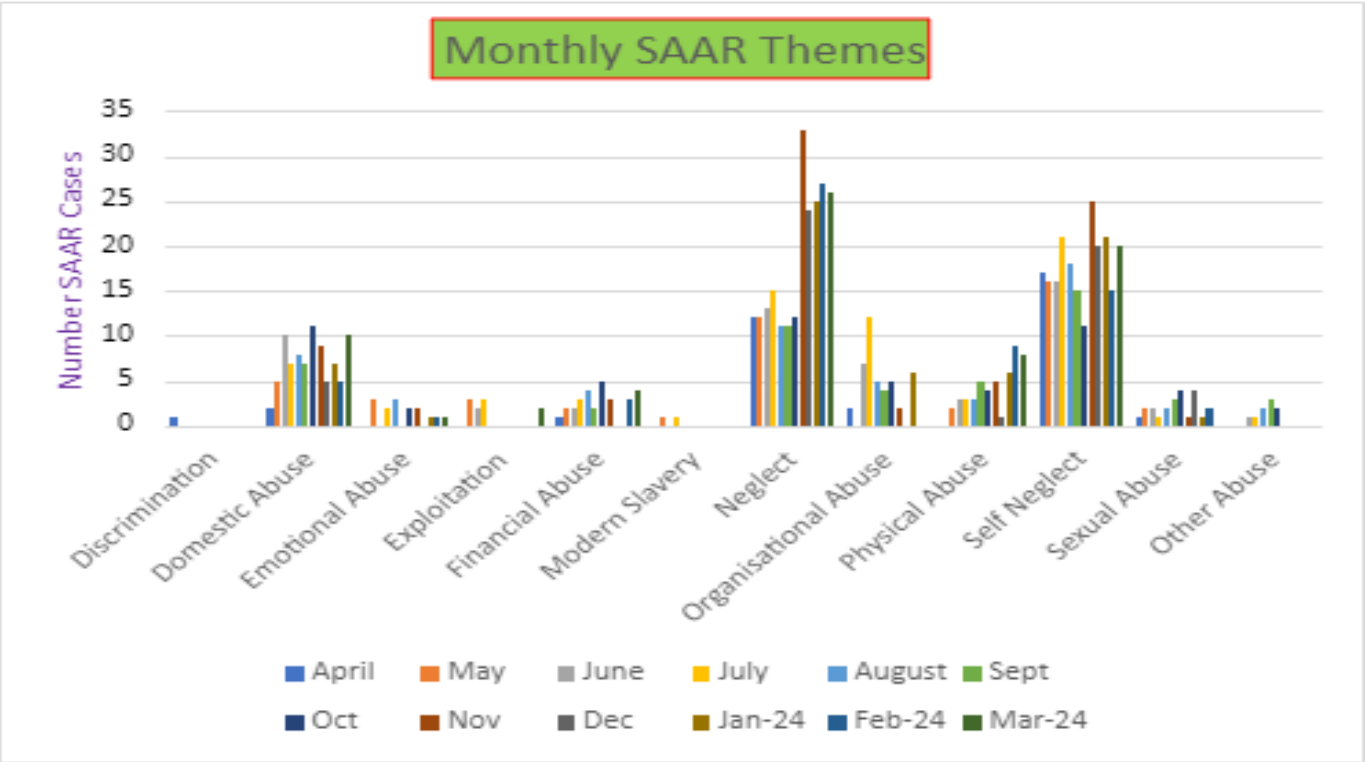


Figure 12

8. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS)

East Sussex Healthcare Trust applies the Deprivation of Liberty Safeguards (DOLS) to those patients that are deemed to lack mental capacity. The Deprivation of Liberty Safeguards were an amendment to the Mental Capacity Act 2005 and within which the procedure, as prescribed in law, cites when it is necessary to deprive a resident or patient of their liberty, when the person lacks capacity to consent to their care and treatment, in order to keep them safe from harm.

Work has continued to embed understanding of the Mental Capacity Act and the ethos of Cheshire West. The increase in DOLS referrals indicates the impact of staff education in this area (figure 13).

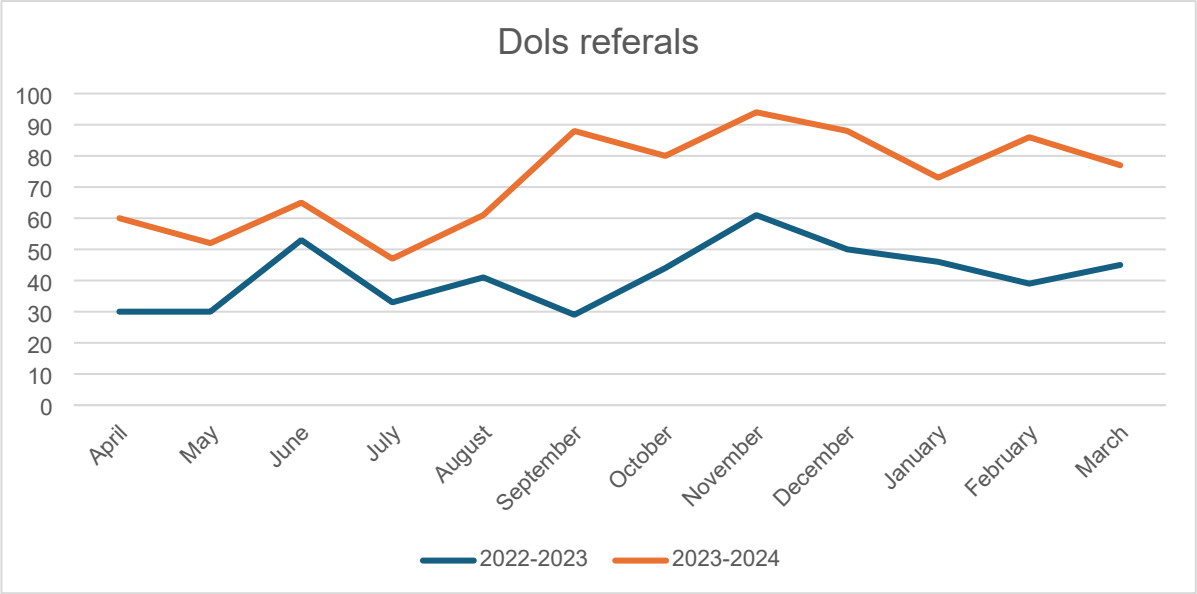


Figure 13

8.1 Actions in progress

- The Mental Capacity Lead has developed training and workshops across the organisation and also provides bespoke training to specific clinical areas across the organisation, including study days.
- The Mental Capacity Lead has established monthly Mental Capacity link meetings, covering different topics relating to MCA/DOLS, via Teams, available to all staff in the Trust.
- The Mental Capacity Lead was involved in testing the new online DOLS referral introduced by ASC DOLS and producing guidelines for ESHT staff.
- The Safeguarding Team attend Matrons and Divisional meetings to discuss the updates on the forthcoming changes.

9. The Mental Health Presentations

9.1 Children

The predominant theme discussed within the weekly children's safeguarding risk meeting has continued to be patients with mental health issues. The meeting continues to scrutinise complex presentations, however, due to the high numbers those where Child and Adolescent Mental Health Services (CAMHS) had seen and established a clear care plan have now been excluded from these discussions. The chart for 2023-2024 reflects that fewer mental ill health cases were discussed in the meeting; this has not, therefore, represented a reduction in overall mental ill health presentations.

Furthermore, there were two completed suicides in this year, the Trust and Safeguarding team were then, as a result, involved in wider multi-agency work aimed to reduce risk in the community of additional children.

Additional data regarding hospital attendances due to self-harm is collated by ESCC Public Health, in response to this data ESHT submitted a deep dive regarding domestic violence to the ESSCP partnership board and were also involved in a multi-agency audit, the results of which have yet to be published.

East Sussex A&Es only (EDGH and Conquest Hospital, MIUs NOT included)	2022/23												2023/24											
	Q1			Q2			Q3			Q4			Q1			Q2			Q3			Q4		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Self-harm 5-17 years	34	45	62	68	48	65	52	92	37	55	55	81	89	77	77	51	47	83	56	69	54	63		
Accidental poisoning 0-4 years	14	16	7	11	17	12	9	9	4	9	11	8	2	11	11	11	6	16	22	4	7	9		
Falls from furniture 0-4 years	51	44	27	53	38	29	41	33	31	50	38	36	54	43	51	55	59	46	38	45	41	47		
All accidents 0-4 years	285	267	239	291	296	263	245	170	153	173	175	195	242	285	262	279	270	279	249	219	198	213		

Deep Dive outcomes

1. There has been a significant increase in the number of attendances of 5 –17 year-olds in the Emergency Department due to deliberate self-harm. The average rolling 6 monthly average was 71 at the end of September 2023, compared to 54 at the end of September 2022 (a 34% increase).
2. Numbers have continued to remain high in quarter 3 (October = 56; November = 69; December = 54) and January 2024 (63 attendances).
3. The figures only capture children attending East Sussex hospitals and do not capture out of county attendances, such as those attending the Royal Alex etc.
4. There is small differentiation across genders, data from December demonstrated 6 males and 7 females attended with suicidal ideation, similarly both January and February showed a slightly higher prevalence in females, with 11 of the 19 overdoses and 12 of the mental health/suicide ideation noted.
5. The average age was 15 -17 years of age.
6. Cutting is seen as the key theme under the criteria of deliberate self-harm

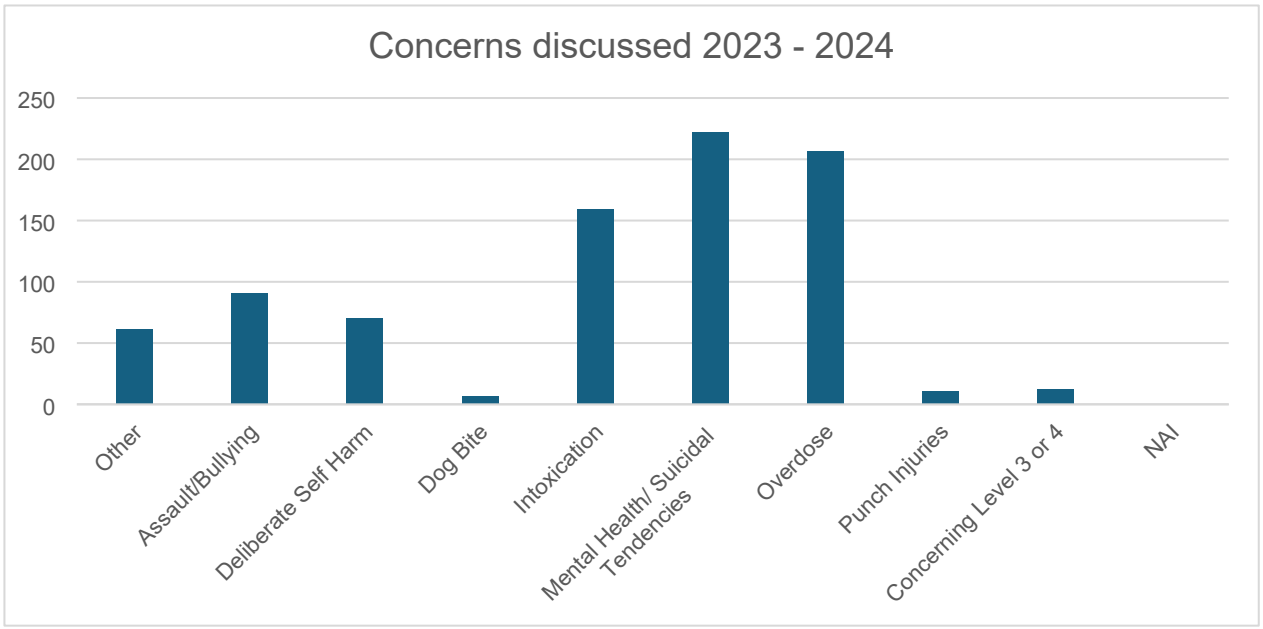


Figure 14

The increasing impact of children seen in the Emergency Department or Children's areas with mental health concerns and discussed in the risk meeting can be viewed over five years.

However, whilst the chart suggests numbers have fallen this is a false positive. The large numbers of child presentations in 2023-2024 required that cases brought to the weekly risk forum were triaged; those where there is an identified care plan and oversight of CAMHS colleagues are not presented to the meeting which allows the focus of discussions to be on cases that require further scrutiny.

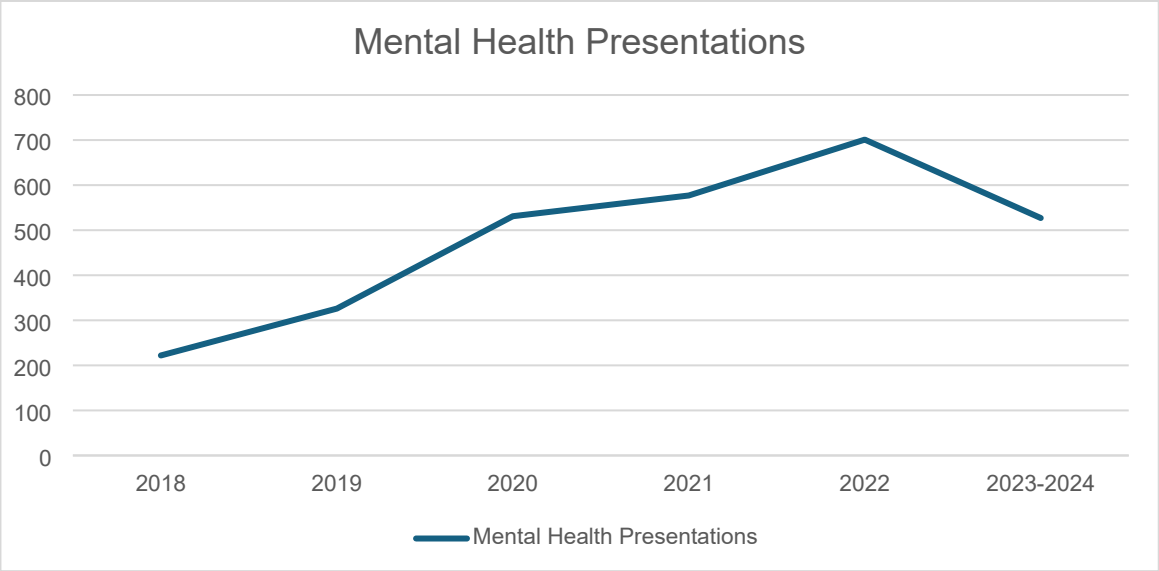


Figure 15

The picture is also with adolescents presenting with complex mental health and psychosocial needs being admitted to the Paediatric ward.

A total of 23 detentions under the Mental Health Act were for children, the largest proportion occurred in quarter 3

Children detained under the Mental Health Act at ESHT:
Financial Year 2023-2024 data
Conquest Hospital

Ward	Section 2	Section 3	Section 5	Total Inpatient
AAU	2	-	3	**5**
Cuckmere	-	-		**-**
Kipling	6	4	4	**14**
TOTAL	8	4	7	**19**

Eastbourne DGH

Ward	Section 2	Section 3	Section 5	Total Inpatient
AMU	2-	-	2	**4**
TOTAL	**2**	**-**	**2**	**4**

Section 136: Financial Year 2022-23 YOUNG PEOPLE

	Conquest	EDGH
Taken to ED under s136	12	9
Assessed under s136 at ED	8	6

9.2 Adult Mental Health Presentations

Similar to Paediatric Mental Health Presentations, adult detentions under the mental health act have remained high (figure 16), this is predominantly sections 2 and 5 with section 3 remaining stable. Patients have been noted to have increasingly complex presentations and are often awaiting the appropriate in-patient destination.

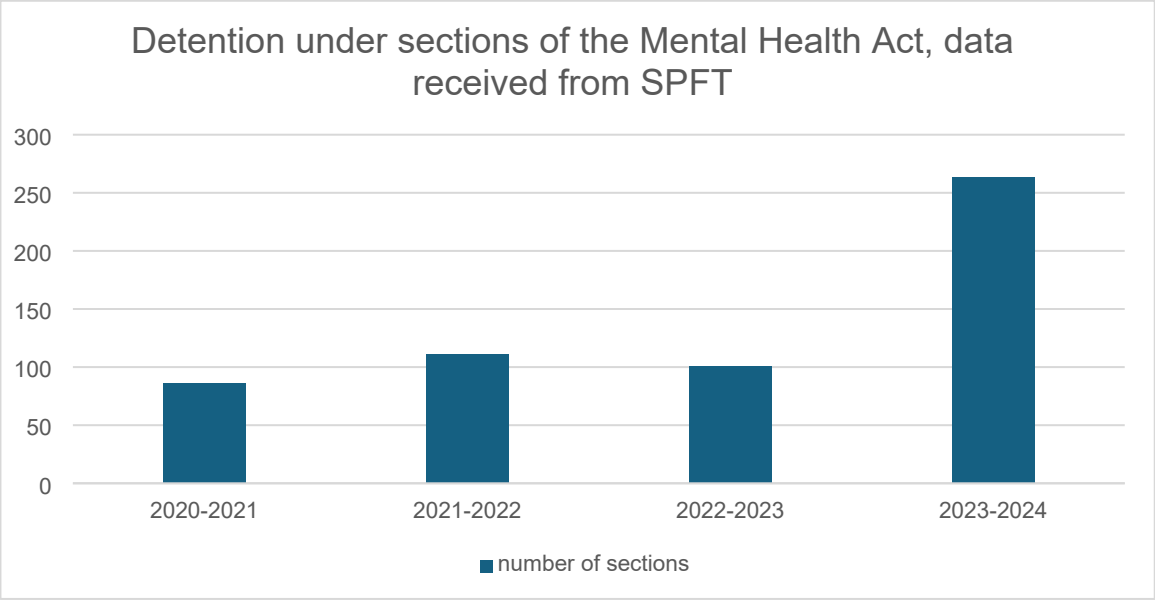


Figure 16

The numbers of section 136 detentions, in which the Police bring people to the Emergency Department when alternatives are unavailable, are similar to the previous year.

Section 136: Financial Year 2022-23 ADULTS

	Conquest	EDGH
Taken to ED under s136	80	153
Assessed under s136 at ED	69	98

9.3. Actions

The Chief Nurse continues to raise this issue at system and regional levels.

- Head of Safeguarding is part of a Sussex Wide multi-agency forums that consider a strategic understanding of mental ill health presentations.
- As part of the shared delivery plan there is now a MHLDA board with ESHT attendance.

9.4 The Mental Health Act – ESHT Duties

There continues to be a service level agreement with Sussex Partnership NHS Foundation Trust (SPFT) to enable the Trust to meet its legal requirements and ensure patients admitted to inpatient beds have their rights protected and their mental health care needs are met by a Responsible mental health clinician.

10. Learning Disabilities Safeguarding

It is known that people with a learning disability can have high levels of health needs that can at times go unrecognised and untreated and it is evidenced that it can be problematic for people with a learning disability to access a hospital setting and support may be required to ensure that individual patient needs are met effectively.

The Trust is in a fortunate position of having an Acute Learning Disability Liaison Nurse in post, which is tri- funded by SPFT, the ICB and ESHT.

The Trust is fortunate to have Learning Disability MDTs across both sites of Conquest and EDGH, which the Acute Learning Disability Liaison Nurse is actively part of. Joint working with all agencies including the Community Learning Disability Team, Adult Social Care and Sussex LeDeR (Learning from the Lives and Deaths of People with a Learning Disability and Autism) remains an important aspect of the role in particular with LeDeR, highlighting the improvement needs and good practice within the Trust.

11. Safeguarding Training

ESHT Safeguarding have continued to provide training through the ‘Think Family’ model, originally developed in 2020, and which combines both adults and children’s level 3 into a holistic, all age offer. The training was updated toward the end of 2023 and comprises an e-learning package, developed by the team, followed by a facilitated workshop to enable more interactive discussions.

The training incorporates current safeguarding themes and trends both locally and nationally and continues to be positively received and well evaluated. Sessions are

available for staff on a weekly basis, with one session a month facilitated as a face-to-face option.

Training around the Mental Capacity Act and Deprivation of Liberty Safeguards is provided as a separate offer.

11.1 Actions going forward.

- The Think Family training is continually refreshed in accordance with current themes and trends.
- Training will comply with the Intercollegiate guidance and thus will continue as a blended version.

Safeguarding Training compliance

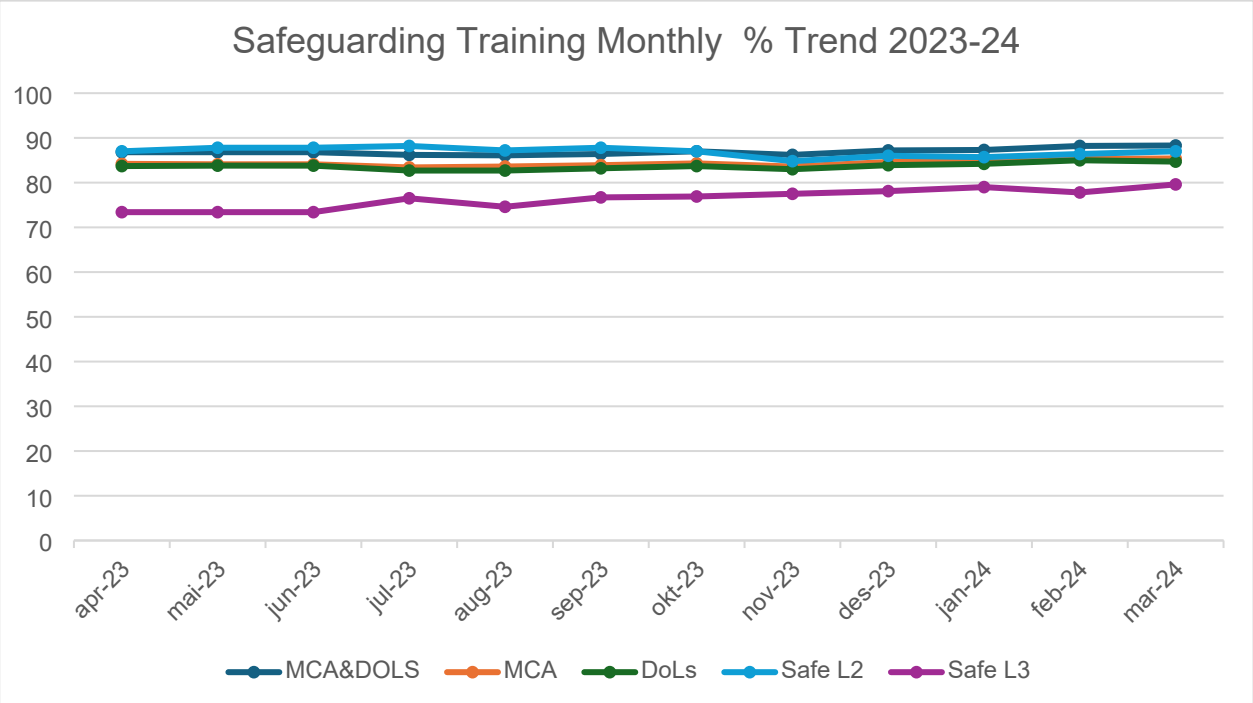


Figure 17

12. Safeguarding Summary

2023-2024 has seen some positive safeguarding work evidenced within the organisation with the embedding of domestic abuse screening within the Emergency Departments, huddles within Urgent care and further organisational work to develop understanding of the Mental Capacity Act.

Additionally, Children's Specialists have worked to develop work streams around child neglect and transitional safeguarding.

Safeguarding data collection has improved over the last year which has again demonstrated high numbers of safeguarding challenges across the ages. Furthermore, the presentation of safeguarding concerns is often multi-factorial and complex.

Data received from SPFT has evidenced the high number of patient's both children and adults being cared for with mental ill health issues and those patients under section are shown as a large increase.

The Safeguarding Think family training programme was refreshed and updated in 2023-2024

The team have remained passionate and professional continuing to support and advise all clinical areas in addition to driving forward the Think family agenda.

PART 2

Children in Care

Children in Care, Introduction

The 2023/24 Annual Report seeks to demonstrate and give assurance as to how East Sussex Healthcare Trust (ESHT) is committed to ensuring that all Children in Care (CIC) receive the highest quality and effective medical and nursing health care that reflects statutory regulations and the intercollegiate guidance.

The aim of the report is to provide assurance to the Trust and Integrated Care Board (ICB) on the progress made against the 2023/24 priorities, the service specification Key Performance Indicators (KPI's), and will also explore challenges faced by the team as well as celebrating its successes.

13. Demographics and staffing

Number for 'CLA starting during the year by characteristics - LA' for All children taken into care and Unaccompanied asylum-seeking children in Brighton and Hove, East Sussex and West Sussex between 2020 and 2023

	Taken into care				Unaccompanied asylum-seeking children			
	All children taken into care							
	2020	2021	2022	2023	2020	2021	2022	2023
Brighton and Hove	79	60	49	44	22	29	25	38
East Sussex	86	91	100	101	23	40	51	64
West Sussex	172	199	155	153	73	54	112	78

ESHT had a decrease of 11 CIC in East Sussex in 23-24 from 22-23, decreasing from 666 in March 2023 to 655 in April 2024. The current number of East Sussex CIC therefore adheres to the intercollegiate requirement of 1WTE nurse per 100 CIC with 6.6 WTE Band 7 Nurses currently in post.

However, additionally there are a number of children who are placed in East Sussex from other areas. Analysis of this cohort described as Other Local Authority (OLA) CIC placed in East Sussex. evidence ESHT Specialist Nurses completed 140 Review Health Assessments (RHA's) for this group in year 2023-24. This represents a figure that is significantly higher than neighbouring trusts; 41 and 30 in West Sussex and Brighton respectively as per NHS Sussex March 2024 data.

Commissioning received from NHS England received via Low Volume Activity (LVA) for OLA RHA's proportionate to 1.4 WTE Band 7 Nurse's as per intercollegiate requirement.

During the period 2023-2024 there have been some staffing challenges. A CIC Band 3 Administrator 0.55 WTE left the service in January 2024, temporary work force administrators were utilised during the recruitment process which spanned until the end of 2023/4 financial year. Additionally, the CIC Named Nurse 0.4 WTE led the service independently from March 2023 until August 2023 following the retirement of the Service Manager. A decision was made jointly with the W&C division to recruit a 0.6 WTE Named Nurse to ensure full time managerial and clinical oversight. The existing postholder, however, then retired and the new CIC Named Nurse has increased her hours to 0.8 over five days.

In summary, the medical and nursing workforce has been unstable at times during the year due to vacancies and recruitment processes. The team are confident we now have a period of stability, in all areas of the workforce.

Historically the Children in Care nursing team has straddled both the corporate and Women's and Children's division, in 2023 the team were moved to sit alongside the Safeguarding Team which mirrors the structure within the ICB and other areas. Ongoing work continues to be undertaken to ensure robust governance structures and that existing positive interface with the Women's and Children's division continues.

14. Quality

During the reporting year all East Sussex children and young people were allocated to individual specialist nurse caseloads at the point of entry to care. Having a named specialist nurse enables the potential of a meaningful relationship to develop between the child/young person and their specialist nurse throughout their time in care. Contacts and visits are offered, as required, based on the nurse's clinical decision and in partnership with the child/carer allowing the nurses to work creatively.

Meaningful Service user feedback has been captured this year via ESHT feedback and ICB feedback forum
Have Your Say - Children In Care & Care Leavers | Sussex Health and Care Your Say (engagementhq.com).

Quality Assurance Dip Sampling of RHAs completed by the specialist nurses and the Named Nurse throughout the year, analysis is included in the report.

15. Service Development and key achievements

15.1 Work has continued to increase compliance with our KPIs in ensuring that statutory Initial Health Assessments (IHA's) and RHA's are a positive and valuable experience, written in child/person centered way using plain English, enabling the child/young person to understand the report, to contribute to building a positive relationship and improve the experience for the children and young people we care for.

- Implementation of a new RHA template on SystmOne in January 2024 streamlining with Sussex to enhance information sharing Pan Sussex.

15.2 Deep data cleanse and process reviews completed. The outcome of which was revised data results for Q1, 2 and 3 reflecting accurate data and clear processes for Specialist Nurses and Administrators to follow.

15.3 Collaborative interagency working between ESHT and East Sussex County Council (ESCC) Children's Services Department (CSD) at management level to build relationships, fluid interagency working, review of processes strengths and challenges and increase KPI's. Named Nurse attends quarterly CSD CIC management meetings.

15.4 Strategic planning with ESHT, ESCC and the ICB of implementation and embedding of rolling consent for all CIC and young people to enable implementation of Nurse led case management model. The CIC team have contributed to steering and working

groups regarding processes, devised wait lists and ensured access to CSD electronic records, this is ongoing.

15.5 Review of roles and responsibilities within CIC team. Allocation tool reviewed, changed and moved to the responsibility of allocation to the Administration team thus freeing responsibility from Duty CIC Nurse. This is ongoing.

- Responsibility of Duty rota transferred to CIC Business Administrator.

15.6 Introduction of champion roles within the ESHT CIC team for; Unaccompanied Asylum-Seeking Children (UASC), LACAMHS, Health Visiting and under 5s, Neurodiversity, LGTBQ+, Women's network, Well-being, Immunisations, Sexual Health and SystmOne to promote interagency working, communication, facilitating optimum and speedy service delivery for our young people which in turn, should improve outcomes.

15.7 Preparatory work to establish UASC IHA clinics within the acute settings on a one stop shop basis. Agreed location, blood sampling, medication in one stop shop. Recruitment of Doctors completed. Provisional start date of July 2024.

15.8 Further work to consider the implementation of 3-month reviews for UASC IHAs with focus on 5 main areas: Immunisations, sexual health, sleep hygiene, vitamins (Multi and Vit D) and mental health. Review form devised and approved on SystmOne with activity code to allow drawing and analysis of data. To commence in unison with implementation of UASC clinics.

15.9 94.3% of IHAs were completed within timescale when considering exception reporting not within ESHT control, Majority of breaches are due to external factors specifically; missing data, late notification, cancellations by Social Worker/Foster Carer and batched requests

15.10 94.5% of own Local Authority Review Health Assessments (RHAs) in over 5s and 92% under 5s completed within timescale when considering exception reporting not within ESHT control. Majority of breaches are due to external factors specifically missing data and late notification

15.11 Liaison between ESHT and ESCC at management level to build relationships and fluid interagency collaborative working

15.12 Zero IHA's of East Sussex County Council (ESCC) placed Out of Area (OOAs) commissioned to other areas in Q4 indicating either few young people being placed out and/or ESHT Doctors completing OOAs.

15.14 13 x RHAs of ESCC placed OOAs commissioned to other areas indicating either few young people being placed out, ESHT Nurses completing OOAs or inaccurate data. This is of particular significance when comparing the level of OLA RHAs completed by ESHT Nurses.

16. Performance

16.1 Initial Health Assessments (IHA)

These are completed within ESHT by Paediatricians when a child enters the care of the local authority. For the period 2023-2024 200 were completed comprising 172 pertaining to children under the care of East Sussex County Council and a further 28 other local authority.

Promoting the health of Looked After Children Statutory guidance states that IHAs reports should be distributed within 20 working days from the day the child enters care to the day the health plan is distributed to a child's social worker. ESCC have a KPI to ensure the IHA referral/consent paperwork is sent to ESHT within 4 working days of the child entering care, and ESHT has a KPI of 16 working days to complete and return the IHA to the Local Authority.

All data is manually tracked and cross checked with the SystmOne database. Data is now more robust, but because children in care are highly mobile the data is not always reliable. The manual tracking of data is time consuming and takes a high proportion of Clinical Service Manager, Named Nurse and admin time.

All requests for IHA are triaged by the Named Doctor. Specialty Doctors are employed to offer 18 clinics over a 4-week rota; All IHAs are offered a face-to-face appointment, and an interpreter was present for all Unaccompanied Asylum-Seeking Children appointments.

16.1.1 Initial Health Assessment Data

Month Ending	IHAs Completed (own local authority) Number of IHAs for ESCC CiC placed in county. Completed (Report distributed in month)	IHAs completed and distributed within 16 working days of referral (own local authority)	IHAs completed and distributed within 16 working days of referral (%) (own local authority) ***(With ALL exceptions removed not within ESHT control)***	IHAs commissioned by ESCC IHA (OOA). *(Only include in the month that the report has been distributed, not month requested)*	IHAs declined by child	IHA's requested by other local authority (OLA)	IHA's completed for other local authority (Only include in the month that the report has been distributed, not month requested)
	Number	Number (%)	Number (%)	Number	Number	Number	Number
April	10	2 (20%)	5 (50%)	2	0	2	4
May	20	13 (65%)	20 (100%)	4	0	5	2
June	17	6 (35%)	16 (94%)	5	0	7	1
Total	**47**	**40%**	**81%**	**11**	**0**	**14**	**7**
July	13	10 (77%)	13 (100%)	3	0	4	2
Aug	19	14 (74%)	18 (95%)	4	0	5	3

Sept	18	6 (33%)	17 (94%)	1	0	5	4
Total	**50**	**61%**	**96%**	**8**	**0**	**14**	**9**
Oct	11	6 (55%)	11 (100%)	2	0	4	3
Nov	20	12 (60%)	20 (100%)	2	0	10	1
Dec	13	10 (77%)	13 (100%)	0	0	3	4
Total	**44**	**64%**	**100%**	**4**	**0**	**17**	**8**
Jan	10	9 (90%)	10 (100%)	0	0	6	1
Feb	9	7 (78%)	9 (100%)	0	0	2	3
March	12	8 (67%)	12 (100%)	0	0	5	0
Total	**31**	**78%**	**100%**	**0**	**0**	**13**	**4**
Year Total	**172**	**103 (60.)%**	**164 (95%)**	**33**	**0**	**58**	**28**

16.2 Review Health Assessments (RHA)

RHA are undertaken by the Specialist Children in Care Nurses, the frequency of which is determined by the child's age. For the period 2023-2024 the Specialist Nurses completed a total of 523 RHAs, comprising 383 that pertained to children cared for by ESCC and a further 140 placed by other local authorities.

Additionally, 13 ESCC were placed out of the area and their assessments were commissioned to be delivered by another provider (OOA).

The Specialist Nurses also compiled Leaving Care Health Summaries for 16–18-year-olds. 62 completed of reported 264 due.

16.2.1 Under 5 years Bi-annual Review Health Assessments

Month	RHAs due in month (own local authority)	RHAs completed (own local authority)	RHAs of those completed number distributed within statutory timescale (own local authority)	RHAs of those completed percentage distributed within statutory timescale (own local authority) With ALL exceptions removed not within ESHT control	RHAs commissioned to be delivered by another provider	RHAs requested by other local authority	RHAs completed for other local authority
	Number	Number	Number (%)	Number (%)	Number	Number	Number
April	7	8	5 (43%)	7 (86%)	0	2	5
May	4	7	5 (71%)	6 (86%)	0	7	4
June	9	2	1 (50%)	1 (50%)	0	2	3
Total	**20**	**17**	**55%**	**74%**	**0**	**11**	**12**
July	7	3	2 (67%)	3 (100%)	0	2	5
Aug	6	3	0 (0%)	3 (100%)	0	0	1
Sept	8	6	5 (83%)	6 (100%)	1	0	1

Total	**21**	**12**	**50%**	**100%**	**1**	**2**	**7**
Oct	7	6	5 (83%)	6 (100%)	0	1	0
Nov	4	13	6 (46%)	13 (100%)	1	2	2
Dec	2	7	4 (57%)	7 (100%)	0	3	1
Total	**13**	**26**	**62%**	**100%**	**1**	**6**	**3**
Jan	6	5	3 (60%)	5 (100%)	0	1	5
Feb	3	11	3 (27%)	11 (100%)	0	2	3
March	4	6	4 (67%)	5 (83%)	1	0	1
Total	**13**	**22**	**51%**	**94%**	**1**	**3**	**9**
Year Total	**67**	**77**	**40 (52%)**	**73 (95%)**	**3**	**22**	**31**

16.2.2 Over 5 years Annual Review Health Assessments

Month	RHAs due in month (own local authority)	RHAs completed (own local authority)	RHAs of those completed number distributed within statutory timescale (own local authority)	RHAs of those completed percentage distributed within statutory timescale (own local authority) With ALL exceptions removed not within ESHT control	RHAs commissioned to be delivered by another provider	RHAs declined (own local authority)	RHAs requested by other local authority	RHAs completed for other local authority
	Number	Number	Number (%)	Number (%)	Number	Number	Number	Number
April	22	25	17 (68%)	23 (92%)	1	11 (x9 SOP criteria not met and x2 no consent)	4	6
May	15	22	9 (41%)	17 (77%)	0	7 (x6 SOP criteria not met and x1 no consent)	9	9
June	20	27	19 (70%)	25 (93%)	1	1 (SOP criteria not met)	6	8
Total	**57**	**74**	**45 (61%)**	**65 (88%)**	**2**	**19**	**19**	**23**
July	23	23	14 (61%)	23 (100%)	0	3 (x1 SOP criteria not met and x2	5	9

						no consent)		
Aug	14	20	8 (40%)	17 (85%)	3	0	6	8
Sept	17	24	14 (58%)	24 (100%)	0	4 (x3 SOP criteria not met and x1 no consent)	10	7
Total	**54**	**67**	**36 (54%)**	**64 (96%)**	**3**	**7**	**21**	**24**
Oct	15	27	19 (70%)	27 (100%)	1	3 (No consent)	5	9
Nov	16	27	18 (67%)	25 (93%)	0	1 (SOP criteria not met)	12	12
Dec	9	27	15 (56%)	26 (96%)	2	3 (No consent)	9	13
Total	**40**	**81**	**52 (64%)**	**78 (96%)**	**3**	**7**	**26**	**34**
Jan	12	34	20 (59%)	34 (100%)	2	2 (No consent)	5	8
Feb	12	28	23 (82%)	28 (100%)	0	0	6	8
March	10	22	19 (86%)	22 (100%)	0	0	3	12
Total	**36**	**84**	**76%**	**100%**	**2**	**2**	**14**	**28**
Year Total	**187**	**306**	**195 (64%)**	**291 (95%)**	**10**	**35**	**80**	**109**

15.2.3 Leaving Care Health Summaries for 16–18-year-olds

Month	Number of Young People reaching 18	Number completed	Comments
April	13	6	
May	21	5	
June	17	5	
Q1 Total	**51**	**16**	
July	23	5	
August	25	5	
September	30	8	
Q2 Total	**75**	**13**	
October	23	3	
November	14	6	
December	31	5	
Q3 Total	**68**	**14**	
January	20	8	
February	25	6	
March	25	5	
Q4 Total	**70**	**19**	
YEAR TOTAL	**264**	**62**	

16.3 Quality Assurance of health assessments

Both initial and review health assessments are quality assured by the Named professionals through a process of dip-sampling.

16.3.1 Initial Health Assessments, dip sampled by Named Doctors

Number of Initial Health Assessments Dip Sampled by the Named Doctor amounted to a total of 55 last year

Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar
2 Vacant Posts	Recruited 1 new speciality doctor	Interviewed 2 new doctors	Inductions and training for LAC

16.3.2 Number of Review Health Assessments Dip Sampled by the Named Nurse (10 per quarter

Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar
0 due to nil NN capacity following reduction of NN hours to 0.4 WTE	10	10	10

17. Adoption

Adoptions are legally regulated by the Adoption and Children Act 2002 and the Statutory Guidance on Adoption (DE 2013). The Department for Education, previously known as the Department for Children, Schools, and Families (DCFS) has the overall responsibility. In the period 2023-2024 when an Adoption order has been granted a new NHS number was issued and the Child Health Information Service (CHIS) created a new record. There has been ongoing work at a national level to advocate that adopted children keep their original NHS number, the outcome of this work being published in spring 2024. ESHT are working towards updating the Standard Operating Procedure for Adoption & NHS Number Change (Electronic Record Keeping SystmOne)

Number of Adoption medical requests, PAM meeting and Adult Health Report 2023-2024

	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar
Adoption Medical request	19	9	21	13
PAM meeting	5	4	2	4
Adult Health Report	29	20	12	8
Total	43	33	35	25

18. Voice of the child

The ethos of the Children in Care team advocates that the voice of Children in Care should shape service provision and be at the heart of everything the team does; the team therefore works hard to gather feedback from service users and adapt practice to meet their needs. Care leavers are now routinely involved with CIC nurse interviews and are always on the interview panel. This has been well received by the applicants who come to the interview.

The previous Named Nurse facilitated the Young Healthwatch East Sussex (YHWES) in late 2022. The objective was to engage with young people (aged 11 to 19) in foster care in East Sussex, to inform how ESHT could improve the Review Health Assessments for young people in care.

18.1 Context

Young people in foster care in East Sussex (aged 5 to 18) are offered a Review Health Assessment (RHA) every 12 months by the Children in Care nursing team. This assessment allows young people to speak with a specialist nurse to identify any physical, emotional, social or mental health needs the young person may have, and to set health actions and goals for the next 12 months.

The nursing team, who are responsible for conducting the reviews in East Sussex, informed Young Healthwatch that many of the young people they encounter appeared disengaged with the process and perceived its only purpose was to 'weigh and measure' them.

The team wanted to establish, in more detail, how the young people felt about the RHA's current format, and what staff could do to make the experiences more personal and helpful.

The young volunteers worked with the previous Named Nurse to co-design a 15-question online survey, incorporating a mix of qualitative and quantitative questions. The purpose was to enable young people in care to provide information about their experiences of having a Review Health Assessments, with the aim of improving their experience.

Results of the survey are available in Appendix 2.

19. Children in Care Training

Level 3 CIC is now an e-learning package, allowing for more staff to join. As with Level 2 e learning there are 5 questions at the end of each section, which must be answered correctly in order to move onto the next section. This gives assurance that knowledge had increased at the end of the e-learning. The level 1 leaflet has a question added at the end for staff to demonstrate an increase in knowledge after reading the leaflet. All CIC training at level 1,2 and 3 is offered on a 3 yearly update.

Figures for April 23 – Mar 24

Level	Q1	Q2	Q3	Q4
Level 1	Unavailable to new Named Nurse	80.8%	71.4%	84.8%

Level 2	Unavailable to new Named Nurse	86%	91.5%	87.2%
Level 3	Unavailable to new Named Nurse	71%	71.9%	71.9%

20. Summary and conclusion

In conclusion 2023/24 commenced with some instability for ESHT Children in Care medical and nursing Team. This has, however, improved. Despite this, staff have risen to the challenge of completing RHA in timescales by working additional hours or accruing TOIL to complete the RHAs in timescales when required. All ESHT children 0 -19 years have been allocated to individual specialist nurse caseloads so the children can form meaningful relationships with their specialist nurse throughout their time in care, and this model is now well embedded and favorably received from staff.

In addition, work has continued around ensuring that statutory health assessments are a positive, person centred and valuable experience, written in child centred and accessible language which is all helping to build positive relationships and improve the experience for the children we care for. A deep data cleanse has provided accurate data evidencing a high level of ESCC and OLA work by both medical and nursing teams. In addition, the team have been open to changes to explore and improve the service assisting in working groups and implementation of changes in practice. All areas identified as in need of improvement such as medical notes for transgender young people, OOA and OLA data have been assessed and added to the coming years' service development plan.

PART 3

Challenges going forward

Summary

Conclusion

Appendix

21. Challenges and Actions Going Forward

21.1 Trauma Informed Care

The presentation of patients with complex needs across the Safeguarding Spectrum can at times be attributed to a trauma history. “Trauma results from an **event**, series of events, or set of circumstances **experienced** by an individual as physically or emotionally harmful or life-threatening with lasting adverse **effects** on a person’s functioning and mental, physical, social, emotional, or spiritual wellbeing” (SAMHSA, 2014)
Patient’s that have experienced Adverse Childhood experiences have been shown by some research to be at greater risk of some physical ill health diagnosis in adult hood. Whilst the Think Family Training introduces the concept of Trauma Informed Care the challenge in 2024-2025 is to enhance training in this area.

Actions

- Consideration to the development of training that informs a trauma informed culture.

21.2 Self-Neglect/Neglect

The Safeguarding Adults Board describes that Self-neglect covers a wide range of situations and behaviours. It can be linked to numerous factors including:

- physical health problems,
- mental health problems,
- substance misuse,
- psychological and social factors,
- diminished social networks,
- personality traits,
- traumatic histories and life-changing events.

Within ESHT Self- Neglect presentations have remained high across all areas. This is also mirrored within Children’s Safeguarding were work in ongoing to develop training around the neglect protocol.

Actions

- Ongoing work to develop a child neglect forum
- Establish an adult self-neglect forum

21.3 Domestic Abuse

East Sussex continues to be an area within which there are high numbers of Domestic Homicide Reviews (DHR). Analysis of these has identified missed opportunities to discuss a person’s lived experience within health settings.
Work to embed the routine enquiry of Domestic Abuse within ESHT systems and processes has progressed significantly in 2023-2024 but further work to embed tools across all trust systems to support the routine enquiry of Domestic abuse needs to advance.

Action

- Embedding domestic abuse screening across all areas

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21.4 Mental Ill Health

The numbers of patients with mental ill health across all age groups, alongside their complexity and an increase in violence and aggression remains challenging within the organisation.

Action

- Joint work will continue with Sussex Partnership NHS Foundation Trust in 2023-2024 to enhance systems and consider pathways going forward.

21.5 Transitional Safeguarding

Children aged 16 plus are largely cared for in the adult in-patient areas, at times children with complex safeguarding needs may thus have limited Paediatric oversight.

Action

- Review and development of paediatric operational policy to consider paediatric outreach for vulnerable 16 and 17-year-olds admitted to adult wards.
- Discussion at ESHT Paediatric Consultant Forum planned for March 2024.
- Development of an MDT forum or similar, where this cohort of complex inpatients can be discussed with paediatric colleagues.
- Development of Transitional safeguarding operational guidance and pledge.
- Development of acute care plans for complex and vulnerable adolescents with repeat attendances, and operational guidance on implementation.

22. Children in Care Action plan

22.1 Improve distribution of Leaving care summaries

Action

Deep cleanse data and review the processes and activity codes

22.1.2 Ascertain accurate ‘out of area’(OOA) and other local authority (OLA) data

Action

Deep cleanse data and review the processes and activity codes

22.1.3 Develop a holistic approach with a one-stop initial health assessment clinics for unaccompanied asylum seekers (UASC) and Nurse follow up.

Action

Work with Women’s and Children’s and Core service to develop clinics.

- Children in Care Nurses to follow up UASC children 3 months after initial assessment.

22.1.4 Timely health assessment have been impacted by the consent processes historically.

Action
Working with the local authority to embed rolling consent alongside Nurse led caseload management.

22.1.5 Social, Difficulties Questionnaires (SDQs) are a tool to understanding the emotional wellbeing of children these are disseminated by the local authority, but the return is poor.

Action

- Work collaboratively to develop the use of SDQs

22.6 Currently there is no clear process for the management of clinical records in regard to transgender young people. It has been identified that children can approach primary care services and obtain a new NHS number linked to their preferred name and gender.

Action
This is being discussed at a national level and with the Sussex ICB locally, any direction from these working groups will need to be disseminated within ESHT.

23.Summary Statement

The Quality and Safety Committee and the Trust Board are asked to note the contents of this report and to continue to offer their support for what is an increasingly complex and challenging agenda.

Name: Gail Gowland Head of Safeguarding
Date: 31st July 2024

References

Intercollegiate Document: Safeguarding Children and Young People roles and competencies for healthcare staff (2014) Royal College of Paediatric and Child Health.

Intercollegiate Role Framework: Looked After Children Knowledge, Skill and Competences of Healthcare staff (March 2015) Royal College of Paediatric and Child Health

Adult Safeguarding: Roles and Competencies for Health Care Staff (First edition: August 2018) Royal College of Nursing

Mental Capacity Act 2005 and the Deprivation of Liberties Code of Practice https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

Equality Act (2010) HM Government

Working Together to Safeguard Children (2013,2015,2018) HM Government

Children Act (1984, 2004) HM Government

Care Act (2014) HM Government

The Modern Slavery Act (2015) HM Government

Isolated and struggling social isolation and the risk of child maltreatment, in lockdown and beyond Eleni Romanou and Emma Belton NSPCC Evidence team June 2020

COVID-19 adult safeguarding insight project - third report (December 2021) | Local Government Association

Safeguarding children, young people and adults at risk in the NHS, Safeguarding accountability and assurance framework

Appendix 1- Work Plan

Action Number	Source	Requirement	Action	Executive Lead	Responsible PERSON	Progress
1	Children Act 1989 and 2004 and the Care Act 2014	East Sussex Healthcare NHS Trust Safeguarding Team must ensure that it meets its statutory responsibilities identified within the Children Act 1989 and 2004 and the Care act 2014	Comply with the legislative guidance within the Safeguarding Acts and meet the statutory responsibilities training compliance all staff all settings Documentation of MCA processes in records	DON	Head of Safeguarding	
2	ESSCP Current Child Practice Reviews (CPR)	To undertake the ESSCP Child Practice review	To undertake any action as required by the ESSCP in relation to commissioned child practice reviews	DON	Named Nurse for children	
3	SAB SAAR	To undertake the SAB Safeguarding Adult Case reviews	Complete all actions to implement recommendations following publication	DON	Named Nurse for Adults	
4	SAB DHR	To undertake the Domestic Homicide Reviews	Complete all actions to implement recommendations following publication	DON	Named Nurse for Adults	
5	NHSE / NHS	To comply with the LD Improvement Standards for NHS Trusts (2018)	Baseline assessment and action plan to address any noncompliance's with LD standards to achieve ESHT compliance	DON	Specialist Nurse Learning Disability	
6	CQC / Safeguarding Legislation	Competent and trained workforce who are able to discharge their safeguarding responsibilities in line with the Safeguarding Roles and Responsibilities (Intercollegiate Documents)	All divisions to meet standards of compliance with training and remedial action plans in place to address any noncompliance	DON	Assistant Directors of Nursing April 2020	
7	CQC / Safeguarding Legislation	To ensure there is a competent and trained workforce who are able to discharge their safeguarding responsibilities in line with the Safeguarding Roles and Responsibilities (Intercollegiate Documents)	All divisions to meet standards of compliance with safeguarding supervision and remedial action plans in place to address any noncompliance	DON	Assistant Directors of Nursing April 2020	
8	Mental Health Act (2017)	To comply with the requirements set for acute NHS providers in relation to detained patients and staff competency	To comply with the legislative guidance within the Mental Health Act and meet the statutory responsibilities	DON	Deputy Chief Operating Officer	
9	Mental Health Act (2017)	To ensure the annual KP90 return is submitted for ESHT	Complete and submit the KP90 return annually	DON	Deputy Chief Nurse	
10	PREVENT Statutory Duty (s26 Counter-Terrorism and Security Act 2015) to safeguard	To meet the statutory requirement to promote the national PREVENT strategy at a local level throughout the NHS	Ensure that there is a nominated lead for PREVENT, staff are trained in PREVENT awareness and WRAP and that the quarterly PREVENT return is submitted for ESHT	DON	Head of Safeguarding	
11	Female Genital Mutilation (FGM) Statutory Duty to safeguard	To meet the statutory requirement to promote the national FGM strategy at a local level throughout the NHS	Ensure that there is a lead for FGM, staff receive training in FGM Awareness at the appropriate level, and the quarterly FGM return is submitted for ESHT	DON	Named Midwife	

Appendix 2- Child in Care survey

The survey contained a mix of qualitative and quantitative questions, keeping the survey simple and engaging, while still giving participants the chance to tell their views and
opinions in their own words.

Results as cited in East Sussex Healthwatch CIC Review Health Assessment Report May 2023;

Findings

A total of 19 young people in care completed the survey and using their answers we were able to identify several key themes and subsequent recommendations. Below is a summary of our findings.

When asked about their previous experiences having a Review Health Assessment, 68.4% (13) felt that the assessment was 'about them', focused on their needs, and felt generally confident about their experience. 100% (19) of participants stated that there wasn't anything they felt they couldn't talk to their nurse about during the assessment.

3 (15%) participants mentioned their nurse in a positive way, highlighting how important it is for young people to feel safe and comfortable talking to their nurse.

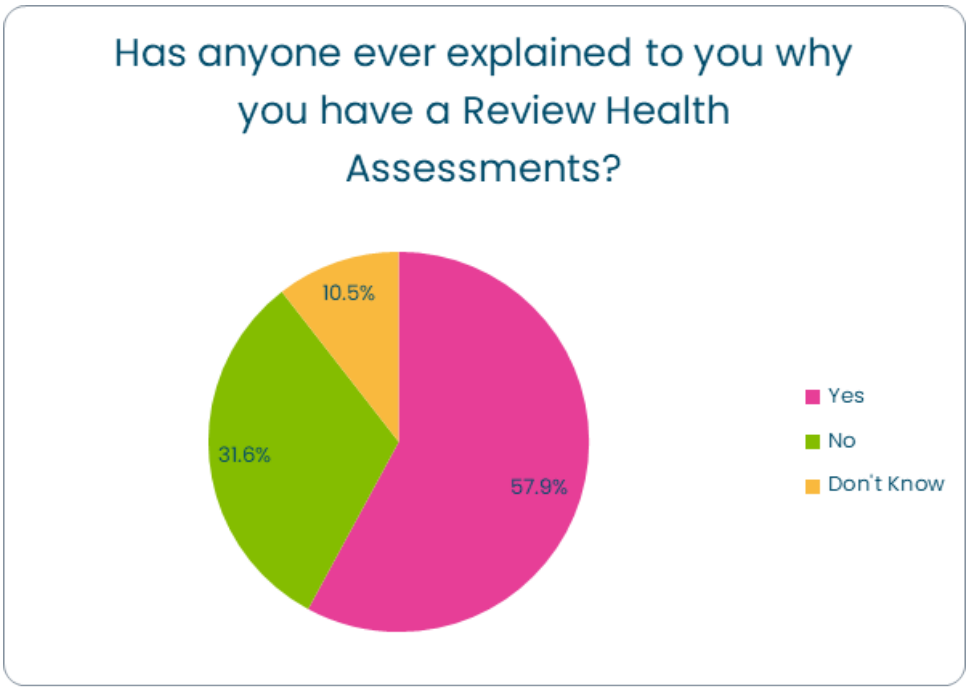
"Yes, I felt comfortable, the nurse was lovely."
"It was all okay I felt comfortable talking to the nurse."

Although mostly positive, not all young people felt their previous experiences of RHA's has been good. A further 3 (15%) participants stated that they felt anxious and/or overwhelmed by the experiences.

"I felt anxious to talk to the nurse and worried about them judging me."
"Anxious (because) she was someone I never had before."

When asked 'Overall, how would you rate your experience of having a Review Annual Health Assessment? (With 1 being very poor and 10 being excellent)' the most common answer given was 6 with the average (mean) answer being 6.9.

When asked if anyone had explained why they had a Review Health Assessment each year, just over half 11 (57.9%) answered Yes. Of those who answered Yes, 8 (72%) stated that it was their foster carer at the time who explained the reason why they had an RHA to them, not their nurse or social worker.



We asked participants if they remembered being weighed and measured during the RHA, and if they did, had anyone explained why they were being weighed and measured. **16 (84%)** participants remembered being weighed and measured, with **12 (75%)** of those stated that the reasoning behind this had been explained.

Although most of the participants understood the reasoning behind the need to be weighed and measured, one participant explained that their wish to not be told their height and weight had not been respected.

"Yes, they did explain why, but I asked not to know the weight and they told me when I told them not to and it made me very upset and broke my trust with them."

When asked if they were aware that they could decline to be weighed and measured, **73.6% (14)** said they did not know that they could decline.

When asked if they remembered agreeing to health actions/goals with their nurse at their last assessment, **53.7% (10)** did not remember if any actions or goals had been set.

79% (15) of participants stated that they had either never been given a copy of their health assessment notes, or that if they had, they did not remember being given them.

We then asked participants if they felt that being given a copy of their RHA notes would be helpful to them. The response was mixed, with **42.1% (8)** saying that they would like to have a copy, **36.8% (7)** saying they did not feel they didn't a copy, and **21.1% (4)** were unsure.

'What would a good/excellent Review Health Assessment look and feel like to you?'

- **(21%)** participants said that they would like to be able to choose to have their foster carer in the room with them.
- **(16%)** participants said they would have liked to be able to be alone with the nurse for the review.
- **(21%)** participants said that a friendly, kind nurse who listened was important to them.
- **2 (11%)** participants expressed desire to choose the topics spoken about during the review.
- **1 (5%)** participant felt that the review could be kept shorter and to the point.

'What does a bad Review Health Assessment look and feel like to you?'

- **3 (16%)** participants said that they did not like having the assessment at school or in a place that they had not been before.
- **6 (32%)** participants felt that not being able to control who was in the room made the experience worse.
- **1 (5%)** participant said that they didn't like being compared to others/the average when discussing height and weight with the nurse.
- **2 (11%)** participants said that nurses being 'rude' or 'rushing' them would make a bad experience.

Key Themes:

- It is important to young people in care to be in control of **who** is involved in their Review Health Assessment and **where** the assessment takes place.
- Young people in care want to **feel respected, listened to and empathised** with by their nurse.
- More could be done to inform young people in care on the **reasoning** behind the RHA's and **their right** to decline being assessed.

Recommendations:

1. Young people should be given the power to choose **who** they would like present during their Review Health Assessment. Before each RHA young people should be reminded that it is their choice who is there during the review, and this should be reiterated at the start of the RHA. This gives the young people a chance to consider their options

and decide without being rushed or pressured.

2. Young people should be given a choice about **where** their Review Health Assessment takes place. A comfortable, safe and known environment is likely to help young people to be more open and engaged during an RHA. This choice should be made clear to young people when they are booked in to have a Review Health Assessment.

3. Young people would benefit from being better informed about the reason for their Review Health Assessments and their right the decline. We suggest that a letter be sent to each young person prior to their RHA with a paragraph which briefly explains **why** the assessment is taking place, and how it is meant to support them. The letter should also explain that the RHA is optional, and that young people do have the power to decline the assessment, and **how** they can do so. We would also suggest that young people are contacted by phone to organise the RHA appointments time and place, as this makes the experience more personal.

4. The nursing team manager should ensure that relevant and appropriate training is available to all specialist nurses who facilitate the Review Health Assessments. These could include training around taking a **Person-Centred Approach** when working with young people and using a **Trauma Informed Approach**. These approaches could work particularly well when talking about **weight and height** with young people, which can be a sensitive and uncomfortable topic.

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	Trust Board	**Date of Meeting**	10th December 2024

Report Title:	Organ Donation Annual Report April 2023 to March 2024

Purpose of the Report/Outcome/ action requested:	Recognition of a patient's wishes regarding organ and tissue donation should form part of routine end of life care. This report provides details regarding organ donation activity at East Sussex Healthcare Trust for the period of April 2023 to March 2024 and is based on data provided by NHS Blood & Transplant who are the national organisation that oversees donation. The Board is asked to: 1. Note the organ donation committee will continue to oversee policy, education, and publicity to inform and support organ and tissue donation activity within East Sussex Healthcare NHS Trust. 2. Agree ongoing communications support for trust communications and social media content during national and local events such as Organ Donation Week and Eastbourne Airborne. 3. Support the organ donation committee in the installation of a memorial bench at Eastbourne District General Hospital, in line with the bench already in place by the lake at Conquest Hospital. This will provide a quiet space for reflection and remembrance for patients, relatives and staff.

Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐

Authority for Decision:	Trust Board

Executive Summary	**Actual & Potential Donors:** Within ESHT, between 1st April 2023 & 31st March 2024, there were 8 families who consented to donation. Seven patients proceeded as solid organ donors leading to 16 patients receiving transplants. In addition, 8 corneas were donated by 4 patients within the trust. The trust has again achieved 100% referral rates for donation after brainstem death and maintained the improvements seen in referral rates for donation after circulatory death achieved over the last 2 years. Specialist nurse presence when approaching families to discuss donation is deemed to represent best practice. Last year this was identified as an area for improvement by the organ donation committee. Since this work was undertaken, there has been a significant improvement in the rates of specialist nurse presence, increasing from 58% of patients eligible to donate following cardiac death to 88%. In association with this increase there was also an increase in the rate of consent to donation, up from 47% last year to 67% this year (UK average 61%). **Funding:** Since 2018, trusts have received financial support from NHS blood & transplant in 3 ways:

	- Donor recognition funding: which is based on the number of proceeding donors in the previous financial year and is intended to support future donation activity, - Funding for the clinical lead position: to provide clinical leadership for donation, & - Clinical Lead & Organ donation committee expenses. Donor recognition funding is not allocated until July at the earliest and the amount each trust receives is re-calculated each year. In 2023/24 ESHT received £4876 of donor recognition funding which was used to purchase new sofas for the ICU relatives' room at Eastbourne District General Hospital, refreshments for a memorial gathering at the organ donation bench at Conquest Hospital to mark the end of the organ donation week and also a stand at Eastbourne Airborne. **Organ Donation week:** To mark the end of organ donation week in September 2023, the organ donation committee arranged a non-denominational service of remembrance which was held at the remembrance bench at Conquest Hospital, with the families of local donors invited to attend. This was followed by refreshments in the atrium of the education centre. It is intended that the committee will fund a similar bench at Eastbourne, so that families local to Eastbourne have a place to reflect and remember their loved ones. A site has been identified and the committee are working with the estates team to ensure the suitability. **Research:** ESHT is enrolled as a research site for SIGNET – a national research study with the aim to examine the effect of a single dose of simvastatin given to consented, proceeding donors following neurological death on the outcome in cardiac recipients. This work is supported by the National Institute for Health Research. The study opened in 2022 and ESHT has enrolled 4 patients in the timeframe of this report.

Regulatory/legal requirement:	This report complies with Memorandum of Understanding between the trust & NHS Blood & Transplant Special Health Authority.
Business Plan Link:	Quality ☒ People ☐ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues had been taken into consideration
Resource Implication/VFM Statement:	Funding to support Organ Donation within ESHT provided directly from NHS Blood & Transplant. In the report year ESHT received £4876 for donor recognition funding and the role of Clinical Lead for Organ Donation is also externally funded.
Risk:	None identified

No of Pages	3	**Appendixes**	1
Name, position and contact details of author:	Dr Judith Highgate Clinical Lead for Organ Donation, Consultant ICU & Anaesthetics		
Report Sponsor	Dr Simon Merritt Medical Director	**Presenter:**	Dr Judith Highgate Clinical Lead for Organ Donation

Governance and Engagement pathway to date:	Organ Donation Committee 4th September 2024 & via email Clinical Excellence Group 23rd September 2024 Quality & Safety Committee 27th November 2024

What happens next?	The organ donation committee with continue to oversee policy, education and publicity to inform and support organ and tissue donation activity within ESHT and East Sussex.

Publication	For publication

Appendix: Organ Donation Annual Report 23/24

1. Introduction

1.1. Recognition of a patient's wishes regarding organ donation and discussion with nominated representatives was highlighted as part of End-of-Life Care Pathways in the Department of Health End of Life Care Strategy, published in 2008.

1.2. The ESHT organ donation committee oversees policy, education, and publicity to educate and support organ donation within ESHT and East Sussex.

2. Background

2.1. On the 31st March 2024 there were 7484 people on the active transplant list in the UK. Over the last year 418 patients in the UK have died whilst waiting for a transplant; 29 across the South East.

2.2. In 2008 the Organ Donation Taskforce published 'Organs for Transplants' which set recommendations with the target of increasing deceased donor rates. By 2013 donation rates had increased by 50% with a 30.5% increase in transplants.

2.3. In England following public consultation, the Organ Donation (Deemed Consent) Bill received Royal Assent on the 15th March 2019 and was passed into law on the 20th May 2020. This means that all competent adults who are freely resident in England for >1 year are now considered as potential donors unless they specifically chose to opt out or are excluded. Under the law donation will still be discussed with families to ensure that the most up to date individual wishes are known and respected. People are still able to register their decision – either to donate their organs or to decline donation, via the NHS organ donor register. On the 31st March 2024, 28 million people had registered their decision to opt-in to organ donation across the UK.

2.4. Organ Donation and Transplantation 2030: Meeting the Need is a 10-year vision for organ donation and transplantation rolled out by NHSBT since 2020 which takes in to account the introduction of 'opt-out' legislation and the impact of the COVID-19 pandemic. The aim of the strategy is to build on past success and deliver future improvements for the diverse populations across the UK, particularly addressing health inequalities in donation and transplantation.

3. Main content

3.1. NHS Blood & Transplant Report 1st April 2023 to 31st March 2024:

Summary:

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2023 - 31 March 2024

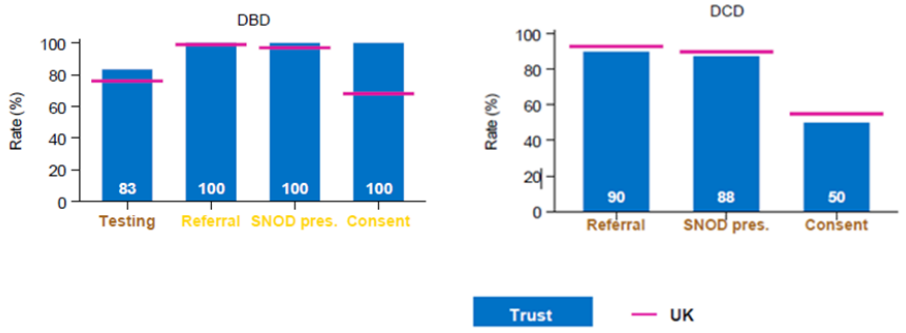


Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2019 - 31 March 2024

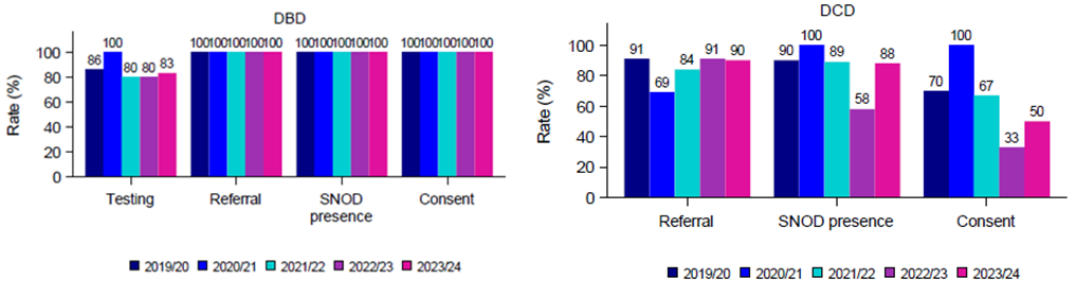


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2023 - 31 March 2024

	DBD Trust	DBD UK	DCD Trust	DCD UK	Deceased donors Trust	Deceased donors UK
Patients meeting organ donation referral criteria¹	6	2029	30	5331	34	6911
Referred to Organ Donation Service	6	2017	27	4949	31	6522
Referral rate %	G *100%*	*99%*	B *90%*	*93%*	B *91%*	*94%*
Neurological death tested	5	1534				
Testing rate %	B *83%*	*76%*				
Eligible donors²	4	1426	20	3635	24	5061
Family approached	4	1259	8	1849	12	3108
Family approached and SNOD present	4	1215	7	1672	11	2887
% of approaches where SNOD present	G *100%*	*97%*	B *88%*	*90%*	B *92%*	*93%*
Consent ascertained	4	858	4	1023	8	1881
Consent rate %	G *100%*	*68%*	B *50%*	*55%*	B *67%*	*61%*
- Expressed opt in	4	533	3	637	7	1170
- Expressed opt in %	*100%*	*95%*	*75%*	*85%*	*88%*	*89%*
- Deemed Consent	0	246	1	323	1	569
- Deemed Consent %	*N/A*	*58%*	*50%*	*47%*	*50%*	*51%*
- Other*	0	78	0	63	0	141
- Other %*	*N/A*	*52%*	*0%*	*34%*	*0%*	*42%*
Actual donors (PDA data)	4	788	3	710	7	1499
% of consented donors that became actual donors	*100%*	*92%*	*75%*	*69%*	*88%*	*80%*

¹ DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

² DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

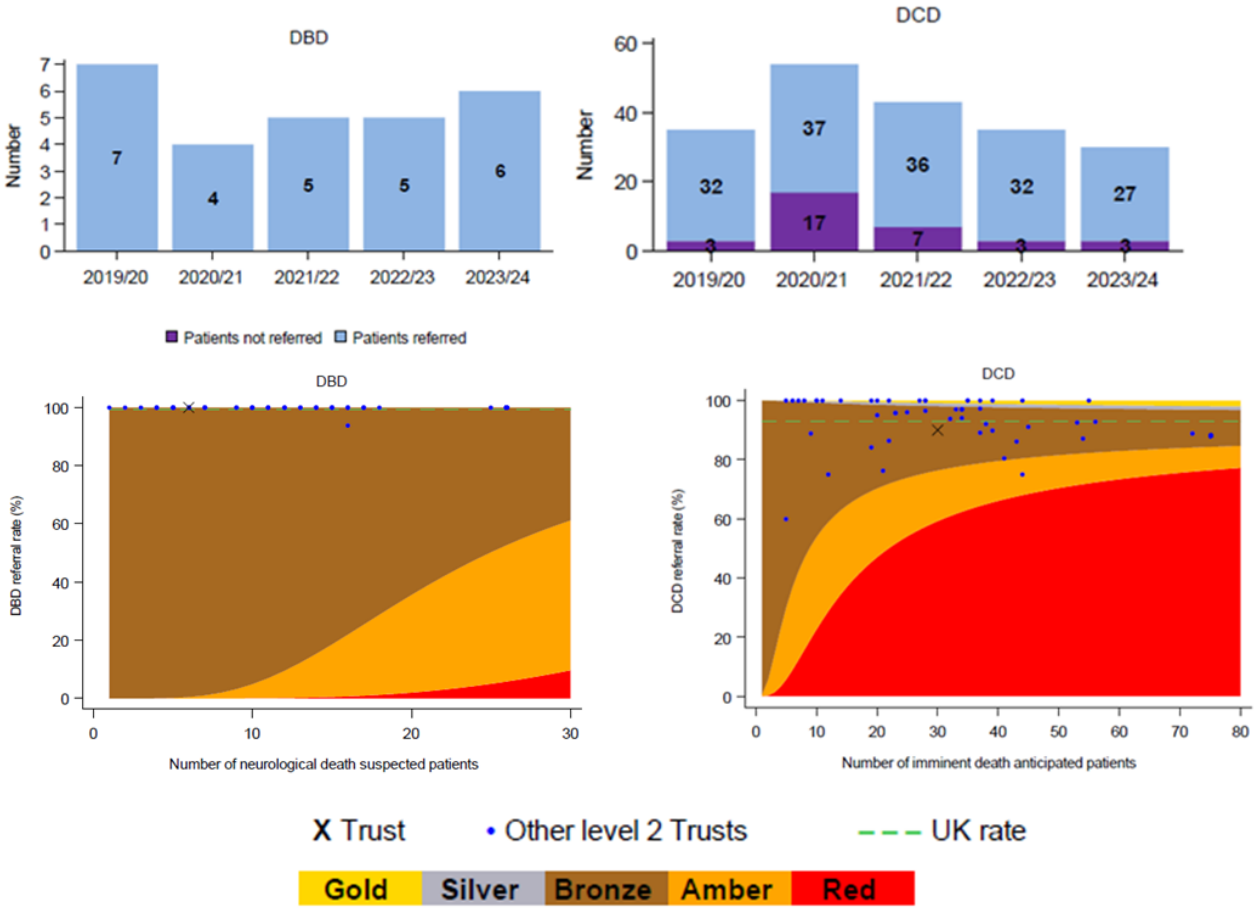
3.2. Referrals & Missed Opportunities:

3.2.1. Referrals:

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135 and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors.

Of 6 potential Donation after Brainstem Death (DBD) donors, all patients were referred to the Specialist Nurse for Organ Donation (SN-OD). Of these patients only 5 patients underwent neurological death tests with 1 patient not tested at the family's request. Of 30 potential Donation after Circulatory Death (DCD) donors, 27 patients were referred to the SN-OD and 8 families were approached regarding donation.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2019 - 31 March 2024



ESHT has been rated as excellent for potential DBD donors and average for referrals for potential DCD donors. Of the patients not referred, 2 were not considered and one family declined donation prior to a referral being made. The clinical lead and specialist nurse continue to provide training for ICU staff to raise awareness of organ donation with the aim of achieving 100% referrals.

3.2.2.Neurological Testing:

Goal: Neurological death tests are performed wherever possible.

Of 6 potential patients with suspected neurological death and potential for Donation after Brainstem Death, 5 patients underwent neurological testing and one did not undergo testing at the request of the patient's family.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2019 - 31 March 2024

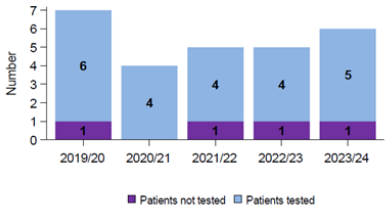
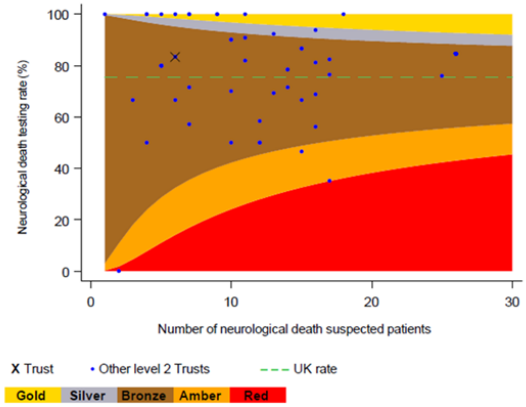


Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2023 - 31 March 2024



3.2.3.Specialist Nurse For Organ Donation presence:

Goal: A SNOD should be present during the formal family approach as per NICE CG135 and NHSBT Best Practice Guidance.

It has been determined that according to best practice a specialist nurse should be present when families are approached to discuss organ donation, to provide specialist support and answer any questions. In the previous report period ESHT had a significant drop in performance when compared with previous performance at ESHT and with other trusts of a similar size. Over the last year the reasons for this drop in performance were explored with the Critical Care teams and several interventions were trialled to attempt to improve specialist nurse presence, including a daily phone call to the nurse in charge of ICU and regular discussion of organ donation at ICU M&M meetings.

These interventions have seen a significant improvement in specialist nurse presence with an increase from 67% to 92%.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2019 - 31 March 2024

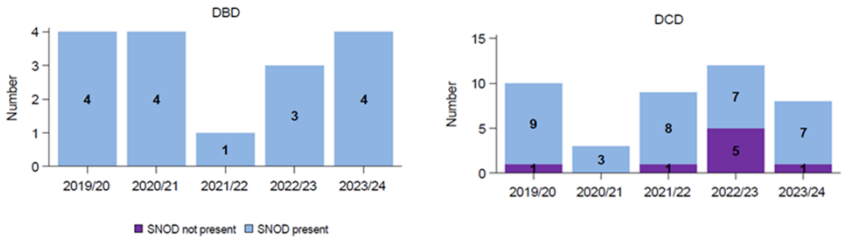
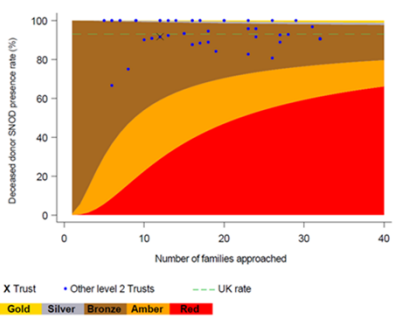


Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2023 - 31 March 2024



3.2.4.Consent:

The consent rate of families approached at ESHT this year was above the national average at 67% (national average 61%). While the number of families approached is low and therefore any change in percentage should be interpreted with caution, this increase would be consistent with findings from national research on consent rates when families are approached as an MDT that includes a specialist nurse from the organ donation team.

Figure 3.4 Number of families approached, 1 April 2019 - 31 March 2024

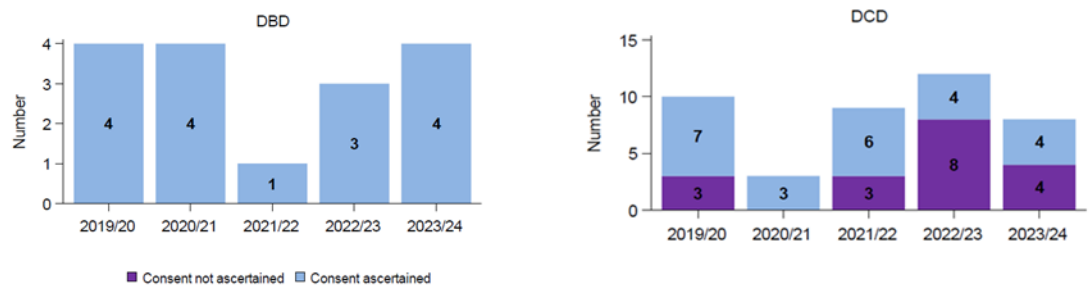
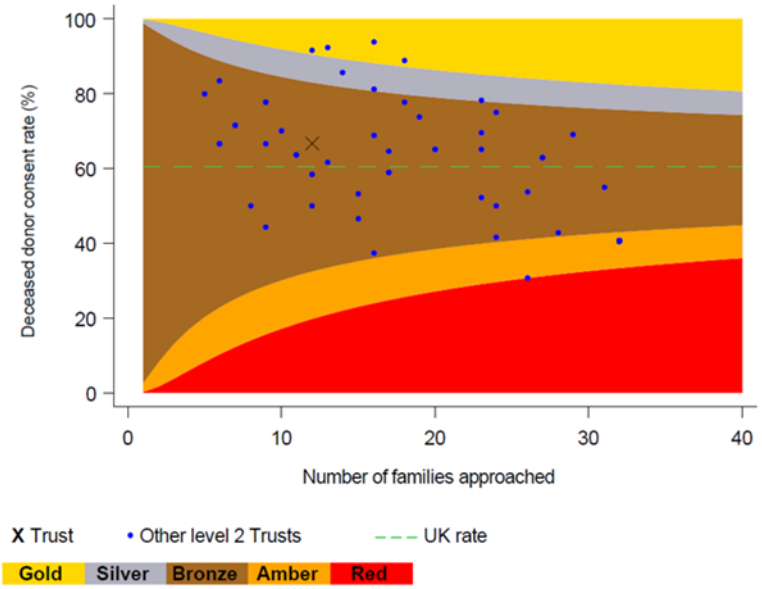


Figure 4.4 Funnel plot of consent rate, 1 April 2023 - 31 March 2024



3.2.5.Emergency Department:

Goal: No one dies in ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.

In 2023-24 there were 2 patients identified as potential donors from A&E across ESHT but not referred. This is an area that the organ donation committee will work with the ED teams to provide training and raise awareness amongst teams outside of ICU.

3.2.6.Tissue Donation:

Donated tissues such as skin, corneas, bone and heart valves can transform the lives of patients and lead to significant improvements in their quality of life. Unlike solid organ donation, where only approximately 1% of patients die in circumstances where solid organ donation can be considered, tissue donation can occur up to 48hours after death and almost anyone can be considered as a tissue donor. Over the last year, 24 potential donors have been referred to the tissue donation services with 4 proceeding donors, each donating 2 corneas. This is an area of practice that the organ donation committee is looking to expand awareness to ensure that all patients that would want to donate have the opportunity.

3.3. Training:

The organ donation team (SNOD & CLOD) have continued to undertake teaching and update sessions for ICU nursing & medical teams as well as Foundation Year 1 Doctors. Since January 2023, ICU has been holding a monthly teaching and M&M meeting and this has been an opportunity for regular updates on the outcome from proceeding donations. The aim of these updates is to raise awareness of the impact of actions taken within ESHT critical care on patients on transplant waiting lists at other trusts.

3.4. Finances:

Donor recognition funding is allocated to the trust by NHS blood & transplant with the intended benefit of raising awareness of organ donation and improving the environment and support provided to family members at an extremely difficult time. Historically it has helped fund decoration of the ICU relatives rooms & a “tea trolley” for use in theatres to provide refreshments to relatives while they remain with their loved ones.

In the last financial year, due to changes to the national process of allocating funds, these were not received until November 2023 and the amount of funding received has decreased to £4876 for the financial year 2023-24. Over the last financial year the organ donation committee utilised these funds to purchase new sofas for the ICU relatives room at EDGH, refreshments for the organ donation memorial gathering at Conquest and a stand at Eastbourne Airbourne to raise public awareness about organ donation.

3.5. Publicity:

Over the last few years we have had excellent collaboration between the organ donation committee, especially our lay member, and the hospital communications team. The communications team supported the committee with social media posts around organ donation week and during Eastbourne Airbourne, where the committee had a publicity stand.

To mark the end of organ donation week in September 2023, the organ donation committee arranged a non-denominational service of remembrance which was held at the remembrance bench at Conquest Hospital. Members of the committee, staff from ICU and the families of local donors were invited to attend. It is hoped that this will become a regular event to mark the end of National Organ Donation week each year.

Over the last year the team have also been endeavouring to identify a suitable site at Eastbourne for the installation of a similar memorial bench, so that families local to Eastbourne have a place to remember and reflect on their loved ones. The clinical lead and specialist nurse are in the process of liaising with the estates team to realise this project and it is hoped that a bench will be installed in the coming financial year.

4. Conclusions & Recommendations

4.1. ESHT has been categorised as a level 2 trust by NHS Blood & Transplant (NHSBT). This is based on the average number of donors proceeding each year and remains unchanged from the previous years.

4.2. Referral rates for patients suitable for donation have remained consistent over the last 3 years. Since interventions introduced by the organ donation committee, rates of specialist nurse presence and consent have increased and the local consent rate is now higher than the national average. The organ donation committee will continue this work, with the aim of achieving 100% referrals including from areas such as ED.

5. References

5.1. End of life care strategy (2008) Department of Health

5.2. Organs for Transplant – a report from the Organ Donation Taskforce (2008) Department of Health.

5.3. Taking Organ Transplantation to 2020. A UK strategy (2013) NHS Blood & Transplant & Department of Health.

5.4. Organ Donation and Transplantation 2030: Meeting the Need. A 10-year vision for organ donation and transplantation in the UK.

5.5. NICE Clinical Guidelines CG135, 2011

5.6. www.nhsbt.nhs.uk

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	ESHT Trust Board	**Date of Meeting**	10th December 2024
Report Title:	Guardians of Safe Working Hours Report		
Purpose of the Report/Outcome/ action requested:	The Board are asked to receive assurance that doctors are safely rostered across the organisation.		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☐ For Discussion ☐		
Authority for Decision:	Board		
Executive Summary	Our Guardians of Safe Working Hours ensure compliance with safe working hours by doctors and the Trust. The role helps to protect both patients and doctors by ensuring that colleagues-in-training are not working unsafe hours. The Guardians act as champions of safe working and receives exception reports, escalating any discrepancies as necessary to enable decisions and relevant actions to take place.		
Regulatory/legal requirement:	There is a regulatory requirement for Guardians to assure the Board that doctors are safely rostered across the Trust.		
Business Plan Link:	Quality ☐ People ☒ Sustainability ☐		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration.		
Resource Implication/VFM Statement:	There are no resource implications. Report is for assurance only.		
Risk:	No risks have been identified.		
No of Pages		**Appendixes**	None
Name, position and contact details of author:	Fraser Wiggins. Consultant in Anaesthetics and Intensive Care Medicine and Waleed Yousef. Consultant in Obstetrics and Gynaecology. Guardians of Safe Working Hours.		
Report Sponsor	Simon Merritt	**Presenter:**	
Governance and Engagement pathway to date:	The report was discussed at the POD meeting. 19th of September 2024.		
What happens next?	N/A		
Publication	May be published		

1. BACKGROUND

Following the recent Doctors and Dentist' Review Body (DDRB) revised offer to end the dispute for 2023/24 pay award, included a recommendation to the term "Junior Doctor" be known as Doctors and Dentists in Training (**Resident Doctors**). The pay award agreed 2023/24 4.05% uplift, 2024/25 uplift to each nodal point by 6% plus £1000 on a consolidated basis effective from 1 April 2024.

Pay for 2025/26 to consider the overall package and career progression for resident doctors to ensure medicine is still a rewarding career choice.

All Resident Doctors are employed on the 2016 Terms and Condition of Service for NHS Doctors and Dentists in Training (England) 2016 Version 11 and the total number of Resident Doctors is 311. This is an increase from the last Annual Report of 9% (277).

EXCEPTION REPORTING (ERs)

The table below shows a comparison between the previous year (May, June, and July 2023) and this year (May, June and July 2024).

MONTHLY ANALYSIS OF EXCEPTION REPORTING: Last quarter of the year May-July											
Month	Total Number of Posts (DiT)	No of Drs Who Submitted an ER	No of ER Processed for Payment By Month	Total Hours Paid at Basic Rate	Total Monetary Amount Paid at Basic Rate to Trainees		Total Hours Paid at Enhanced Rate	Total Paid at Enhanced Pay		Total Hours Paid Overall	Overall Cost of ER
May-23	277	7	14	19.25	**556.09**		0.00	**0.00**		0.00	556.09
Jun-23	277	8	5	6.00	**159.31**		1.00	**32.64**		7.00	191.95
Jul-23	277	9	16	25.5	**877.88**		7.00	**378.82**		32.50	1256.70
					1,593.28			411.46		TOTAL	**2004.74**
May-24	296	21	56	52.50	**1577.67**		1.00	**44.72**		53.50	1622.39
Jun-24	296	16	33	44.25	**1254.99**		1.50	**67.08**		45.75	1322.07
Jul-24	296	15	37	42.75	**1191.65**		5.50	**203.68**		48.25	1395.33
					4024.31			315.48		TOTAL	**4339.79**

MONTHLY ANALYSIS OF EXCEPTION REPORTING - AUGUST 2023-JULY 2024											
Month	Total Number of Posts (DiT)	No of Drs Who Submitted an Exception Report	No of ER Processed for Payment By Month	Total Hours Paid at Basic Rate	Total Monetary Amount Paid at Basic Rate to Trainees		Total Hours Paid at Enhanced Rate	Total Paid at Enhanced Pay		Total Hours Paid Overall	Overall Cost of ER
Aug-23	277	32	60	55.65	**1498.68**		5.25	**192.50**		60.90	1691.18
Sep-23	277	13	21	18.25	**512.90**		3.00	**112.58**		21.25	625.48
Oct-23	277	18	46	25.00	**687.54**		5.00	**223.48**		30.00	911.02
Nov-23	277	14	24	19.25	**568.78**		1.00	**60.15**		20.25	628.93
Dec-23	296	18	28	14.00	**363.76**		0.00	**0.00**		14.00	363.76
Jan-24	296	15	23	27.00	**724.97**		1.50	**48.96**		28.50	773.93
Feb-24	296	16	35	37.75	**1058.64**		2.00	**70.43**		39.75	1129.07
Mar-24	296	16	25	27.75	**742.46**		1.50	**60.14**		29.25	802.60
Apr-24	296	13	23	25.75	**733.80**		2.00	**65.28**		27.75	799.08
May-24	296	21	56	52.50	**1577.67**		1.00	**44.72**		53.50	1622.39
Jun-24	296	16	33	44.25	**1254.99**		1.50	**67.08**		45.75	1322.07
Jul-24	296	15	37	42.75	**1191.65**		5.50	**203.68**		48.25	1395.33
					10915.84			1149.00		TOTAL	**12064.84**

GOSWH FINES/GUARDIAN PENALTY FINE EXPENDITURE

Guardian Fines										
Period	No of Drs Who Submitted an Exception Report	No of ER Processed for Payment By Period	Total Hours Paid at Basic Rate	Total Monetary Amount Paid at Basic Rate to Trainees		Total Hours Paid at Enhanced Rate	Total Paid at Enhanced Pay		Total Hours Paid Overall	Overall Cost of Guardian Fines
01.12.21 - 05.04.22	24	56	0.00	**0.00**		0	**0.00**		0.00	**0.00**
06.04.22 – 02.08.22	20	54	0.00	**0.00**		0	**0.00**		0.00	**0.00**
03.08.22 - 30.11.22	53	90	11.00	**437.03**		0	**0.00**		0.00	**437.03**
01.12.22 - 31.03.23	22	47	0.00	**0.00**		0	**0.00**		0.00	**0.00**
01.04.23 - 31.07.23	20	49	0.00	**0.00**		0	**0.00**		0.00	**0.00**
01.08.23 - 30.11.23	57	91	0.00	**0.00**		0	**0.00**		0.00	**0.00**
01.12.23 - 31.03.24	65	111	0.00	**0.00**		0	**0.00**		0.00	**0.00**
01.04.24 - 31.07.24	42	146	61.75	**2856.75**		2	**108.88**		63.75	**2965.63**
				23280.64			462.46		TOTAL	**23828.72**

2016-2021 data hidden for space

Guardian Fines total remaining after subtraction of sum of fine application by Resident Doctors conclusion/summary **£10,821.88**

RESIDENT DOCTOR FORUMS

The following Resident Doctors forums have been arranged and advertised for 2025:

Date			Venue	Time
14	March	2025	Microsoft Teams	12.30 – 2.00
6	June	2025	Microsoft Teams	12.30 – 2.00
12	Sept	2025	Microsoft Teams	12.30 – 2.00
5	Dec	2025	Microsoft Teams	12.30 – 2.00

2. ISSUES

Exception Reports

A proposed change to exception reporting about moving responsibility of processing reports to Medical HR from the GOSWHs. Concerns are raised on the workload for medical staffing departments and encroaching on and undermining the role of the Guardian of Safe Working hours. It was noted Medical Staffing do not have the medical or rota knowledge of a particular department if a trainee staying late is necessary and undermines the intended function of exception reporting of supporting “safe working hours”. The ESHT Guardians understand the potential impact on Medical HR and after discussion are very happy to continue to review and process ER’s as we always have done.

Monthly analysis

The last 3 months demonstrate an uptick in ER’s of more than double in comparison to the previous year; 37 as compared with 16. This represents an increase in costs from £2004.74 to £4339.79.

This follows the general trend of the year, month on month, where increased exposure to and encouragement from the Guardians, closer working with the Pastoral Fellows and easier access to the reporting system via a QR code has led to better reporting overall.

In addition, Since August 2023, the trust has allowed the locally employed Doctors (LED) to be included in the Exception reports system. This meant more cohort of doctors are now able to submit exception reports than the previous years.

Yearly analysis

2022 to 2023: 214 Exception Reports
2023 to 2024: 462 Exception Reports
The reasons for this are discussed in the previous section

Work Pattern Review

The quarterly GOSWH reports update the Committee regularly on work pattern reviews and overall this is done on a request basis, usually from trainees, to look at a particular reason.

Unless the number of overall doctors increases in the work pattern; the principle of 7 x long days, 7 x night shifts and 2 x weekends remains constant and does not decrease the intensity. Paediatrics changed their pattern for all the out of hours shifts being worked within the first 4-5 weeks of the pattern with the remainder of the pattern with standard days. This was a worklife balance request facilitating taking annual leave without swapping shifts but does not reduce the demand or change.

In August 2024, Urology changed from 1:14 to 1:10 doctors following the 3 x Orthopaedic doctors joining a new Conquest pattern with one less doctor working overnight to one F2/CT and a non resident Registrar for the H@N team. The Guardians will monitor the Exception Reports for this and the

increased workload and the service manager is carrying out a diary card exercise to monitor the activity at night.

All other patterns are reviewed as and when the request is received.

Less Than full Time (LTFT)

The number of Resident Doctors training less than full time remains constant with 46 trainees (14%) with the number of male trainees increasing. There are no reasons required as in the past and we accept all approvals that NHSE agree. All doctors require an individual work pattern and in some case three a year due to the number of specialty rotations within the programme.

Fine Update

The Guardians have not issued a fine to a department since 2022, so July's fine to Medicine is quite exceptional. It comes after two resident doctors worked significantly above the 48 hours allowed. Further information is offered in the Safety section below.

3. CONSEQUENCES FOR NOT TAKING ACTION

N/A

4. SUMMARY & RECOMMENDATIONS

The Guardians welcomed a new intake of August 2024 trainees at the Induction and hopefully will meet the new representatives who will support the Resident Doctor Forum with the first meeting on the 14 October 2024.

The introduction of the LED Contract for non-training doctors is working well with Exception reports being received on an increasing, regular basis. This allows continuity of payment for extra work in a timely way and alerts the Specialty and Guardians of problems areas.

Safety Concerns

Concerns are highlighted above under Exception Reports for both Units at Eastbourne and Conquest for the AAU and AMU, which constantly receive high numbers of exception reports. Three wards at Conquest also receive high numbers of ERs and this year has seen the first GOSWHs fine to the department for the breaches of the 2016 Contract. Rest breaks were unable to be achieved as were attending teaching/training sessions due to shortness of doctors.

The Deputy Chief of Division at the Conquest is currently reviewing the three patterns that overlay the juniors to see if there is a way to provide safe cover to facilitate safe working environment and to attend teaching. This work was executed by a Company 10 years ago but patient demand seems to have out-stripped the capacity we are able to provide within the number of doctors, that have not increased in Medicine.

Without the investment of more doctors and the introduction of the provisions of rest days afforded in the 2016 Contract, reducing numbers of doctors attending after weekend working and consecutive day working, has made it more difficult for Trusts to deliver a safe service to compensate the increase in demand on patient care and services.

Finally, to mention that although it falls outside of the review time period as the incidents occurred in August 2024 it is important to mention that staffing was so poor on AAU on both sites that 3 "patient safety" exception reports have been made in the last month. 2 from Eastbourne and 1 from Conquest. These reports have been appropriately escalated and the Guardians have been in contact with the Divisional leads regarding this matter.

KEY INITIATIVES THROUGH JULY 23/24

- QR Code for ease of exception reporting.
- Engagement talks with Resident Doctors of all levels, including LED's throughout the year.
- Quality walks with Pastoral Fellows into areas identified as "hotspots" through verbal reports and exception reports.

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	Trust Board	**Date of Meeting**	10th December 2024
Report Title:	Use of Trust Seal		
Purpose of the Report/Outcome/ action requested:	The Board is asked to noted the usage of the Trust Seal.		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐		
Authority for Decision:	East Sussex Healthcare NHS Trust Standing Financial Instructions		
Executive Summary	This report informs the Board of the use of the Trust Seal since the last Board meeting in public. The Trust Seal was used to seal one document between 27th September 2024 and 3rd December 2024: **Sealing 114** Compass Group UK and Ireland, 16th October 2024. Agreement for supply of patient ready prepared meals.		
Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☐ People ☐ Sustainability ☐		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues had been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	1	**Appendixes**	None
Name, position and contact details of author:	Pete Palmer, Board Secretary		
Report Sponsor	Damian Reid, Chief Financial Officer	**Presenter:**	Steve Phoenix, Trust Chair
Governance and Engagement pathway to date:	Not applicable		
What happens next?	Not applicable		
Publication	Report is for publication		