EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Wednesday, 14th December 2016, commencing at 10:45 in the St Mary's Boardroom, EDGH

	AGENDA		**Lead:**	**Time:**
1.	a) Chair's opening remarks b) Apologies for absence c) Monthly award winner(s)		Chair	1045 - 1215
2.	Project Search Update	A		
3.	Quality Walks – AB/CA	B	Chair	
4.	Declarations of interests		Chair	
5.	Minutes of the Trust Board Meeting in public held on 12th October 2016	C	Chair	
6.	Matters arising	D		
7.	Chief Executive's Report	E	CEO	
8.	Board Committees Feedback • Audit – to note appointment of Trust External Auditor • F&I - Formal approval of revised Terms of Reference	F	Comm Chairs	
9.	Board Assurance Framework	G	DCA	

QUALITY, SAFETY AND PERFORMANCE

					Time:
10.	ESHT 2020 Improvement Programme	Assurance	H	CEO/DN	1215 - 1320
11.	Integrated Performance Report Month 7 (October) 1. Performance (including plan and recovery trajectories for statutory targets) 2. Finance 3. Workforce	Assurance	I	DN/MD COO HRD DF	
12.	Financial Recovery Plan & Action Plan	Assurance	J	DF	
13.	Junior Doctor's Contract Update	Assurance	K	HRD	

STRATEGY

					Time:
14.	Quality Account Timetable 2017	Assurance	L	DN	1335 - 1355
15.	Developing a New Model for Accountable Care	Assurance	M	DS	

GOVERNANCE AND ASSURANCE

					Time:
16.	Trust Fire Safety Policy	Assurance	N	COO	1355 - 1415
17.	Review of Corporate Governance Documents	Assurance	O	DCA	
18.	Board sub-committee minutes: a) Audit Committee b) Finance & Investment Committee c) People and Organisational Development Committee d) Quality & Safety Committee	Assurance	P	Comm Chairs	

ITEMS FOR INFORMATION

				Time:
19.	Meeting Dates and Planner for 2017	Q	Chair	1415 - 1430
20.	Questions from members of the public (15 minutes maximum)		Chair	
21.	Date of Next Meeting: Tuesday 24th January 2017, Conquest		Chair	

Key:	
Chair	Trust Chairman
CEO	Chief Executive
COO	Chief Operating Officer
DCA	Director of Corporate Affairs
DS	Director of Strategy
DF	Director of Finance
DN	Director of Nursing
HRD	Director of Human Resources
MD	Medical Director
QID	Quality Improvement Director

David Clayton Smith

David Clayton-Smith

Chairman

21st November 2016

PROJECT SEARCH

2016

What is Project SEARCH?

Project SEARCH is a supported internship programme which provides work experience for young people with learning difficulties and/ or disabilities. It is a collaborative project between Sussex Downs College, East Sussex County Council and the East Sussex Healthcare NHS Trust.

All interns are voluntary members of staff, working at the Eastbourne District General Hospital, and the programme runs Monday to Friday 9.30—4.30 with breaks during academic holidays.

My highlight

We asked Mitchell Rook why he loves Project SEARCH:

Q: What have you enjoyed most about Project SEARCH?
A: Getting to know my colleagues and learning what they do in their jobs

Q: What do you hope to gain from Project SEARCH
A: I want to get a job and make a good life for myself

Benefits of Project SEARCH

- Participate in a variety of internships to explore employment interests
- Gain increased independence, confidence and self-esteem
- Be supported to find paid employment at the end of the programme

"My ambition is to acquire a job at the hospital. Project SEARCH has influenced me by increasing my motivation and helped me gain a better understanding of the workplace"

- Hamish Grant-Hastings

Employer Engagement Event, March 2016

The types of jobs we do:

- Working in Pathology Stores
- Working in Decontamination
- Working in Post
- Working in Housekeeping
- Working in Portering
- Working in Health Records

Dan at work

Dan's Story

Dan graduated from Project SEARCH in June 2015, and wanted to work for the NHS. He signed up to the NHS Jobs website which enabled him to see job alerts from the NHS and apply online. He applied for the position of *Clinical Orderly* as it was similar to his experience he acquired from his time on Project SEARCH working as a Housekeeper.

Dan says 'I am now working for the NHS Trust. My role includes cleaning the medication trolley, checking there is enough clean linen and cleaning various pieces of medical equipment. It feels great to finally be working full time, I like being independent and earning my own money. I enjoy working on the ward, everyone is really friendly and helpful and the nurses say that they appreciate my help. It feels good on a Friday afternoon knowing that I have worked a full week.'

Interns from 14/15

Project SEARCH gets results

11 young people graduated from the Project SEARCH programme last June, and of these 11 young people, we have helped 10 find paid jobs.

Am I ready?

If you want to join Project SEARCH, you need to ask yourself just one question:

"Do I want a job?"

If the answer is yes, then Project SEARCH can help.

Meet Shannon

15/16 intern, Shannon

Project SEARCH began it's second year in September, when Shannon joined the programme. After doing her induction she worked in roles such as Administration, Housekeeping and Laundry.

Shannon is now thinking about a career in Housekeeping, and applying for housekeeping jobs in local hotels, or possibly working in a supermarket where she can meet new people.

Shannon would like a job where she has a sense of achievement at the end of each day and wants to find a job where she can find new friends.

Working in the hospital

To work at the hospital, you need to complete the full NHS induction, just like any other member of staff employed by the hospital.

You are then given an NHS staff lanyard and ID badge, and given an honourary contract.

Interns are treated the same as any other employee of the hospital, and are given a great deal of trust and responsibility.

Our Job Coaches

Job coaches are available along every step of the way as an intern prepares to be-come independent in the world of work.

This is achieved through coaches giving highly supportive training to each intern.

Internships are chosen to enable the intern to develop core skills for employment and Coaches will already know everything about each department and they learn the tasks themselves in order to demonstrate them.

The Coach uses a genuine job description to make sure the intern is working as closely to the same standards as their colleagues.

A Job Coach can make sure than any reasonable adjustments can be made to make the intern's life easier at work so the intern can perform the role as confidently and efficiently as possible.

15/16 interns ready for work

A typical day

9:30 - 10:30 Training session
We spend an hour each morning working towards our Qualification in Learning, Employability and Progression

10:45 - 12:45 Work
Interns begin initially with 1-2-1 coaching before the Job Coach steps back and helps the intern work more independently in their department.

12:45 - 1:30 Lunch
Either at the project base room, the canteen or integrated within the department routine.

1:30 - 3:30 Work
These hours increase over the year. For the 3rd rotation interns are expected to work the same hours as their colleagues in preparation for full time employment.

3:45 - 4:30 Back to base room
Interns can share their individual experiences during these sessions, reflect on and evaluate their experiences, work on an individual career plan and apply for jobs

After Work
Our interns like to organise social activities after work too!

How to apply

If Project SEARCH sounds like something you, or someone you know , might be interested in, the next step is to contact us on the details to the right and request a referral form. Just remember, all that we ask is that you:

- Are ready for work/ looking for work
- Are aged between 18—24
- Have an EHCP (or one is being written)
- Are able to commit to a full time course running between September 2016 and June 2017

What's next?

The next step is to contact us on the details to the right and request a referral form. Once you've completed the referral form and returned it to us, we'll be in touch to arrange a taster day here at the hospital, where you can come along and meet the team, have a tour and try a few of the many jobs that we have on offer for you to experience.

We'll then be in touch to confirm your place on the course, and if you're successful we'll meet up a few times over the summer to get you ready for the start of the course and fill out some paperwork.

We're also planning to host a social event over the summer where you can get to know the rest of the group, have some food and hopefully enjoy some sunshine!

Contact Us

Give us a call for more information about our programme

Project SEARCH

Eastbourne DGH
Flat 2, Addison House, BN21 2YD

01323 435 602

07946 335 715

Penny.Morgan@sussexdowns.ac.uk

Visit us on the web at:

www.sussexdowns.ac.uk/courses/project-search/

@ProjectSearchEB

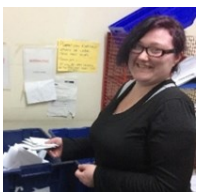
Our interns are applying for these jobs:

Seb has applied for bank work in admin and a Library Clerk role here at the EDGH.

Louis has applied for an assistant warehouse role at B & Q Eastbourne.

Andy has also applied for bank admin as well as a Pathology Quality Management Assistant role.

Roshanne has applied for full time work as a Theatre Orderly at the EDGH.



Louise has applied for bank administration roles here at the EDGH.

Sam has been applying for receptionist roles in General Administration and Radiology.

The PS Express

Sept-Oct 2016

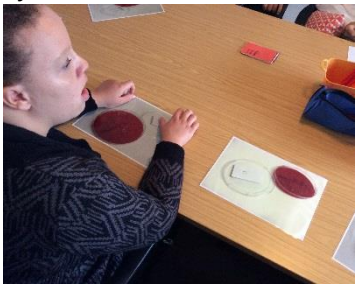
Project SEARCH is 3 years old!

The interns at EDGH at the start of the programme which commenced on Sept' 15th 2016.

Fire Fire . . . . . .

Amy came to give a talk on fire safety. She explained fire safety to the group and the importance of it within the trust. Amy also gave a clear explanation of the fire alarms and what to do in the event of a fire. Amy was extremely knowledgeable and the interns were able to put forward plenty of valuable questions to her. Overall a very informative session had by all involved. Thank you Amy!

The wonderful Sammi from the Infection Control team gave a great **'Glow & Tell'** demonstration on how to effectively clean your hands. She offered really helpful advice about hand hygiene explaining why it is so important and we really enjoyed guessing the items that hold the most bacteria. Sammi was able to answer all the interns' questions.
A massive thank you to Sammi.



We have had a busy first few months of the programme with the NHS Induction, mini tours of all the hospital departments and meeting some very important people such as Ruth Agg –'Speak up Guardian'. The interns have all now started and are settled into their placements.

Coffee Morning . . .

The base room was a hive of activity as we welcomed interns and their families to the base room. This was a chance for the interns to discuss their department choices with the team and their parents/carers. The interns discussed the pros and cons for each department and what department would suit them best with the help of the Project SEARCH team and those closest to them.

The interns took part in some team building at Bowles in Tunbridge Wells. They enjoyed an action packed day working together on several different team building activities. Lots of problem solving, communication and listening skills being developed.

Meet The Interns

First up is **Josh**, he is a Porter, transporting patients and equipment around the hospital.

Max is working in Patient Experience & Health Records. He is gaining experience in administration.

Steven is working in Residential Maintenance. One of his responsibilities so far is to paint an entire 3 bed flat!

This is **Marcus** who is currently working in Post. He handles internal and external post and delivers internal post around the hospital.

Alex who is currently working in Decontamination. His main duties include unpacking sterile goods and packing and labelling these.

This is **Ashley,** he is working in administration for Respiratory which includes data input, faxing and photocopying.

Kieran is working within the Hospital Estates team. He is learning about the electrical and mechanical workings of lots equipment and machines that keep the hospital running.

Sophie is working in Radiology on floor control. She has started to meet and greet patients and arrange transport for patients too.

Victoria is part of the Laundry team and using large automated machinery to dry and iron linen.

This is **Isias** who works in Pathology Stores. His main tasks are receiving orders, picking the items and packing them into boxes ready for delivery.

This is **Adam** who is currently placed in Occupational Therapy as an assistant. He has a range of administrative duties and will soon be assisting the Occupational Therapists with their visits.

Interns goody bag to celebrate their achievements so far! Thank you Jeanette Williams for the ''Take a Break' goodies and for the CEO Adrian Bull himself for signing and acknowledging the hard work the interns have put in during their mandatory training.

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2016
Meeting:	Trust Board
Agenda item:	3
Subject:	Quality Walks September - October 2016
Reporting Officer:	Alice Webster

Action: This paper is for **(please tick)**					
Assurance	✓	**Approval**		**Decision**	

Purpose:

This paper provides a summary of the Quality Walks that have taken place during September and October 2016.

Introduction:

Quality Walks are currently carried out by Board members and the Executive team and are either planned or carried out on an ad hoc basis. They are intended to provide an opportunity to observe and review care being delivered, listen to feedback from patient's, visitors and staff and enable quality improvement actions to be identified and addressed from a variety of sources in order to provide assurance to the Board of the quality of care across the services and locations throughout the Trust. Consideration is given to the following themes:

- How communication and engagement can be strengthened
- Reporting, action and learning from incidents and risks
- Fundamental safety issues – cleanliness, drug security, records management.

Analysis of Key Issues and Discussion Points Raised by the Report:

11 services/departments were visited as part of the Quality Walk programme by the Executive Team between 1st September and 31st October as detailed below. The Chief Executive and Director of Finance have also visited over 25 departments and staff groups in addition to the formal programme.

Date	Time	Service	Site	Visit by
15.9.16	1.30pm	AAU	Conquest	Jackie Churchward-Cardiff
23.9.16	9.30am	Respiratory Team	Conquest	Alice Webster
28.9.16	1pm	Diabetes & Endocrinology	Conquest	Barry Nealon
28.9.16	12-2pm	Occupational Therapy	Conquest	Jackie Churchward-Cardiff
26.9.16	5.30pm	AAU (Additional Walk)	Conquest	Jackie Churchward-Cardiff
7.10.16	2-4pm	Day unit	Lewes Victoria	Monica Green
26.10.16	11.30am	Speech & Language Therapy	EDGH	Mike Stevens
26.10.16	1pm	Hailsham Ward 2 & 3	EDGH	Barry Nealon
27.10.16	10am	Rainbow Nursery	EDGH	Monica Green
31.10.16	9.30am	Speech & Language Therapy	Conquest	Monica Green
31.10.16	3pm	Rye Memorial	Rye	Alice Webster

All of these visits were pre-arranged and the Ward or Unit Manager was notified in advance to expect the visit, other adhoc visits may also have taken place.

At the time of writing feedback had been received relating to 8 of the visits to individual services or departments, copies of which have been passed on to the relevant managers for information.

Summary of Observations and Findings during September and October relating to the themes collated from the feedback.

How communication and engagement can be strengthened
In one area some staff raised concerns about the new organisational structure and commented that it had caused some anxiety amongst staff as to their future divisional position and management reporting lines, this is in contrast to the staff nursery and the Speech and Language teams who felt they were involved in any changes, were listened to, and were aware of what was happening within the rest of the Trust.
In the assessment unit it was noted that they have developed good links to the Crisis Team, Frailty Team, Mental Health and District Nursing but find that differing referral processes can be burdensome and consume significant clinical time.
Occupational Therapy teams have suffered reduced staffing due to vacant posts but through a positive collaboration with the Physiotherapy department and Human Resources there has been a strong recruitment drive leading to the employment of 10 new therapists. The venture focussed on advert format/design and included promotional material and a staff booklet. The department took a values based approach and are confident of the calibre of their new recruits.
At one of the community sites the nursing staff reported good communications with their managers and others in the Trust but the administrative and secretarial staff were less positive. All staff however spoke of good communication within their site but did cite frequent system and IT problems.

Reporting, action and learning from incidents and risks
The Occupational Therapy team at the Conquest felt there is a lack of site consistency for treatment for patients on the stroke pathway reporting that their patients do not appear to have the same access to the stoke unit as those at Eastbourne. This has been raised with the service manager and is being pursued to ensure more parity.

Fundamental safety issues – cleanliness, drug security, records management
The introduction of safety huddles on the wards has been well received. There were no significant safety or security issues reported at any of the visits.

Other Issues
Lack of adequate numbers of PC stations was reported in some areas and that SystmOne is not yet available to all therapy staff.
One of the community sites had received outstanding feedback from students following their placements in the unit
It was noted the Speech and Language pilot of support in ENT (due to end in November) had been hugely successful and had reduced waiting lists from 20 weeks to 4 weeks.

Patient feedback
In one area patients and relatives reported that the air movement was poor so they were either too hot or too cold, and they also felt the 6 person bays were too crowded with limited patient privacy. However they stated that the staff were kind and helpful but did feel communication could be improved.
Positive patient feedback was noted in several other areas.

Benefits:

Quality Walks are an opportunity for the views of staff, patients and visitors to be sought by the Board and help raise the profile of patient safety and compliance standards within the Trust. It enables the Board members to identify areas of excellence, identify risks and ensure Board visibility within the organisation.

Risks and Implications
Any risks identified are acted upon and escalated to the risk register as appropriate

Proposals and/or Recommendations
The Board are asked to note the report and agree if any changes to the current themes are required.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
N/A

For further information or for any enquiries relating to this report please contact:	
Name: Hilary White Head of Compliance	**Contact details:** Hilary.White2@nhs.net

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Wednesday, 12th October 2016 at 11:00 in the Lecture Theatre, Conquest Hospital.

Present: Mr David Clayton-Smith, Chairman
Mr Barry Nealon, Vice Chairman
Mrs Sue Bernhauser, Non-Executive Director
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Ms Miranda Kavanagh, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Mrs Catherine Ashton, Director of Strategy
Dr Adrian Bull, Chief Executive
Mrs Pauline Butterworth, Acting Chief Operating Officer
Ms Monica Green, Director of Human Resources
Mr Jonathan Reid, Director of Finance
Mrs Lynette Wells, Director of Corporate Affairs

In attendance:
Mr Nathan Goodwin, VitalPAC Administrator (for item 096/2016)
Mr Matt Hardwick, Hospital Director (for item 105/2016)
Ms Sally Herne, Improvement Director
Mr Chris Hodgson, Associate Director, Estates & Facilities (for item 189/2016)
Miss Jan Humber, Joint Staff Committee Chairman
Mrs Claire Lippiatt, Lead Nurse Clinical Systems (for item 096/2016)
Dr Kate Murray, Consultant Anaesthetist (for item 096/2016)
Mr Ashley Parrot, Associate Director of Governance
Mr Pete Palmer, Assistant Company Secretary (minutes)

095/2016 **Welcome and Apologies for Absence**

a) Chair's Opening Remarks

Mr Clayton-Smith welcomed everyone to the meeting of the Trust Board held in public. He reported that the Trust had recently been inspected by the CQC, and noted that he was not expecting the CQC's reports to be published until early in 2017.

He welcomed Mrs Ashton, Mr Reid and Dr Walker to their first Trust Board meeting in public, and advised that Joe Chadwick-Bell had been appointed as Chief Operating Officer and would be starting her role on 14th November 2016. He thanked Mrs Butterworth for the all of the work that she done whilst Acting Chief Operating Officer, noting that this was her final Board meeting in public.

Mr Clayton-Smith thanked Liz Walke for the letters that she had given to

Board members and explained that the Trust would formally respond to the letters outside of the meeting.

b) Apologies for Absence

Mr Clayton-Smith reported that apologies for absence had been received from:

Mrs Alice Webster, Director of Nursing
Ms Ruth Agg, Speak Up Guardian (for item 081/2016)

c) Monthly Award Winners

Mr Clayton-Smith advised that the monthly award winner for July was Rosy Shrubbs, a Senior Occupational Therapist at Eastbourne DGH who won for the work she had undertaken to develop the Occupational Therapy garden. He explained that this was an inspirational, quiet and interactive space within one of the courtyard areas at the hospital that was valued by both staff and visitors.

He reported that August's winner was Catrina Turner, Foundation Programme Administrator in the medical education department, who won the award for her pastoral support to around 50 Foundation Year 1 and 2 junior doctors in training at Conquest Hospital.

096/2016 **VitalPAC Update**

Dr Murray presented the Board with an update on VitalPAC explaining that the system was a real time bedside observation system that enabled the capture of patient observations on an iPod touch. She explained that staff were able to swiftly identify and escalate deteriorating patients, and the proactive approach taken by Outreach teams was integral to this process. She explained that the Trust was seeing a downward trajectory of cardiac arrest rates as a result.

Dr Murray explained that the Trust aimed to take more than 92% of patient observations on time and monthly meetings were held with areas that were not meeting this standard in order to support them in doing so. In September 2015 the Trust were taking 77% of observations on time, and we are now rated in the top five Trusts in the country at 91%.

Mrs Churchward-Cardiff asked why observations were not being completed on time, and Dr Murray replied that issues included competing priorities for nursing staff, pressure on wards and agency staff.

Mrs Bernhauser explained that she had undertaken several visits to wards within the Trust at night and been delighted to meet the Outreach teams. She said that their skills in providing support to nursing staff while not disempowering them had been outstanding.

Mrs Ashton asked what the reasons had been for the increase in cardiac

arrests that was reported in December 2015. Dr Murray replied that the Trust had had problems with staffing at the time, and issues with Wi-Fi which had led to observations being taken on paper rather than iPods. She noted that these issues had since been resolved.

Mr Nealon said that it was wonderful to see capital investment resulting in improved patient care, and asked whether additional investment in the system could see further service improvements. Dr Murray reported that VitalPAC was currently only used in adult inpatient areas, but that additional modules for infection control, paediatrics and emergency departments were due to be introduced into the Trust.

Dr Walker commented that the work that had been undertaken by the VitalPAC team had made a large improvement to patient safety within the organisation and commended the team for their efforts. Mr Clayton-Smith thanked the team for ensuring that VitalPAC worked so well within the Trust, and for realising a very clear benefit to patients through their work.

The Board noted the update on VitalPAC

097/2016 **Feedback from Quality Walks**

Ms Green reported that she had recently visited the Infection Control team at the Conquest, explaining that they had recently employed a new head of department, who had reported good communications within the team, with the wider trust and with the CCG in looking at infection control work within the community.

The recent introduction of a new uniform policy for staff and of clinical orderlies on wards had made positive improvements to infection control outcomes, although staff had reported concerns that they sometimes felt that they were adding pressure to the workload of other staff by raising infection control issues.

Ms Green reported that she had visited the Outpatient Department at the Conquest and had observed a number of good recent developments, including the introduction of safety huddles which were well liked by staff and found to be very useful. She explained that staff felt they were well supported by the Head of Nursing and General Manager and that they were aware of the process for reporting risks and incidents.

She reported that lockable cabinets for patient notes had recently been introduced, and regular cleanliness checks with 'I am Clean' stickers for equipment were undertaken. Ms Green explained that the department felt 'tired' and that she had suggested applying to the charitable funds for assistance in remedying this. She noted that the Outpatients teams demonstrated an excellent example of cross site working.

Mr Reid reported that he had enjoyed visiting many different areas of the Trust since joining, and that he had found very consistent messages from all of the areas visited about incident reporting and improved communication. He reported that he had recently visited the Emergency

Departments on both sites and had found the calm, measured way in which staff dealt with the huge pressure they experienced on a daily basis to be inspirational.

He said that he had discussed issues with patient flow throughout the hospital with staff and that he had found there to be a growing understanding that the issues experienced by the Emergency Departments needed to be resolved by the entire organisation. He reported that the departments were working to improve facilities for paediatric patients and patients with mental health issues.

Mr Reid reported that he had visited the relocated Endoscopy Suite at EDGH and that the department's new location had given the team the opportunity to improve the experience of patients..

He had also visited the SDU, explaining that the department sterilised equipment for the Trust and for local general practices. Mr Reid noted that the roof and general infrastructure of the department was in need of some improvement. He reported that the Trust would be working to modernise the way it did business with other providers as this would provide an opportunity to improve income.

On a visit to Health Records at Apex Way he had been impressed by the clear sense that the team had about how their work directly contributed to patient experience. He explained that the team had undergone a challenging journey within the organisation, and that team leaders were looking at ways to provide support to staff.

The Board noted the feedback on quality walks.

098/2016 **Declarations of Interest**

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

099/2016 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 3rd August 2016 were considered and were agreed as an accurate account of the discussions held.

The minutes were signed by the Chair and would be lodged in the Register of Minutes.

b) Matters Arising

062/2016 – Revised Terms of Reference and membership for People and Organisational Development Committee

Mrs Kavanagh noted that the revised People and Organisational Development Committee Terms of Reference were being presented for Board approval under item 112/2016 (c).

064/2016 – Impact of changes to nurse training

Ms Green reported that she had discussed the impact of nurses having to pay for their training with Mrs Webster, and would be with the University of Brighton. Ms Green reported that the Trust was considering introducing apprenticeships in order to support nurses through their training, and that nurse associate roles at Band 4 had been introduced. She said that contact had been made with Northumbria Trust about designing a new nursing qualification for people with past healthcare experience, which would enable them to resume nursing more quickly.

066/2016 (ii) – Review of actions being taken to improve Trust's finances

Mr Reid explained that this issue had been discussed at the meeting of the Trust Board in private on 12th October 2016, and that a full review would be presented at December's Board meeting. **JR**

067/2016 – Safe Nurse and Midwifery Staffing Report

Dr Bull explained that figures for community nurse staffing levels would be included with in the Integrated Performance Report once this work had been completed.

072/2016 – Progress on plan to reduce violence and aggression towards community and urgent care staff

Mrs Butterworth reported that work was being undertaken with Sussex Partnership NHS Foundation Trust to review the length of stay and pathways for mental health patients within the Emergency Departments. She explained that the Clinical Units undertook reviews of any issues that arose on a weekly basis. She reported that Community staff had lone working protocols in place, and that any emerging risks were being managed at clinical unit and divisional levels. She said that many teams faced similar risks and patients who were known to be violent and aggressive were flagged up by GPs and social care and were visited in pairs.

100/2016 **Chief Executive's Report**

Dr Bull reported that the CQC had undertaken their inspection of the Trust the previous week. He explained that verbal feedback had been given by the lead inspector following the inspection, providing very limited information with no intimation about a potential rating. Dr Bull said that the CQC would inform the Trust within three weeks of any urgent issues or regulatory issues that have been identified during their visit, and that he expected the Trust to receive draft reports from the CQC in early 2017.

Dr Bull explained that he had been very pleased with the organisation's response to being inspected, with excellent co-ordination of the

inspection and staff attendance at focus groups being outstanding. He reported that the CQC's lead inspector had asked the Trust to compliment colleagues on their openness, the welcome they had given to the inspection team and their willingness to show what they were doing in an open fashion whilst recognising the issues that they faced.

Dr Bull reported that the CQC had identified a small number of specific issues, none of which were a surprise to Trust. These had included issues which had been addressed immediately concerning monitoring patient pain scores in urgent care, monitoring of patient temperatures in theatres and risk assessments of outlying medical patients. He noted that the issues raised by the CQC were not done with significant risk or concern.

Dr Bull explained that the CQC had fed back that they had found the Trust to have a workforce that was responsive, clear about their purpose and that had a sense of optimism and confidence about the direction the Trust was moving in. He noted that one of key factors in the CQC's final rating would be whether they considered that the organisation provided a quality of care that no longer merited being in special measures, and whether the Trust had demonstrated that improvements were sufficiently embedded in a way that would not lead the Trust to return to special measures in the future.

Dr Bull reported that issues with patient transport remained, and that this had been scrutinised at the recent meeting of the Health Overview and Scrutiny Committee (HOSC). .

Dr Bull reported that the Trust had recently been in black status due to a high number of urgent patients presenting. He noted that both EDGH and Conquest hospitals had received an improvement in patients rating their experiences via NHS choices to four out of five stars.

Dr Bull reported that Obs & Gynae doctors in training would shortly be the first to start on the new junior doctors contract, and that the Trust had all the requirements for this contract in place.

Dr Bull explained that the Trust continued to work with social services and CCGs to develop East Sussex Better Together (ESBT), explaining considerable recent progress had been made in developing propositions in principal for an accountable care model,, and that a seminar to discuss proposals would take place with HOSC in the future. He noted that this work would feed into the Sustainable Transformation Plan (STP) for Sussex and Surrey, which now comprised three place based plans looking to integrate healthcare across primary, secondary, community and social care.

Mr Nealon asked when a public statement would be made about the overarching STP strategy and Dr Bull replied that an announcement would be made in due course by the STP. He noted that transforming the agreed principles of how the strategy would operate into a realistic plan would be a significant step for the STP, and that operational details

would emerge over the next two to three months.

Mrs Churchward-Cardiff asked whether a review of skill gaps was being undertaken to understand what skills would be required when seven day working was introduced. Ms Green explained that meetings had taken place with Clinical Units to discuss the implications of the change, and what new roles and working patterns would be required to support seven day working.

The Board noted the Chief Executive's Report.

101/2016 **Speak Up Guardian's Report**

Dr Bull reported that he was presenting the report on behalf of Ms Agg as she was unable to attend the meeting. He explained that Ms Agg provided one of a number of channels through which staff could raise concerns without fear of reprimand and reprisal. He said that she had worked hard to ensure that her role was well positioned to facilitate the raising of issues within the Trust, and that while Ms Agg helped to resolve some issues locally the Trust maintained responsibility for resolving issues that were highlighted.

Ms Green reported that the Trust was identifying and reviewing trends that were emerging from the Ms Agg's work. She explained that a training programme for staff had being introduced to reinforce the need to treat each other professionally and reported that a national Speak Up Guardian network had been introduced, to provide support and guidance on handling cases.

The Board noted the Speak Up Guardian's report

102/2016 **Board Assurance Framework**

Mrs Wells highlighted that four areas within the BAF had been rated as red.

- Reconfiguration of A&E departments
- Mortality indices
- The Trust's financial position
- Patient transport

She explained that she was recommending the removal of the gap in control relating to the lack of an aligned Trust Estates Strategy as this had now been developed. She asked the Board to consider changing the rating for mortality to amber due to controls that were now in place.

Dr Walker explained that the Summary Hospital-level Mortality Indicator (SHMI) was designed for acute trusts, rather than integrated Trusts, and included deaths that occurred in Rye and Uckfield. He explained that this variance had a negative impact on the Trust's SHMI compared to other Trusts. He reported that the SHMI had returned to within the normal range, and that other mortality indicators were also much

improved. Dr Walker noted that an enormous amount of work had taken place and was being progressed within the Trust, including developing a new medical model, new work-streams for mortality and improved coding of co-morbidities and diagnoses. He explained that improved clinical governance was now in place within all CUs and that this had led to 75% of all deaths being reviewed within three months. Dr Walker explained that he felt that in light of the range of improvements demonstrated that the rating for mortality should be changed to amber.

Mr Parrott noted that governance improvements, including those in Venous thromboembolism (VTE), sepsis and End of Life Care (EOLC) now had a very clear structure and pathway through Trust, which enabled issues to be spotted more swiftly.

Mr Nealon asked whether there were any areas which still required urgent attention and Dr Walker noted that post-operative paediatric mortality rates remained higher than the national average. He reported that analysis was being undertaken in order to understand why this was the case. Mr Nealon asked if the rating should remain red in order to maintain a focus on the issue, and Dr Walker replied that he felt the rating was too high as the Trust's figures were now improving, and the issues were understood. Ms Kavanagh noted that she was assured by the progress the Trust was making but wished to see sustained improvement before the rating was changed from red. Mrs Wells explained that an amber rating meant that controls were in place, but that the Trust was not assured that the controls were sustained and was therefore an appropriate rating. Mr Clayton-Smith agreed that the rating should be changed to amber and that there was sufficient improvement to merit this.

Ms Herne explained that NHS Improvement (NHSI) had asked for recommendations and progress against infection control assurances under item 2.1.3. to be made more transparent in reports to the Board and Quality & Standards Committee. Mr Parrott said that he would speak to the Trust's Infection Control leads about improving the representation of information to ensure visibility and assurance for the Board.

The Board confirmed that the main inherent/residual risks and gaps in assurance or controls had been identified in the Board Assurance Framework and actions were appropriate to manage the risks.

The Board approved the removal of the gap in control relating to a lack of Estates Strategy and that the Mortality rating be revised to Amber.

QUALITY, SAFETY AND PERFORMANCE

103/2016 **ESHT 2020 Improvement Programme**

Dr Bull presented a highlight report outlining progress made on the Trust's 2020 Improvement Programme. He explained that an Improvement Sub-Committee had been set up to steer through a programme of actions arising from the initial CQC reports, that much of this work was now completed with appropriate controls in place.

Dr Bull reported that the rating for the patient flow project had been amended to red due to concerns with performance in the Trust. He explained that it had been agreed that the Sub-Committee's agenda would be refocussed onto four key areas – mortality, EOLC as an individual item, the patient flow programme and pain scores in Urgent Care. Dr Bull explained that the upcoming CQC report would lead to revision of the Sub-Committee's agenda.

Ms Kavanagh noted that the work undertaken to improve privacy and dignity within radiology had a target of 100%. She asked why it was rated green when it showed a completion rating of 50%. Dr Bull replied that the rating was green due to the work having been completed, and said that he would find out why the rating was 50%. **AB**

Mr Nealon asked if changes to ratings could be highlighted, as they were not currently shown. Dr Bull agreed to amend the report to reflect this. **AB**

The Board noted the report updating the Trust's progress on the 2020 Improvement Programme.

104/2016 **Integrated Performance Reports – August 2016 (Month 5)**

i) Patient Safety & Clinical Effectiveness

Mr Parrott explained that the national averages for total patient safety showed 71% of incidents to be rated as no harm or near miss, compared to the Trust's rate of 81%, which showed a high number of incidents being reported, demonstrative of a positive cultural shift for the Trust.

He reported that six clostridium difficile (c. diff) cases had been declared in August, all on different wards. He explained that issues identified in these cases were communicated to consultants Trustwide. Mr Nealon asked whether the Trust would be liable for a fine or penalty due to the number of c. diff cases reported during the year and Mr Reid explained that he expected that Trust to be liable for a fine of £10-12k.

Mr Parrott reported that two incidents causing severe harm or death had been reported during August. He explained that investigations into never events could only be closed off by a review panel who checked that actions arising were embedded prior to closure. Mrs Bernhauser noted that the Trust had not always ensured that action plans were followed after never events in the past, and that the Quality and Standards Committee were now receiving evidence that this was being undertaken properly.

Mr Clayton-Smith asked whether learning from Serious Incidents and never events was being shared throughout the organisation as standard practice. Dr Walker explained that the quality of medical meetings had improved greatly during 2016 and that far more information and data was available to clinicians. He explained that information about incidents was shared, triangulated and actioned and that the Trust enjoyed a much improved process of sharing learning with colleagues.

ii) Performance, Access and Responsiveness

Mrs Butterworth explained that the report showed the Trust's performance for August 2016 and that there had been a 17% increase in A&E attendances compared to the previous year. She noted that Referral to Treatment (RTT) performance in August had experienced pressure relating to A&E, ophthalmology, gynaecology and surgical performance and that recovery plans were being worked on.

Mrs Butterworth reported that she expected the backlog experienced in endoscopy to be cleared by the end of October, and that the issues with radiology had now been resolved.

Delayed transfers of care during August had been at 8% with between 80-100 medically fit patients occupying beds at any given time, and that this had led to increased lengths of stay in non-elective pathways across the Trust compared to the previous year. She noted that issues with social care placement and access to beds in community services had contributed to the significant pressures experienced by the Trust, and explained that she expected these pressures to increase with the onset of winter.

Mrs Butterworth reported that the Trust continued to meet two week wait and 31 day standards for cancer, but had seen an 11% increase in referrals on two week cancer waits from primary care and were working to reduce this.

Mrs Churchward-Cardiff asked why an increase in pressure sores was being reported, as she felt that there was appropriate equipment and processes in place to prevent these. Dr Bull explained that the figures for Trust acquired pressure sores included those reported in the community and agreed to alter the report to ensure that this made clear in the future. **AB**

iii) Finance

Mr Reid explained that the Trust had set a challenging financial plan for 2016/17, with an agreed deficit of £42million, which included a contribution from the Strategic Transformation Fund (STF) of £10.4. This meant that the Trust's portion of the deficit for the year had been agreed at £32million. He reported that by month 5 the Trust was £5.6million adverse to the plan, although this slightly overstated the level of adverse variance as performance levels meant that access to STF funds had not been available. He explained that the actual variance was

£3.2million, and that work was being undertaken to address the issues contributing to this adverse position.

Mr Reid reported that a financial recovery plan was in place and that the Trust expected to deliver on plan for the year. He noted that the Trust had longstanding issues with periodic pressures around its cash position, but that there was now a plan in place to manage this.

Mr Clayton-Smith advised that a detailed discussion had taken place about the Trust's finances during the Private Board meeting that morning, and explained that plans were scrutinised by the Finance and Investment Committee. He said that the full financial recovery plan would be discussed at December's Board. **JR**

iv) Workforce

Ms Green reported that recruitment to the Trust remained challenging, this was being mitigated with an ongoing programme of overseas recruitment, open days, and the use of social media to gain new staff. She reported that during 2016/17 turnover had reduced by 2%, reflecting effective changes to the culture of the organisation. She reported that staff sickness had reduced and appraisal rates had increased, noting that an audit on the quality of appraisals had been started.

Ms Green advised that mandatory training rates had fallen slightly during the summer, but had since increased again. She explained that the Trust carried out regular Pulse surveys which used questions from the annual staff survey, and that these showed a marked increase in positive responses since the previous staff survey. She noted that the annual staff survey had recently been sent to staff, and that she hoped that this improvement would be reflected in the annual results.

Ms Green reported that an ESHT vine had been successfully introduced in order to spread messages throughout organisation. She said that a mentor celebration evening had been held, and that a celebration of Unsung Heroes within the organisation was due to take place the following week.

Mr Clayton-Smith asked why the workforce report showed the Trust as having 70 Full Time Equivalent staff above budget, and Ms Green explained that this referred to usage of temporary workforce staff when there was high pressure on services.

Mrs Churchward-Cardiff explained that she wanted to commend the Occupational Physical Therapy team on the work they had done in conjunction with HR in recruiting an additional 15 members of staff. She suggested that their learning should be shared throughout the Trust. Ms Green noted that different initiatives worked for different areas, and that the Trust was learning about effective strategies and sharing these throughout the organisation.

Mr Stevens noted that most of the figures reported by HR had

significantly improved since the previous year, but asked whether there were any concerns about sickness levels. Ms Green explained that there were some areas of concern around sickness, and when these were identified they were reported to managers who received HR support in dealing with them in line with Trust policies. Dr Bull explained that one or two members of staff with long term issues could drive up the figures, so teams were reviewed on an individual basis in order to establish if there were any underlying issues.

Ms Kavanagh asked about measures being taken to improve recruitment of consultants, and Ms Green advised that different approaches were taken depending on the department, and that these had included employing head-hunters, going abroad and establishing academic links with Brighton. She noted that there were nationwide shortages of consultants in some areas and that the Trust needed to be innovative in order to manage these issues. Dr Bull explained that discussions had taken place with Clinical Units about ways to mitigate the risks of not having enough consultants and plans for resolving these issues in the long term.

The Board noted the Performance, Workforce and Finance Reports for August 2016.

STRATEGY

105/2016 **Urgent Care and the Four Hour Trajectory**

Mr Hardwick reported that the Trust had seen a consistent rise in the number of patients attending A&E during the year, alongside a rise in admissions. This rise was being experienced nationally, and the Trust's plans were responding tot meeting this increase in demand in a safe, high quality fashion. He reported that the Trust's performance against the four hour waiting standard in A&E had deteriorated during 2016 and that an improvement programme had been instigated in July 2016 to review the flow of patients throughout the organisation and into community and social care.

He explained that five 5 key areas for improvement had been identified, which incorporated recommendations made following review of the A&E departments by the Academic Health Science Network. He noted that this included A&E specific actions to improve performance and patient flow and a revised medical model within the Trust which aimed to avoid admissions where possible. Dr Bull reported that there had been a very rapid commitment from medical colleagues to the changes to the medical model, explaining that this had been important for the process as it demonstrated that the consultant body agreed that they would all have to change how they worked in order to resolve the issues.

Mr Hardwick reported that the SAFER bundle had been implemented across both acute sites to improve patient flow and discharge planning prior to being rolled out to community settings. He explained that the bundle included achievements for patient flow and discharge that had to

be adhered to, as well as ensuring that discharges from hospital happened earlier in the day to make transport for patients easier, and to free up capacity. Dr Bull noted that the Trust were working to free up space in the hospitals, but needed to look at the capacity required by the Trust and ways of providing this that would allow the organisation to free up patient flow when necessary.

Mr Hardwick noted that seasonal pressures were now experienced throughout the year, and different departments suffered pressure at different times. He explained that predictable spikes in trauma presentations were experienced, and planned for, in April and during winter. Mr Hardwick noted that the Trust planned to introduce new electronic dashboards for A&E performance to enable site meetings to run more effectively and to allow rapid access to site data. He reported that the Urgent Care Board, chaired by Dr Murray, had begun to meet, with clinical representation from across the CUs. Work had also begun on a dashboard to show Trust-wide performance against a number of indicators.

Mrs Churchward-Cardiff asked whether the Trust was being explicit about where the access points were for urgent care. Mrs Butterworth explained that a high turnover among local GPs meant that while good use of Trust pathways had been made in the past, this was no longer the case and that work on improving this would be carried out. Mrs Churchward-Cardiff noted that she would like to see explicit standards developed to ensure that patients were placed in the right place in the first instance. Mr Hardwick agreed, explaining that pressure experienced on the hospitals later in the day often led to a limited choice as to where patients could be placed, and that it was hoped that earlier discharges would alleviate this issue.

Dr Bull explained that metrics were being developed to help with this process, and a red and green system for wards adhering to these processes would be introduced. He said that support would be offered to areas struggling to meet the metrics, noting that the time and energy being put into resolving the issues was huge, but that doing so would have an extremely positive effect felt throughout Trust.

Ms Kavanagh asked how the Board would receive assurance that the Trust had achieved success in resolving the issues and Dr Bull replied that the plans would be considered successful if the Trust consistently and constantly achieved four hour wait and RTT targets. He said that this would play a huge part in helping the Trust to resolve its performance issues, and that progress would be reported to the Board within the QIP report on a regular basis in order to provide assurance.

Dr Walker explained that the biggest delay in implementing the plan would be in appointing A&E consultants, due to the national shortage. He explained that plans had been developed to change the way that medical consultants worked within the Trust and it was hoped that this overhaul of the medical model would be an attractive proposition to perspective doctors. He noted that the Trust being in special measures

had had a negative impact on the recruitment of consultants.

Mr Clayton-Smith explained that the plans were very welcome and highlighted the need for the Board to ensure that resources were prioritised for this plan in order to ensure that it was successful. He recognised that it would take a lot of time and effort to implement effectively, and noted the Board's support for the project, alongside the expectation that it would lead to measurable improvements.

The Board noted the Urgent Care and the Four Hour Trajectory plans

106/2016 **Annual Business Plan Quarter 2 Update**

Mr Reid presented the Quarterly Update on the Annual Business Plan to the Board noting that most issues within the document had been covered within other papers presented to the Board. Mr Clayton-Smith agreed that the issues within the paper had been presented to, and discussed by the Board.

The Board noted the Annual Business Plan Quarter 2 Update

107/2016 **Winter Preparedness**

Mr Clayton-Smith explained that one of the key challenges facing the Trust was in delivering winter preparedness across the system. Mrs Butterworth explained that she was presenting ESHT's winter plan which had been produced in conjunction with system wide plans being made by the CCG and ESCC. She explained that ESHT's plan would feed into the larger system wide plan which was due to be submitted to NHS England at the end of October. Mrs Butterworth said that the plan would ensure that staff knew what to do during periods of pressure, allowing for a co-ordinated response and that it set out the actions that were expected to be taken during these periods to ensure safe, timely care for patients and methods of freeing up resources to enable this.

Mrs Butterworth explained that the Trust would always require additional capacity during the busiest periods and difficulty was found in deescalating following these periods. She reported that agreement had been reached for 19 additional locally sourced beds in nursing homes to help with capacity issues. She said that 10 beds had already been identified, alongside 12 additional beds on the Irvine unit and 5 in Rye to provide additional community capacity.

Mrs Butterworth explained that other initiatives had been introduced across the system, including the ability to set up homecare services, which would provide greater support to patients with basic needs. She reported that the Local Health Authority hoped to introduce Care Home Plus in December, which would lead to local residential care homes caring for slightly more acutely unwell patients.

Dr Herne explained that she had concerns about the thresholds set within document not allowing for sufficient time to resolve issues properly. She noted that there had been discussion about holding a 'breaking the cycle' week, and suggested holding this in January prior to the expected busiest period. Dr Bull agreed that this was a good idea, and noted that the decision on when to hold this would be made by the Executive Team.

Mrs Churchward-Cardiff explained that she was concerned that the plan was reactive and only dealt with problems when the occurred, asking whether early indicators could be included so that decisions were made early in the day rather than in the evening. Mr Hardwick explained that the new systems had been trialled during a period in September when the Trust was on Black status and that these had been operated proactively. He said that predictive data would help to ensure that issues were recognised earlier, and that a large amount of preplanning would take place when escalation beds had to be opened.

Dr Bull noted the need to ensure that the Trust applied a high level strategic approach to the escalation process, with executives providing an overview of pressures. Mrs Butterworth explained that daily meetings took place with social care and the CCG in order to discuss metrics, blocking factors and issues in order to try to improve patient flow during periods of pressure.

The Board noted the report on Winter Preparedness

108/2016 **Capital Programme Mid-Year Review**

Mr Clayton-Smith noted that the Review had not yet been presented to the Finance and Investment Committee, and asked the Board to delegate authority to the Committee to approve the Review.

The Board agreed to delegate authority to the Finance and Investment Committee to approve the Capital Programme Mid-Year Review.

109/2016 **2016 Premises Assurance Model Update**

Mr Hodgson noted that the Premises Assurance Model (PAM) had been presented to the Board three months previously, explaining that all evidence requirements had now been reviewed, and had been mapped against the PAM enabling the Trust's score to be improved significantly. He explained that some areas were being targeted for further improvement.

Mr Clayton-Smith asked how priorities within the PAM were linked into the overall strategy for the Trust to ensure that work was taking place on those items considered to be the most important. Mr Hodgson explained that further work needed to take place to ensure that business planning was embedded to a greater degree within estates and facilities. He

explained that doing this would ensure that staff were aware of plans, and would lead to improvements of both organisational governance and patient experience.

The Board noted the 2016 Premises Assurance Model Update

110/2016 **Risk and Quality Delivery Strategy**

Mr Parrott explained that the strategy had been presented to the Quality and Safety Committee, noting that it replaced the previous Trust Risk Strategy and Governance Strategy. He explained that it also incorporated elements of the Trust's 2020 strategy.

Mrs Bernhauser explained that the document had been thoroughly scrutinised by the Quality and Safety Committee, noting that collating the information into a single document was a major step forward to the Trust, and was of great credit to Mr Parrott.

Mr Clayton-Smith asked how often the document would be reviewed and Mr Parrott explained that he expected the strategy to undergo annual review, unless there were major policy changes within the Trust.

Mrs Churchward-Cardiff noted that the diagram on page 28 of the strategy contained a box titled 'Organisation development leadership and culture' which should be removed as it didn't link to anything. Mr Parrott agreed to review this. **AP**

Mrs Churchward-Cardiff noted that there were existing issues around initial contact for patients with mental health issues within the Trust and suggested that an existing metric could be included within the strategy. Dr Bull replied that this would sit on the Emergency Department's risk register as it was a specific issue for that department, explaining that it would not be included within the strategy as the document described the Trust's structure and the way in which the Trust managed risk.

Mr Clayton-Smith explained that he was happy to ratify the strategy and agreed that it should be reviewed annually. He said that he would be happy for the Quality and Safety Committee to ratify the strategy on an annual basis unless there was a major change to it.

The Board approved the Risk and Quality Delivery Strategy.

GOVERNANCE AND ASSURANCE

111/2016 **Annual Reports**

a) Infection Prevention Annual Report 2015/16

It was noted that the report had previously been approved by the Quality and Safety Committee.

The Board noted the Infection Prevention report

b) Workforce Race Equality Standard (WRES) Report 2015/16

It was noted that the report had previously been approved by the People and Organisational Development Committee.

The Board noted the Workforce Race Equality Standard (WRES) report

c) Safeguarding Annual Report 2015/16

Mrs Bernhauser agreed to check with Mrs Webster to ensure that the report had previously been approved by the Quality and Safety Committee. The Board agreed to revisit the report if the Quality and Safety Committee had not previously approved it. **SB**

The Board noted the Safeguarding report

d) Fire Safety Annual Report 2015/16

Mr Hodgson explained the report had previously been presented to the Senior Leaders Forum. He advised that it was a mandatory requirement to present the report to the Board, reporting that the Trust's fire safety risks were being addressed via a five year capital plan. He noted capital plan were in place to address existing risks and that some risks would be addressed over a period of time, explaining that these were mitigated by annual inspections by fire officers from East Sussex Fire and Rescue Service.

The Board received the Fire Safety Annual Report

112/2016 **Board Sub Committee Reports**

a) Audit Committee

The Board noted the Audit Committee report.

b) Finance and Investment Committee

The Board noted the Finance and Investment Committee report.

c) People and Organisational Development Committee

Ms Kavanagh asked for approval of the revised Terms of Reference for the People and Organisational Development Committee. Mr Clayton-Smith queried whether the People and Organisational Development Committee could be quorate with no NEDs present.

The Board noted the People and Organisational Development Committee Minutes and approved the revised Terms of Reference, with the provisio that the terms of quoracy were amended.

d) Quality and Safety Committee

The Board noted the Quality and Safety Committee Minutes,

113/2016 Any Other Business

Mrs Kavanagh asked if there was any way to lessen the huge amount of information being presented to the Board. Mr Clayton-Smith noted that the Board's sub-committees had already reviewed much of the information presented to the Board and Mrs Wells suggested that a front sheet summarising annual reports could be presented to the Board alongside links to full versions of reports.

ITEMS FOR INFORMATION

114/2016 **Questions from Members of the Public**

ESHT
Mrs Walke explained that she had given members of the Board a letter, explaining what the Save the DGH campaign felt was the best way forward for the Trust. She said that she wanted to ensure that the public's voice was heard, and asked for a response from the Trust giving reasons why the proposals would not happen in order to provide closure.

She explained that the campaign group wanted the Trust to succeed and not to disappear, noting that it would be great news if the organisation was successful in leaving special measures. She explained that she felt that the journey of going into, and hopefully leaving, special measures had left the Trust as a better place than it was before.

Dr Bull said that he had held a productive discussion with Mrs Walke about the Trust's maternity services and had agreed to relook at the case for changing maternity services in light of current circumstances and would report back on this. He noted that discussions were taking place with ESBT to ensure that correct levels of public and patient involvement were maintained when proposed structures were discussed.

A formal response would be issued to the letter.

Waiting in A&E Departments
Mrs Walke asked whether there was a method for the public waiting in A&E to raise issues with staff. She suggested that more openness about the issues faced by the Emergency Departments would help patients to understand the issues being faced better, and may help to reduce the number of patients coming to department, particularly those that didn't need to be there. Mr Clayton-Smith agreed about improving dialogue

within the departments, especially around patients being given a realistic idea of how long they would have to wait for treatment.

System-wide Escalation Plans
Mrs Walke asked if ESHT could help Brighton and Sussex University Hospitals NHS Trust with escalation plans when they experienced issues. Dr Bull explained that discussions took place on a system-wide basis when pressures were experienced and Mrs Butterworth reported that when the system was 'hot', the CCG chaired calls between all local organisations to see what whole system could do to manage issues.

Coperforma
Mrs Walke noted that when discussed at HOSC, Coperforma staff explained that prior to the change of provider they would undertake 20 journeys a day on average, and were now only managing 3-4 journeys a day due to new inefficiencies. She said that staff were reporting having to wait for work, and were frustrated with much lower levels of job satisfaction. Mrs Bernhauser explained that she had written to the CCG as chair of the Quality and Safety Committee to highlight the Trust's concerns about the quality and experience for patients of transport under Coperforma. She said that she understood the situation had improved somewhat, but there was still plenty of scope for further improvement.

ESHT 2020
Mrs Walker asked why within the ESHT 2020 papers there was no discussion of a possible two site solution for maternity, explaining that would like to see explanations included within the reports about why this was not possible. Dr Bull explained that the ESHT 2020 paper did not cover this possibility as it was focussed on the specific issues raised during the previous CQC inspection.

115/2016 **Date of Next Meeting**

Wednesday, 14th December 2016, in the St Mary's Boardroom, EDGH.

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 12th October 2016 Trust Board Meeting

Agenda item	Action	Lead	Progress
066/2016 (ii) and 104/2016 (iii)	Full review of Trust's plans for financial improvement to be presented at December's Board meeting	Jonathan Reid	On Agenda
103/2016	Query about why ESHT 2020 programme rated radiology improvements as green, whilst noting 50% achievement of 100% target	Adrian Bull	Green rating shows improvements are on target, not completed. Rating will be changed to blue once work is completed and embedded.
103/2016	Request to highlight any changes to ratings within ESHT 2020 report	Adrian Bull	Projects do not monitor up and down trends as they do for performance. Board is requested to note red ratings and the need for any support in addressing those issues.
104/2016 (ii)	Clarification of pressure sores acquired within Trust and those acquired within community to be made within performance report.	Adrian Bull	Additional narrative has been added to the Integrated Performance Report
110/2016	Review inclusion of 'Organisation development leadership and culture' on p28 of Risk and Quality Delivery Strategy	Ashley Parrott	Committee removed from 2020 structure and Risk and Quality Delivery Strategy as no longer accurate.
111/2016 c)	Confirm that Safeguarding Annual Report 2015/16 has been approved by the Quality and Safety Committee	Sue Bernhauser	Discussed and report circulated to QSC members for comments. No comments received.

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2016
Meeting:	Trust Board
Agenda item:	7
Subject:	Chief Executive's update
Reporting Officer:	Dr Adrian Bull

Action: This paper is for **(please tick)**					
Assurance	X	**Approval**		**Decision**	
Purpose:					
The purpose of this report is to provide the Board with a summary update from the CEO's perspective.					

Chief Executive's Update

1. Introduction

The key focus this month has been the development of the Financial Recovery Plan which was submitted to and approved by Stephen Hay and NHSI on 29th November. The team are now working to complete the programmes of work to ensure delivery of the actions.

On the 5th and 6th of December the Trust was visited by a large team of people from the GMC and HEE who had come to inspect ESHT for the quality of training that is being provided to junior doctors. This inspection was triggered by the very adverse results to the Junior Doctor survey conducted in March/April this year. The verbal feedback was very positive, with the Trust being complimented on the good progress that has been made in addressing the issues, on the change in culture and approach that was clear to the visiting team, and on the fact that the great majority of trainees would be happy to recommend ESHT as a place for others to come to pursue their medical training. HEE will continue with enhanced surveillance of training of CT in Medicine at the Conquest – but this was presented clearly as being supportive rather than punitive.

2. Safety and Patient Experience

2.1 Quality and Safety

HealthWatch have been working in the Trust conducting two invited 'Enter and View' activities. The first was to our two Dementia Friendly wards - Macdonald at Conquest and Folkington at EDGH. Both areas were visited over a two week period and were subject to 'observations of care'. Patients and staff, where appropriate, were spoken to. There were some very positive elements that came out of the visits. However, although nothing critical or clinically unsafe was identified, there were some very helpful comments which will result in further work being undertaken.

HealthWatch, also at our invitation, completed their 24 hour 'Round the Clock' care review over the period of 28/29 November. Activity was high on these days so the volunteers saw the hospitals (Conquest, EDGH and Bexhill) in a very busy state. The focus was about how patients experience care whilst in our services. Patients reported that they were happy with their care which was observed to be positive. An overriding comment was that staff members were proud of their services, and reported that they would not wish to do another job! Inevitably there are areas we can build on, but the team saw an improvement from their last visit (April 2016). Once the report is through, in the early part of 2017, this will be shared with the teams and through the Quality and Safety Committee.

2.2 Education and Training / Workforce

A successful international recruitment for nursing staff from the Philippines (80) and Spain (25) has taken place. We will start to see these recruits join us in 2017.

2.3 Mortality

The SHMI indicator preview is out for July 15-June 16 and is 1.11 again (in range). The number of coding diagnoses based on symptoms is still high at 13.2%, but we

are still not into the time frame and because of the delay in the audit we will have to wait a few more months to see if we have managed to improve the quality of note recording.

3. People, leadership, culture

3.1 Operational HR

Recruitment

- Participating in a programme to recruit to 60 integrated care roles
- Recruitment visit to the Philippines resulted in 80 offers of employment being made to nurses, expecting them to be work-ready by March 2017

Junior Doctors contract

- 73 FY1 and FY2's have been offered new contracts effective 7th December
- Junior Doctors Forum with Guardian of Safe Working held on 28th November
- Junior Doctors Forums held with CEO at both sites.

Employee Relations

- Undertaken work to review Grievance, Disciplinary and Dignity at Work procedures with support from Improvement Director.

3.2 Staff Engagement & Wellbeing

Staff Survey

National staff survey closed on 2nd December 2016. We are waiting the final response rate but the latest data we have is 47%. Staff survey results will be published in February 2017.

Flu vaccinations

The flu campaign is continuing to run through December 2016 and January 2017. 1762 of our frontline staff have received their flu jab, which is 40.6% of our frontline staff. We are aiming for a response rate of 60%.

Listening Conversations

Listening conversations/staff forums continue to run to ensure staff feedback and involvement in the development of new roles.

3.3 Workforce Development

Apprenticeships

We now have a steering group in place to manage the new processes with input from finance and procurement. The levy monies will be available from May 2017 to use for apprentice training and are likely to be in the region of £90,000 per month. There are a wide range of apprenticeship opportunities for our current staff which include business administration, customer care and team leading. New apprenticeship frameworks are being developed led by Health Education England and will include qualifications up to and including Masters Level through the apprenticeship route. Trust managers who are recruiting new staff are encouraged to consider putting apprenticeship frameworks into job descriptions so that there is a consistent approach trust wide to the education of new staff.

Mandatory training
There are still some areas where compliance does not meet trust recommendations, information governance compliance was 84% (latest figures based on October). Safeguarding adults and children are also lowest compliance with a range from 82-84%.

Training for staff in customer service has now been rolled out trust wide and attendance is good.

E-Learning
E-Learning support is available from L&D for those who want to borrow laptops or have one to one support in departments to increase e-learning/mandatory training compliance.

4. Delivery and Access

There continues to be significant pressure on hospital beds. Performance against the 4 hour target improved somewhat through the month – to 82% in November – but has slipped back in the first week of December. ECIP have completed their initial assessment and have agreed a work programme with the COO. Despite the significant pressure and continued high numbers of long stay patients, elective surgery throughput has been protected. There is increasing focus on discharge procedures with revision of the operational management of the hospital beds and site management meetings. Community services continue to provide excellent support from intermediate care facilities and HIT/Crisis Response/Frailty teams.

5. Finance and Capital

Key focus on finance recovery plan – on the agenda.

6. Strategy

ESHT have been fully participating in the STP planning process for the Sussex and East Surrey STP submission. This is now complete and has been made available publically.

The ESBT programme is the key element of service transformation for East Sussex in the STP and The Trust are joint leads for the ESBT Programme Board and we continue to be active participants in all the work streams. We are working closely with our partners to agree governance structures for the emerging ACO which will operate in shadow form from April 2017.

We are developing integrated strategic plans with commissioners to ensure alignment between ESBT and the Trust's emerging clinical strategy. This work is now progressing with additional support in place funded by NHSI improvement monies.

A Care Group work stream has been identified that will facilitate the review of end to end pathways of care in eight key areas. Small working groups are currently being identified to progress these work streams.

We have been meeting with local GP federations in the Hastings and Eastbourne localities to discuss how we can support resilience in Primary Care.

7. Recommendations

The Board is asked to note the contents of the report and receive the update.

Dr Adrian Bull
Chief Executive

East Sussex Healthcare NHS Trust

Audit Committee

1. Introduction

Since the Board last met an Audit Committee was held on 23rd November 2016. A summary of the items discussed at the meeting is set out below.

2. Board Assurance Framework and High Level Risk Register

The Director of Corporate Affairs presented the High Level Risk Register and the Board Assurance Framework and noting that risks relating to emergency department reconfiguration/patient flow, patient transport and finance were rated as red. It was noted that the provision of patient transport services was due to be taken over by South Central Ambulance Services.

3. Research Governance Annual Report

The Research Governance Annual report was presented to the Committee. A reduction in the level of core research funding from KSS Deanery was noted, and the need to look for alternative forms of funding and ways of working in the future was discussed.

4. Clinical Audit Forward

It was noted that the Trust had resolved issues around participation in the Irritable Bowel Syndrome – Biologics Audit which had been submitted within deadlines. The IT issues preventing participation in the National Adult Diabetes Audit remained, and were being taken forward by the Medical Director.

The Committee asked for greater assurance around audits abandonment.

5. Internal Audit Progress Report and Recommendation Tracker

The Committee received an update on internal audit progress. Five final audit reports were issued – two gave "Reasonable" assurance, three gave "Limited" assurance. Good progress was being made against the 2016/17 internal audit plan. An excellent response from staff across the Trust to an audit of appraisals was noted, with 1,400 responses from staff.

The Audit Recommendations tracker was reviewed and progress in completed actions noted.

6. Local Counter Fraud Service

The Committee received the Counter Fraud progress report and noted actions that were being taken. There had been four new referrals since the previous meeting.

A recent review of Declarations of Interest and improved processes within the Trust were discussed. A review of 'Health Tourism' within the Trust was discussed and was due to be carried out in 2017.

7. Information Governance

The Committee received the IG Update Report, noting that issues with pseudonymisation of patient data were being resolved. It was noted that new legislation and guidance would be introduced in 2017 which would remove charges for subject access requests from patients, and reduce the timeframe for responding from 40 to 28 days. The impact that this would have on the IG team was noted and discussed.

The Committee received a Registration Authority report on the use of smartcards within the Trust, noting that compliance figures had improved during 2016 as legacy data issues were reosolved.

8. Annual Review of Corporate Documents

The Committee received the annual review of the Trust's Standing Financial Instructions, Scheme of Delegation and Standing Orders. They approved the recommended changes and agreed that these should be presented to the Board for approval in December 2016.

9. Committee Dates and Work Planner 2017

The Committee noted the dates and work planner for 2017.

Approved minutes of the meeting held in September are attached for the Board's information.

Mike Stevens
Chair of Audit Committee

6th December 2016

East Sussex Healthcare NHS Trust

Finance & Investment Committee

1. Introduction

Since the Board last met a Finance & Investment Committee meeting was held on 28 October 2016 (minutes approved and attached) 23 November 2016 (to review the Financial Recovery Plan prior to submission to NHS Improvement) and on 30 November 2016. A summary of the items discussed at this meeting is set out below.

2. Financial Recovery Plan

Mr Reid presented the Financial Recovery Plan for the delivery of the 2016/17 control total which was presented and agreed by NHS Improvement on 29 November 2016.

NHS Improvement were very encouraged and acknowledged that a lot of work had been done. They said it was good to be working with a new management team and they were very pleased that the Trust Board were signed up to the plan. There would be a further meeting with NHS Improvement in January 2017.

3. Contracts & Income Monthly Report

The Committee received an update on the contract position and ongoing dialogue that was taking place with the CCG, and highlighted the key contract risks.

4. Cashflow Monthly report

The Committee received an overview of the cash flow position for the Trust. It was noted that there were significant pressures on the Trust's cash flow now and in the foreseeable future. The detailed cashflow forecast indicated that if the financial position of the Trust did not improve creditor balances would continue to rise until they reach unsustainable levels.

5. Approval of Loan Facility 2016/17

It was noted that discussions were ongoing with NHS Improvement with a view to securing a further injection of financing to meet its current outstanding creditor balance issues. The Committee was asked to review two options for enabling the Trust to access additional cash above the original agreed facility value. The Committee agreed to apply for £5.8m, the amount that met the deficit plan. It was agreed that this would be formally ratified by the Trust Board in private in December 2016.

6. Draft Operational Plan 2017/18 and 2018/19

The Committee received the first draft operational plan for 2017/18 and 2018/19 which was submitted to NHS Improvement on 24 November 2016.

7. Budget Setting

The Committee received a paper outlining the process for Budget Setting and Business/Operational Planning for 2017/18. The possible risks and challenging timescales for clinical division teams, knowledge management and finance teams were noted.

8. Sussex and East Surrey STP and East Sussex Better Together

The Committee received a brief update on the STP and East Sussex Better together.

9. Draft minutes of the Financial Improvement and Sustainability Committee held on 25 October 2016

The Committee received a copy of the draft minutes of the first meeting of the Financial Improvement and Sustainability Committee which took place on 25 October 2016, for information.

10. Draft Procurement Transformation Plan

Mr Reid presented a draft Procurement Transformation Plan (PTP) in line with instructions from the NHSI Financial Efficiency Directorate. It was noted that the procurement service in East Sussex Healthcare scores well against the metrics (in general), noting the intention is for all Trusts to do better.

11. Commercial Strategy and Market Developments

The Committee received an update on the tenders position and business cases approved as at 21 November 2016. It was noted that the joint work on the development of the Commercial Strategy was still on the agenda and it was planned to have this available by the end of the financial year.

12. Track4Safety - GS1 barcoding and Pan European Public Procurement Online (PEPPOL) Standards - Outline Business Case

Mr Reid presented the Committee with an overview on the Trust's progress with regard to Track4Safety – GS1 barcoding and Pan European Public Procurement (PEPPOL) Standards. The Finance and Investment Committee recognised the progress that had been made on the Outline Business Case and also on the work around the assumptions.

13. Revised Terms of Reference

The Committee agreed the revised Terms of Reference which now included a specific clause about the link with the Audit Committee and the Quality and Safety Committee. This was one of the recommendations from the recent Capsticks governance review of Committees. It was agreed that the revised Terms of Reference would be passed to the Trust Board for ratification.

Barry Nealon
Chair, Finance & Investment Committee
1 December 2016

East Sussex Healthcare NHS Trust

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

2. Purpose

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

- Oversight of the Trust Financial Strategy including a review of future financial challenges and opportunities for the Trust
- The future financial risks of the organisation
- The integrity of the Trust's financial structure
- The effectiveness and robustness of financial planning
- The effectiveness and robustness of investment management
- The robustness of the Trust's cash investment approach
- The investment and market environment the Trust is operating in, and the process for agreeing or dismissing investment decisions
- The risk appetite that is appropriate for the organisation
- The process for business case assessments and scrutiny
- Review and approve business cases including tracking of delivery against plan and benefits realisation
- Monitoring the capital investment programme
- Undertake substantial reviews of issues and areas of concern.

3. Membership and attendance

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

- At least three non-executive directors (one of whom shall be a member of the Audit Committee)
- Chief Executive
- Director of Finance
- Chief Operating Officer
- Director of Strategy, Innovation and Planning (optional)
- Director of Corporate Affairs

4. Quorum

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

5. Frequency

Meetings shall be held at least four times a year and at such other times as the Chairman of the Committee shall require.

6. Duties

The Committee shall review and monitor the longer-term financial health of the Trust.

In particular its duties include:

- Reviewing the financial environment the Trust is operating within, and supporting the Board to ensure that its focus on financial and business issues continually improves
- Supporting the Board to understand and secure the financial and fiscal performance data and reporting it needs in order to discharge its duties
- Understanding the market and business environment that the Trust is operating within and keeping the capacity and capability of the Trust to respond to the demands of the market under review
- Understanding the business risk environment that the organisation is operating within, and helping the Board to agree an appropriate risk appetite for the Trust
- Supporting the Board to agree an investment and business development strategy and process
- Supporting the Board to agree an integrated business plan
- Approval for business cases with a value between £250k-£500k and recommendation of business cases over £500k to the Board
- Ensure that business cases submitted for approval are in line with the priorities identified in the Board's agreed Development Plan
- Receive assurance and scrutinise the effectiveness of demand and capacity planning.

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 will review the work of other Committees within the organisation whose work can provide relevant assurance to the Finance and Investment Committee's own scope of work; in particular this will include the Audit Committee and the Quality and Standards Committee.

7. Reporting arrangements

The minutes of the Committee meetings shall be formally recorded by the PA to the Finance Director and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive actions.

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

December 2016

East Sussex Healthcare NHS Trust

Quality and Safety Committee

1. Introduction

Since the Board last met a Quality & Safety Committee meeting was held on 23 November 2016. The minutes of that meeting are due to be approved at the next meeting in January 2017. A summary of the items discussed at the meeting is set out below.

2. High Level Risk Register

Two new risks had been opened since July 2016:

- IT and data flow completion. These would be addressed through the Information Governance Steering Group.
- Nurse recruitment risk would remain the same following a successful overseas recruitment due to a lead time of up to a year.

10 risks remained at a score of 20, mostly around Estates. Each corporate risk was aligned to a Committee which would, from December 2016, receive its own report.

The QSC would be monitoring the risk regarding the new chemotherapy system – a plan was in place to address.

Board Assurance Framework

It was noted that 3 areas were showing red:

- Emergency Department Reconfiguration/Patient Flow
- Patient Transport. The Trust had been invited to contribute to lessons learned.
- Finance

Mortality had reduced to Amber.

3. Quality Improvement Plan

Urgent and Emergency Care - many areas at Amber leading to an overall score of Red. The right strategies were in place and work was on-going to make those strategies have an impact.

It was noted that *Sock it to Sepsis* was to be rolled out into the Community setting.

The Committee noted receipt of initial feedback from the recent visit of Emergency Care Improvement Programme (ECIP).

3. Governance Quality Report

Triangulation of in depth reports that had been presented to the Patient Safety and Quality Group had confirmed that issues were being managed. Key highlights:

- Complaints had shown a slow improvement in response rates.
- Family and Friends Test responses were up slightly on October 2016 rates.
- Ophthalmology had been identified as the main specialty concern regarding reports of Never Events and Serious Incidents.

4. **Patient Safety and Quality Group**

The Group had been meeting since August 2016. Work plans and Terms of Reference for the subgroups had been agreed.

Items discussed at the October meeting were:

- Floor to Board dashboard had issued.
- Patient falls – work being done to address concerns over the numbers.
- Duty of Candour Training for staff had been delivered.
- Clinical Record Keeping to be looked at by a new group, chaired by Simon Walton.
- Quality Account Priorities – work was being done to monitor outcome measures.
- Patient pathway would be scrutinised by the Group going forward.

5. External Visits and Reviews Report

There had been 10 external visits and 6 external reviews in the period 1 April 2016 to 30 September 2016. Kings College Medical School review team, following a visit to Conquest Hospital had commended the enthusiastic medical education team approach to the support of those on medical student placements.

6. Urgent Care Update

An interim paper updated the Committee on Urgent Care issues pending a Deep Dive that was scheduled for January 2017. Senior Responsible Officer confirmed as Joe Chadwick-Bell, Chief Operating Officer.

7. **Deep Dive – People and Organisational Development**

The Committee received an update on the new People and Organisational Development Group which was addressing topics, such as workforce, that had previously been presented to the Quality and Safety Committee. Assurance was received that topics previously covered by the QSC were being incorporated into the POD Group. It was agreed that an integrated assessment of safety by both the QSC and the POD should be undertaken, to triangulate trips, falls and complaints with staff absences and other staff issues.

Sue Bernhauser
Chair, Quality and Safety Committee
5 December 2016

East Sussex Healthcare NHS Trust

Date of Meeting:	14 December 2016
Meeting:	Trust Board
Agenda item:	9
Subject:	Board Assurance Framework
Reporting Officer:	Lynette Wells, Director of Corporate Affairs

Action: This paper is for **(please tick)**					
Assurance	√	Approval		Decision	

Purpose:

Attached is the updated Board Assurance Framework (BAF) which brings together the strategic priorities and objectives of the organisation, with an assessment of their risks, the controls in place and details of the internal and external assurance along with associated actions. .

Introduction:

The Assurance Framework has been reviewed and updated since the last meeting and clearly demonstrates whether the gap in control or assurance remains unchanged, has increased or decreased since the last iteration. There are actions against identified gaps in control and assurance and these are individually RAG rated and updates marked in red

Analysis of Key Issues and Discussion Points Raised by the Report:

The refreshed document is attached and there are 3 areas rated red:

2.1.2 Emergency department reconfiguration/patient flow
3.3.1 Patient transport
4.1.1 Finance

There are no new gaps in control or assurance added to the BAF this month and no proposals to revise RAG rating or remove any of the gaps.

Benefits:

Identifying the principle strategic risks to the organisation allows the Committee to provide assurance to the Trust Board that these risks are effectively controlled and mitigated which supports the Trust in achieving its strategic aims and objectives.

Risks and Implications

Failure to identify and monitor the strategic risks to the organisation will lead to an inability to demonstrate effective systems of internal control and an increase in the likelihood of adverse outcomes for the Trust.

Assurance Provided:

The BAF identifies the principal strategic risks to achieving the Trust's aims and objectives and the gaps in controls and assurance and subsequent actions being taken to mitigate these.

Proposals and/or Recommendations
The Board is asked to review and note the updated Board Assurance Framework and consider whether the main inherent/residual risks have been identified and that actions are appropriate to manage the risks.

Consideration by other Committees
Audit Committee/Quality and Standards Committee 23 November 2016 These Committees also reviewed the high level risk register for the Trust.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
None identified.

For further information or for any enquiries relating to this report please contact:	
Name: Lynette Wells, Director of Corporate Affairs	**Contact details:** lynette.wells2@nhs.net

Assurance Framework - Key

RAG RATING:

Effective controls definitely in place and Board satisfied that appropriate assurances are available.
Effective controls thought to be in place but assurance are uncertain and/or possibly insufficient.
Effective controls may not be in place and/or appropriate assurances are not available to the Board

Status:

▲	Assurance levels increased
▼	Assurance levels reduced
◄►	No change

Key:	
Chief Executive	CEO
Chief Operating Officer	COO
Director of Nursing	DN
Director of Finance	DF
Director of Human Resources	HRD
Director of Strategy	DS
Medical Director	MD
Director of Corporate Affairs	DCA
Committee:	
Finance and Investment Committee	F&I
Quality and Standards Committee	Q&S
Audit Committee	AC
Senior Leaders Forum	SLF
People and Organisational Development Committee	POD

C indicated Gap in control
A indicates Gap in assurance

Assurance Framework - Key

RAG RATING:

Effective controls definitely in place and Board satisfied that appropriate assurances are available.
Effective controls thought to be in place but assurance are uncertain and/or possibly insufficient.
Effective controls may not be in place and/or appropriate assurances are not available to the Board

Status:

▲	Assurance levels increased
▼	Assurance levels reduced
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Key:	
Chief Executive	CEO
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Director of Nursing	DN
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Medical Director	MD
Director of Corporate Affairs	DCA
Committee:	
Finance and Investment Committee	F&I
Quality and Standards Committee	Q&S
Audit Committee	AC
Senior Leaders Forum	SLF
People and Organisational Development Committee	POD

C indicated Gap in control
A indicates Gap in assurance

	Strategic Objectives:
1.	Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.
2.	All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.
3.	
4.	We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.
5.	We will operate efficiently and effectively, diagnosing and treating patients in

	Risks:
1.1	We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our
2.1	registration and compliance with regulatory bodies.
	We are unable to demonstrate that the Trust's performance meets expectations
2.2	against national and local requirements resulting in poor patient experience,
3.1	adverse reputational impact, loss of market share and financial penalties.
	There is a lack of leadership capability and capacity to lead on-going
3.2	performance improvement and build a high performing organisation.
3.3	We are unable to develop and maintain collaborative relationships based on
	shared aims, objectives and timescales with partner organisations resulting in
4.1	an impact on our ability to operate efficiently and effectively within the local
4.2	health economy.
	We are unable to define our strategic intentions, service plans and
4.3	configuration in an Integrated Business Plan that ensures sustainable services
4.4	and future viability.
5.1	We are unable to demonstrate that we are improving outcomes and experience
5.2	for our patients and as a result we may not be the provider of choice for our
	local population or commissioners
	We are unable to adapt our capacity in response to commissioning intentions.

Board Assurance Framework - November 2016

Strategic Objective 1: Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care							
Risk 1.1 We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with							
Key controls	Effective risk management processes in place; reviewed locally and at Board sub committees. Review and responding to internal and external reviews, national guidance and best practice. Feedback and implementation of action following "quality walks" and assurance visits. Reinforcement of required standards of patient documentation and review of policies and procedures Accountability agreed and known eg HN, ward matrons, clinical leads. Annual review of Committee structure and terms of reference Effective processes in place to manage and monitor safe staffing levels						
Positive assurances	Internal audit reports on governance systems and processes Weekly audits/peer reviews eg observations of practice Monthly reviews of data with each CU 'Quality walks' programme in place and forms part of Board objectives External visits register outcomes and actions reviewed by Quality and Standards Committee Financial Reporting in line with statutory requirements and Audit Committee						
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/milestone**	**RAG**	**Lead**	**Monitoring Group**
1.1.1	A	Quality improvement programme required to ensure trust is compliant with CQC fundamental standards.	March CQC inspection reports published Sept 15, trust in special measures. Quality	end Jan-17	◄►	DN	Q&S SLF

Board Assurance Framework - November 2016

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.1.2	C	In order to deliver an effective service, there is a requirement to improve controls in Health Records; to encompass systems and processes, storage capacity and quality of case note folders.	Oct-15 iFIT embedding with rolling improvement programme. Mitigating actions continue and extended to provide daily information re availability of notes. New escalation procedure for missing notes	end Mar-17	◄►	COO	Q&S SLF

Strategic Objective 2: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.					
Risk 2.1 We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact,					
Key controls	Robust monitoring of performance and any necessary contingency plans. Including: Monthly performance meeting with clinical units Clear ownership of individual targets/priorities Daily performance reports Effective communication channels with commissioners and stakeholders Healthcare Associated Infection (HCAI) monitoring and Root Cause Analysis Single Sex Accommodation (SSA) processes and monitoring Regular audit of cleaning standards Business Continuity and Major Incident Plans Reviewing and responding to national reports and guidance Cleaning controls in place and hand hygiene audited. Bare below the elbow policy in place Monthly audit of national cleaning standards				
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Exception reporting on areas requiring Board/high level review Dr Foster/CHKS HSMR/SHMI/RAMI data Performance delivery plan in place Accreditation and peer review visits Level two of Information Governance Toolkit External/Internal Audit reports and opinion Patient Safety Thermometer Cancer - all tumour groups implementing actions following peer review of IOG				
Gaps in Control (C) or Assurance (A):	**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**

2.1.1	C	Effective controls required to support the delivery of cancer metrics and ability to respond to demand and patient choice.	IST review to supplement work with KSS Cancer network on pathway management. Focused work to improve 2ww	end-Mar 17	◄►	COO	SLF

Board Assurance Framework - November 2016

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.1.2	C	Emergency departments require reconfiguration to support effective patient assessment-treatment time and subsequent discharge to other specialist/bed areas. CQC report identified privacy and dignity issues. ED has impact on patient flow, use of gateway areas, ambulatory care and adherence to pathways of care.	Meet SECAMB monthly to review on going issues and joint working to resolve. Action plan and escalation process in place	end-Mar 17	◄►	COO	SLF

2.1.3	A	Assurance is required that there are effective systems in place to minimise infection control incidents and share learning throughout the organisation.	Jun-Dec 15 Audit cleaning team strengthened. Infection control team being restructured, to increase management of audit / assurance process. Weekly walks round both sites with facilities and IC to review	end Mar-17	◄►	DN	Q&S

Strategic Objective 2: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.							
Risk 2.1 Continued - We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse							
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.1.4	A	Mortality levels above expected range and assurance is required that there are robust mechanisms in place to understand the metrics and implement best practice.	Mar-16 Focussed action plan being developed. Identified top 10 drivers for elevated indices and reviewing pathways for cause in these	end Mar-17	▲ Oct-16	MD	Q&S
2.1.5	C	Effective controls are required to ensure children requiring an appointment with a community consultant paediatrician are seen in a timely manner.	Feb-15 to Oct-15 Action plan implemented and waiting list backlog cleared. Patient Tracking List developed	end Mar-17	◄►	COO	SLF Q&S

2.1.6	C	Effective controls are required to ensure increasing numbers of young people being admitted to acute medical wards with mental health and deliberate self harm diagnoses are assessed and treated appropriately.	Aug-15 Training requested from mental health team at CAMHS for ward nurses to ensure a competent and confident workforce. Mental health nurse requested via TWS to	end Jan-17	◄►	COO	SLF Q&S

Risk 2.2 There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.					
Key controls	Clinical Unit Structure and governance process provide ownership and accountability to Clinical Units Clinicians engaged with clinical strategy and lead on implementation Job planning aligned to Trust aims and objectives Membership of SLF involves Clinical Unit leads Appraisal and revalidation process Implementation of Organisational Development Strategy and Workforce Strategy National Leadership and First Line Managers Programmes Staff engagement programme Regular leadership meetings Succession Planning				
Positive assurances	Effective governance structure in place Evidence based assurance process to test cases for change in place and developed in clinical strategy Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Training and support for those clinicians taking part in consultation and reconfiguration. Outcome of monitoring of safety and performance of reconfigured services to				
Gaps in Control (C) or Assurance (A):	**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**

2.2.1	A	Assurance is required that robust controls are in place in relation to mandatory training and appraisals are effective and evidenced by improved compliance in these two areas.	Mar 16 - Appraisal process and paperwork redesigned along with a developme nt programme for Appraisers. New L&D manager started Feb and key objectives	end Mar-17	◄► Mar-16	HRD	POD SLF
2.2.2	A	The Trust needs to develop and support its clinical leadership to empower them to lead quality improvement in order to realise the ambition of becoming an outstanding organisation by 2020.	Jul-16 Reviewing medical leadership roles to ensure they are appropriatel y	end Mar-17	◄►	MD	POD

Strategic Objective 3: We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local					
Risk 3.1 We are unable to develop and maintain collaborative relationships based on shared aims, objectives and timescales with partner organisations resulting in an impact on our ability to					
Risk 3.2 We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.					
Key controls	Develop effective relationships with commissioners and regulators Proactive engagement in STP and ESBT Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work. Relationship with and reporting to HOSC Programme of meetings with key partners and stakeholders Develop and embed key strategies that underpin the Integrated Business Plan (IBP)				
Positive assurances	Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. Monthly performance and senior management meetings with CCG and TDA. Working with clinical commissioning exec via East Sussex Better Together and Challenged Health Economy to identify priorities/strategic aims. Board to Board meetings with stakeholders. Membership of local Health Economy Boards and working groups Two year integrated business plan in place Stakeholder engagement in developing plans Service delivery model in place				
Gaps in Control (C) or Assurance (A):	**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**

3.2.1	A	Assurance is required that the Trust will be able to develop a five year integrated business plan aligned to the Challenged Health Economy work.	Challenged Health Economy and Better Together Work on-going. Trust developing clinical strategy. Dec-15 ESBT work continues. Board to Board meeting	end Dec 16	◄►	DS	F&I SLF

Strategic Objective 3: We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local					
Risk 3.3 We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we may not be the provider of choice for our local population or					
Key controls	Development of communications strategy Governance processes support and evidence organisational learning when things go wrong Quality Governance Framework and quality dashboard. Risk assessments Complaint and incident monitoring and shared learning Robust complaints process in place that supports early local resolution External, internal and clinical audit programmes in place				
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Board receives clear perspective on all aspect of organisation performance and progress towards achieving Trust objectives. Friends and Family feedback and national benchmarking Healthwatch reviews, PLACE audits and patient surveys Dr Foster/CHKS/HSMR/SHMI/RAMI data				
Gaps in Control (C) or Assurance (A):	**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**

3.3.1	A	Assurance is required that patient transport services will be improved to minimise any detrimental impact on patient care and experience.	Incidents logged, issues escalated to SECAMB /CCG. Service spec reviewed by commissioner; Trust engaging with process. Apr-15 Inpatients - Trust has access to additional vehicles via	end Jan-17	◄► May-16	COO	SLF

Board Assurance Framework - November 2016

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.3.2	C	A number of concerns have been identified following the centralisation of reception and outpatient services on the two acute sites. Shortage of staff in appointment and admissions booking teams Further controls are required to support delivery of an efficient service and good patient experience.	Review instigated to support implementation of focussed actions. Feb-15 Central team in place and systems being monitored. Considering developing specialist teams to support areas with complex processes. Apr-15 - Dec15 Close	end Mar-17	◄►	COO	SLF Q&S

Strategic Objective 4: We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially					
Risk 4.1 We are unable to adapt our capacity in response to commissioning intentions, resulting					
Key controls	Clinical strategy development informed by commissioning intentions, with involvement of CCGs and stakeholders QIPP delivery managed through Trust governance structures aligned to clinical strategy. Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work				
Positive assurances	Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. Written reports to SLF on progress with QIPP targets to ensure improvements in patient outcomes are planned and co-ordinated. Performance reviewed weekly by CLT and considered at Board level.				
Gaps in Control (C) or Assurance (A):	**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**

4.1.1	C	Require evidence to ensure achievement of the 2016/17 Financial Plan and prevent crystallisation of risks as follows: activity and income targets are not achieved; contractual fines and penalties are levied; activity, capacity and unplanned cost pressures arise; the CIP plan is not delivered;	PBR contract in place. Activity and delivery of CIPs regularly managed and monitored. Monthly accountability reviews in place and remedial action undertaken where necessary. Timely reporting of finance/activity/workforce performance in place. Regular reviews by BPSG, CLT, SLF,	Commenced and on-going review and monitoring to end Mar-17	◀▶	DF	F&I

Risk 4.2 In running a significant deficit budget we are unable to invest in delivering and improving quality of care and patient outcomes. This could compromise our ability to invest in our ability to make investment in infrastructure and service improvement. **Risk 4.3: We are unable to effectively align our finance, estate and IM&T infrastructure to**					
Key controls	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Monitoring by F&I Committee Essential work prioritised within Estates, IT and medical equipment plans				
Positive assurances	Draft assessment of current estate alignment to PAPs produced Essential work prioritised with Estates, IT and medical equipment plans. Significant investment in estate infrastructure, IT and medical equipment required over and above that included in the Clinical Strategy FBC. Capital Approvals Group meet monthly to review capital requirements and				
Gaps in Control (C) or Assurance (A):	**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**

4.2.1	A	Assurance is required that the Trust has the necessary investment required for estate infrastructure, IT and medical equipment over and above that included in the Clinical Strategy FBC. Available capital resource is limited to that internally generated through depreciation which is not currently adequate for need. As a result there is a significant overplanning margin over the 5 year planning period and a risk that essential works may not be affordable.	May-16 – Capital programme has been submitted to NHSI as part of the 2016/17 business planning submission. The Trust Board will undertake a further review the capital programme with a view to ensuring that priorities for	On-going review and monitoring to end Mar-17	◄►	DF	F&I

Risk 4.4 We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.	
Key controls	Horizon scanning by Executive team, Board and Business Planning team. Board seminars and development programme Robust governance arrangements to support Board assurance and decision making. Trust is member of FTN network Review of national reports
Positive assurances	Policy documents and Board reporting reflect external policy Strategic development plans reflect external policy. Board seminar programme in place Business planning team established Clear process for handling tenders/gathering business intelligence and

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
4.4.1	A	In order to retain and develop services the trust requires the capacity and capability to effectively respond to tenders. Specialist skills are required to support Any Qualified Provider and tendering exercises by commissioners.	Oct-15 Portfolio moved to DF and being reviewed. Dec 15 - additional external resource has been commissioned by the Trust for a limited period with	end Mar-17	◀▶ May-16	DS	SLF

Strategic Objective 5: All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they					
Risk 5.1 We are unable to effectively recruit our workforce and to positively engage with staff at all levels.					
Key controls	Workforce strategy approved Jun-15 - aligns workforce plans with strategic direction and other delivery plans; - ensures a link between workforce planning and quality measures Recruitment and Retention Strategy approved Jun-15 with planned ongoing monitoring Workforce metrics reviewed as part of the Integrated scorecard and alongside quality and performance data (plans to include vacancies) Rolling recruitment programme Monthly vacancy report and weekly recruitment report to CLT				
Positive assurances	Training and resources for staff development Workforce planning aligned to strategic development and support Workforce assurance quarterly meetings with CCGs Implementing Values Based Recruitment and supported training programme Success with some 'hard to recruit to' posts Well functioning Temporary Workforce Service. Full participation in HEKSS Education commissioning process.				
Gaps in Control (C) or Assurance (A):	**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**

5.1.1	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties e.g. cardiac physiologists, ODPs and anaesthetic staff.	May-16 Recruitment hotspots - Medical Consultants, A&E, Histopathology, Stroke, Gastroenterology, Other areas of focus are Dermatology, Obstetrics, Neurology, Haematology Paediatrics Middle	end Mar-17	◄►	HRD	SLF
5.1.3	C	Assurance is required that the Trust has effective controls in place to maintain sufficient staffing levels in A&E; recruitment difficulties in consultant, middle grade and nursing. Deanery short falls in fill rate for junior positions.	Aug-15 Business continuity plans in place to cover short term difficulties. Overseas	end Mar-17	◄►	COO	SLF

Strategic Objective 5: All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they	
Risk 5.2 If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale	
Key controls	Leading for Success Programme Leadership meetings Listening in Action Programme Clinically led structure of Clinical Units Feedback and implementation of action following Quality Walks. Organisation values and behaviours developed by staff and being embedded Staff Engagement Plan developed OD Strategy and Workstreams in place
Positive assurances	Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Embedding organisation values across the organisation - Values & Behaviours Implementation Plan Staff Engagement Action Plan Leadership Conversations National Leadership programmes Surveys conducted - Staff Survey/Staff FFT/GMC Survey

Gaps in Control (C) or Assurance (A):	Actions:	Date/ milestone	RAG	Lead	Monitoring Group

5.2.1	A	The CQC staff surveys provide insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others.	May-16 Staff survey results – three priorities have been identified for improvement for 2016/17. Clinical units are working on action plans for their local issues. Cultural review has been commissioned and will commence April 2016 Number of local staff	end Apr-17	◄►	HRD	POD SLF

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2016
Meeting:	Trust Board
Agenda item:	10
Subject:	ESHT 2020 Improvement Programme
Reporting Officer:	Alice Webster Director of Nursing

Action: This paper is for **(please tick)**					
Assurance	✓	**Approval**		**Decision**	

Purpose:

To provide a highlight report of the ESHT 2020 Improvement Programme initially developed from the recommendations made by the CQC in their reports published in March and September 2015 following the Chief Inspector of Hospitals visits in September 2014 and March 2015

Introduction:

CQC inspections of the Trust were undertaken in March and April 2015, with the report published in September 2015. The overall rating of the Trust was 'inadequate' and the Trust was placed in special measures in September 2015 following recommendation from the Chief Inspector of Hospitals. A detailed Quality Improvement Plan was developed to ensure that the Trust worked together to achieve the commitment of delivering safe, high quality care for all of our patients. This has now been transitioned into the ESHT 2020 Programme providing robust governance for all improvements linked to strategic objectives

The full Quality Improvement Plan and CQC reports are available at:
http://www.esht.nhs.uk/about-us/cqc-report/

Analysis of Key Issues and Discussion Points Raised by the Report:

The purpose of this report is to update on progress in achieving the recommendations made by the Care Quality Commission (CQC) following their visits in September 2014 and March 2015. The aim of the programme is to ensure the Trust is able to respond to the recommendations made in the reports and make any improvements required in order to ensure compliance is met with the Regulations (2014) of the Health and Social Care Act 2008. This report provides an update on the following aspects in relation to the progress of the improvement Plan:

1. **Highlights and Milestones**
   This section describes the outcomes of the Warning Notice deep dive exercise and how this has informed the future delivery of the programme

2. **Project Summary Dashboard**
   For each objective this shows the current delivery and sustainability RAG status including KPIs where appropriate.

3. **Key activities and Significant Risks**
   Risks that potentially seriously threaten the progress of the Improvement Plan

4. **Improvements**
   Update of outcomes from the Improvement Programme that have already been met improving the quality and efficiency of our care.

Benefits:
The report notes that there is progress being made against the actions and by addressing the recommendations services and patient care will be improved and the Trust will be compliant with CQC regulations.

Risks and Implications
Non-compliance with the action plan may mean the Trust is not providing high quality care and good experience for our patients. If the recommendations are not acted upon the Trust is also at risk of not meeting the Regulations set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and may receive sanctions.

Assurance Provided:
Improvement Sub-Committee meetings attended by Executive Leads and Patient Experience Liaison Representatives take place monthly chaired by the Chief Executive, weekly meetings take place between the Senior Responsible Owner of the ESHT 2020 Programme, Alice Webster – Director of Nursing and the ESHT 2020 Programme Manager, Lesley Walton. Monthly meetings take place between the Project Executives the Project Manager and the Objective Leads.

Review by other Committees/Groups (please state name and date)**:**
Quality and Safety Committee Nov 2016 QIP Monitoring Group Nov 2016

Proposals and/or Recommendations
The Committee is asked to review and note the progress in implementing the ESHT 2020 improvement plan.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
None identified.

For further information or for any enquiries relating to this report please contact:	
Name: Alice Webster Director of Nursing	**Contact details:** alice.webster@nhs.net

East Sussex Healthcare NHS
NHS Trust

November 2016

TRUST BOARD

ESHT 2020 Improvement Programme Update

Introduction

The purpose of this report is to update on progress in achieving the recommendations made by the Care Quality Commission (CQC) following their visits in September 2014 and March 2015. The aim of the ESHT 2020 Improvement programme is to ensure the Trust is able to respond to the recommendations made in the reports and make any improvements required in order to ensure compliance is met with the Regulations (2014) of the Health and Social Care Act 2008.

ESHT 2020 Improvement programme Status

This report provides an update on the following aspects from the last two months:

1. Highlights and Milestones
2. Programme and Project Progress
3. Next key activities and Significant Risks
4. Improvements

Programme Highlights: The main focus since the last report to the Committee has been the progression of the projects that are currently delivering improvements. The current status of the programme is:

Key highlights are:

- ESHT 2020 Improvement Programme Sub-Committee chaired by Dr. Adrian Bull has met in November, and continues to meet, monthly embedding the governance to ensure challenge to projects and continual improvement at ESHT.
- Eight Projects have been delivered and transferred into business as usual.
- A new End of Life Care project has been set up to focus on supporting the expansion of improvements required following the CQC visit
- Four main projects are now the key focus, Urgent & Emergency Care Improvement Project, Mortality and Morbidity Assurance Project, End of Life Care Project, Exemplar Ward Project and a new project agreed to focus on patient driven improvements, Expert Patient.

- ☐ Project Manager for Mortality and Morbidity Projects resigned and left the Trust. Interviews for replacement held and offer made.
- ☐ Improvement Sub-Committee reviewing purpose to potentially operate as assurance and scrutiny for all improvement/change work delivering the strategy and business plans
- ☐ Improvement Forum held their first meeting, staff interested in embedding improvement skills at ESHT. Two schemes running by PMO, radiology diagnostics and patient communication
- ☐ NHS Elect Service Improvement Programme Commenced
- ☐ Expert Patient project proposal to the Improvement Sub-Committee
- ☐ Elective Care Programme initiated and resources to support to be identified
- ☐ Financial Special Measures Programme Manager recruitment in progress
- ☐ Visit to Guys and St. Thomas's to learn ideas for improvement – fed back to David Walker and Alice Webster. Some good ideas were shared.

Milestone Name	Forecast Completion Date	Responsible	RAG	Comments
SRO - Alice Webster				
Vision	04-Apr-16	Alice Webster	C	
Set Up Programme Board	31-Mar-16	Lesley Walton	C	
Programme Governance, Assurance and Terms of	09-May-16	Lesley Walton	C	
Programme Plan	30-Apr-16	Lesley Walton	C	
Communications and Engagement Strategy	30-Apr-16	Suzanne Gouch	C	
Benefits Management Strategy	30-Aug-16	Catherine Ashton	C	
Resource Management Strategy	31-May-16	Lesley Walton	C	
Risk Management and Issue Resolution Strategy	31-May-16	Lesley Walton	C	
Programme Gateway Assurance	30-Sep-16	NHS Digital	R	**Advised no capacity to provide assurance. Requested suggested external reviewers from NHS Imp.**
Programme Gateway Assurance	31-Jan-17	Internal/External (TBC)	A	
Programme Gateway Assurance	31-Jul-17	Internal/External (TBC)	A	
Delivering The Capabilities - PROJECT DOSSIER				
Programme Management Office Capability and Capacity for sustainable improvement	30-Jul-16	Jonathan Reid	C	
Service Improvement Hub Established	31st Dec-2016	Catherine Ashton	C	
Warning Notice Compliance	30-Dec-16	Alice Webster	C	No warning notices held against the Trust following recent CQC inspection
Mortality and Morbidity Project Complete	31-Mar-18	David Walker	A	Progress being made but expected to increase pace once new PM is in post early next year.
Environmental Cleanliness, Infection and Prevention Control Project Complete	30-Nov-16	Alice Webster	C	
Evidence Base Care Project Complete	30-Nov-16	David Walker	C	
Medicines Management Project Complete	16th July 2015	David Hughes	C	
Workforce Capacity Capability & Engagement Project Complete	31-Dec-17	Monica Green	C	
Effective Relationships with External Stakeholders & the Public Project Complete	31-Mar-17	Lynette Wells	C	
Governance Project Complete	28-Feb-17	Ashley Parrott	C	
Health Records Project Complete	30-Jun-16	Liz Fellows	C	
Urgent and Emergency Care project Complete	31-Mar-17	Joanne Chadwick-Bell	R	The constitutional standards are not being met with the exception of 2 week wait and 31 day cancer targets. Improvements in relation to A&E, the medical model and discharges are required to be embed to achieve sustained delivery of the key constitutional standards.
Maternity Project Complete	30-Dec-17	Pauline Butterworth	C	
Secure and Safe Premises and Faculties Complete	30-Nov-16	Chris Hodgson	C	
Ward Improvement project Complete	31-Dec-17	Alice Webster	A	Project Manafer no longer joining the trust. May revise approach but schemes continuing independantly.
End Of Life Care Complete	31-Mar-17	Alice Webster	G	
Mock Inspection	22-Jun-16	Lynette Wells	C	
Mock Inspection	27-Jul-16	Lynette Wells	C	
CQC Inspection	03-Oct-17	Lynette Wells	C	

Mortality and Morbidity Assurance Project

The aim of the East Sussex Healthcare Trust (ESHT) regarding Mortality and Morbidity is to have:

- **Zero avoidable deaths**
- **Minimal patient harm**

The Project will ensure changes and improvements in clinical practice, governance and operational management are well co-ordinated, progress is monitored and reported to provide maximum contribution to the achievement of our Mortality and Morbidity aim.

On closure of the Project, all operational and support teams will have embedded the requisite governance requirements into their "business as usual" activities.

The changes and improvements that constitute the Project currently have multifarious sources, including the Care Quality Commission's (CQC) findings, set out in the 2015 inspection reports.

Project Status

AMBER	The key mortality indicator (SHMI) has come within range, the scope of the Project is nearing finalisation, with clear direction from the Executive Lead, a baseline of the "as is" stocktake has been completed and a set of immediate actions and measures in place. **Project Manager and AKI Lead required.**

East Sussex Healthcare NHS
NHS Trust

Mortality and Morbidity Assurance Project

Project Highlights: The main focus since the last report to the Committee has been the progression of activities and the expansion of this project to identify all activities and KPIs. Key highlights are:

- VTE RCA Fatal and Non-Fatal backlog 100 % complete. An analysis will be provided to explicitly progress actions against any themes or lessons. No themes revealed from initial analysis
- Funding agreed with Finance director for a Quality Improvement practitioner to support the sepsis education and project for 9 months. Recruitment successful with start date of post holder 3rd October 2016
- Parents Sepsis awareness information document from KSS AHSN inserted into all new baby Red books
- Sock it to sepsis campaign week undertaken week beginning 26th September with Exec support and involvement across the week. New lead Lisa Forward, Head of Governance and new governance assistance.
- COPD re-joining the AHSN EQ, KPIs defined
- Community Acquired Pneumonia scope and KPIs defined
- Targeted training in progress to improve health notes to ease coding to ensure mortality reviews efficient
- Mortality Review rates now part of individual performance reviews
- Call held with Medical Director from St. Georges to review different mortality review models to inform ESHT Model.
- Visit to Western Sussex and Brighton arranged to further inform
- Mortality Review updates improved significantly in September to 76% within 3 months but tracked down to 70% in November.
- Quality of notes continues to be a major factor in incorrect coding resulting in inaccurate reflection of low risk deaths. Targeted training to junior doctors and AAU.
- Logic models in production for all workstreams.

East Sussex Healthcare NHS
NHS Trust

Mortality and Morbidity Assurance Project

Milestone Name	Forecast Completion Date	Responsible	RAG	Comments for Unplanned/Red/Amber Status (In no more than 255 characters)
Project Initiation Document Approved	30th Nov 2016	Lesley Walton	A	AKI Lead to be identified to finalise PID
Gap Analysis/Governance Vision Defined	31st Oct 2016	Lesley Walton	C	
Milestones & detailed schedule for Sepsis Improvements defined	31st Oct 2016	Emma Tate	C	Complete
Number of preventable Sepsis deaths reached target and sustainable	31st Oct 2017	Dr. Vondras	G	
Number of preventable CAP deaths reached target and sustainable	31st Sep 2017	Dr. Kankam	G	
Number of preventable VTE deaths reached target and sustainable	31st Aug 2017	Dr. Berliti	G	
Non-Fatal and Fatal VTE (PE) rates Post Op CHKS within peer average	31st Mar 2017	Dr. Berliti	G	
RCAs completed for PE Fatal/Non-Fatal within 3 months	31st Dec2017	Dr. Berliti	G	
Milestones & detailed schedule for Pneumonia defined	30th Nov 2016	Lesley Walton	G	
Milestones & detailed schedule for AKI defined	30th Nov 2016	Lesley Walton	A	Clinical Lead to be identified
Milestones & detailed schedule for COPD defined	30th Nov 2016	Lesley Walton	G	
Best Evidence Base Care for Sepsis, AKI, COPD, Pneumonia, VTE embedded	31st Dec 2017	Dr. Walker	G	
New Mortality Review governance structure embedded and sustainable	31st Mar 2017	Dr. Walker	G	
Strong medical and nursing leadership evidenced in whole mortality process	31st Mar 2017	Dr. Walker	G	
Current Reporting 'As Is' and 'To be' mapped	31st Dec 2016	David Peerless	G	
Management Information provided to assure and monitor Mortality Review process	31st Sep 2017	Dr. Walker	G	
90% of Mortality Reviews within 1 month	31st Oct 2017	Dr. Walker	G	
Project Closed	31st Dec 2017	Dr. Walker	G	-

East Sussex Healthcare NHS
NHS Trust

Mortality and Morbidity Assurance Project

A	MORTALITY AND MORBIDITY PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	Improve the Process and Governance of Mortality and Morbidity (IP 53)				
	Increase number of Mortality Meetings held per month to review deaths across the Trust	31-Dec-16	26	37	First measure
	Increase percentage of Mortality Cases reviewed within one months of death	31-Oct-17	90%	23%	First measure
	Increase percentage of Mortality Cases reviewed within three months of death	31-Mar-17	95%	70%	
	Increase Percentage of Code E Deaths Reviewed as Serious Incidents	31-Mar-17	100%	100%	First Measure
	ERQ data for specific conditions being uploaded to ERQ programme	31-Mar-17	3	2	n/a
	% of Dr completed health record training within rolling year	31-Mar-17	90%	Data from Dec	
	Reduction in number of care episodes coded without health record available per month	31-Aug-18	100%	Data from Dec	
	Number of complaints due to the cause of death being changed	31-Mar-17	0	Data Source tbc	
	Number of coded Cs reviewed at Mortality Review Group	31-Mar-17	100%	100%	First Measure
	Percentage of coded Ds that have has an internal investigation	31-Mar-17	100%	100%	First Measure
	Audit compliance with VTE Guidance (IP 37)				
	Increase Rate of VTE Assessments undertaken within 24h of admission	31-Dec-16	95%	97.1%	
	Percentage of Fatal PE RCAs undertaken within 3 months	31-Mar-17	98%	0%	First Measure
	Percentage of backlog Fatal PE RCAS completed	31-Dec-16	100%	100%	n/a
	Percentage of Non-Fatal PE RCAs undertaken within 3 months	31-Mar-17	98%	0%	First Measure
	Percentage of backlog Non-Fatal PE RCAS completed	31-Dec-16	100%	63%	First Measure
	Number of preventable Non-Fatal PEs	31-Mar-17	0	2	First Measure
	Number of preventable Fatal PEs	31-Mar-17	0	2	First Measure
	Annual VTE audit embedded	31-Mar-17	100%	0%	n/a
	EQ Sepsis				
	Increase sepsis Screening Compliance	31-Mar-17	100%	5%	First Measure
	Increase Antibiotics prescribed and administered within 1 hour of red flag sepsis pathway trigged	31-Mar-17	100%	38%	First Measure
	Increase Antibiotics reviewed within 72 hours	31-Mar-17	100%	75%	First Measure
	Increase Oxygen administrered within 1 hour of red flag sepsis pathway trigged	31-Mar-17	100%	50%	First Measure
	Increase Blood cultures taken within 1 hour of red flag sepsis pathway trigged	31-Mar-17	100%	25%	First Measure
	Increase Intravenous fluids administered within 1 hour of red flag sepsis pathway trigged	31-Mar-17	100%	38%	First Measure
	Increase Serum lactate's tested within 1 hour of red flag sepsis pathway triggered	31-Mar-17	100%	63%	First Measure
	Increase Urine Output monitored hourly once red flag sepsis pathway triggered	31-Mar-17	100%	50%	First Measure
	increase in MET/SET calls per ward patients red flag sepsis pathway	31-Mar-17	100%	Data from Dec	
	reduction in preventable hospital acquired sepsis deaths	31-Mar-17	0	Data from Dec	
	reduction in sepsis admissions to Critical Care	31-Mar-17	Monitoring	Data from Dec	
	Sepsis audit embedded within ESHT	31-Mar-17	100%	0%	
	reduction of sepsis as 1a Cause of Death	31-Mar-17	Monitoring	17	
	EQ AKI				
	AKI risk assessment completed before surgery	AKI Lead to specify when appointed			
	AKI assessment by measuring serum creatinine wth acute illness or/and chronic kidney disease	AKI Lead to specify when appointed			
	Percentage of Fatal AKI RCAs undertaken within 3 months	AKI Lead to specify when appointed			
	Percentage of Non-Fatal AKI RCAs undertaken within 3 months	AKI Lead to specify when appointed			
	Number of preventable Fatal AKI	AKI Lead to specify when appointed			
	CAP				
	Blood cultures obtained before 1st antibiotic administration	31-Mar-17	95%	Data Source tbc	
	Chest X-ray within 4 hours of hospital arrival	31-Mar-17	95%	Data Source tbc	
	Initial antibiotic received within 4 hours of hospital arrival	31-Mar-17	95%	Data Source tbc	
	Appropriate initial antibiotic regimen received in adherence to local antibiotic guidelines	31-Mar-17	100%	Data Source tbc	
	Oxygenation assessment within 1 hour of admission	31-Mar-17	95%	Data Source tbc	
	Respiratory failure recognised within 1 hour	31-Mar-17	95%	Data Source tbc	
	Oxygenation appropriately prescribed	31-Mar-17	95%	Data Source tbc	
	CURB-65Score documented within 4 hours of admission	31-Mar-17	95%	Data Source tbc	
	Percentage of Fatal CAP RCAs undertaken within 1 month	31-Mar-17	100%	Data Source tbc	
	Number of preventable Fatal CAP	31-Mar-17	0	Data Source tbc	
	Number of in-patients admitted to ITU with serious Sepsis following an initial diagnosis of CAP	31-Mar-17	Monitoring	Data Source tbc	
	EQ AECOPD				
	Correct diagnosis of AECOPD confirmed	31-Mar-17	95%	Data Source tbc	
	Respiratory Level 2 Beds	01-Apr-17	Monitoring	Data Source tbc	
	Oxygen Assessment and target range prescribed within 30 minutes	02-Apr-17	95%	Data Source tbc	
	Recognise and respond to respiratory acidosis within 1 hour of admission	03-Apr-17	95%	Data Source tbc	
	Medication (Steroids and nebulisers) to be administered within 4 hours of admission	04-Apr-17	95%	Data Source tbc	
	Number of front Line staff trained in respiratory admission bundle	05-Apr-17	Monitoring	Data Source tbc	
	Review by Respiratory team to take place within 24 hours of admission	06-Apr-17	95%	Data Source tbc	
	Junior and senior doctors trained in how to write up AECOPD patient treatment	07-Apr-17	Monitoring	Data Source tbc	
	Number of on-floor Snap-train AECOPD sessions	08-Apr-17	Monitoring	Data Source tbc	
	Number of AECOPD Training Sessions held	09-Apr-17	Monitoring	Data Source tbc	
	Number of preventable Fatal AECOPD (low risk)	10-Apr-17	0	Data Source tbc	

Urgent and Emergency Care Project

The aim of the project is to ensure that patients on the urgent and emergency care pathway are treated in the right place at the right time first time by the right staff in order to improve:

- Patient experience
- Clinical outcomes
- Staff experience and well-being

The project is being delivered through 5 work streams – A&E improvements, medical model, patient flow/discharge planning, capacity planning and governance.

Project Status

Red	The A&E4 hour waiting target is not being met, progress is being made through the work streams, albeit slowly in some areas. The governance arrangements through the Urgent & Emergency Care Board are now in place and the KPI dashboard is being developed to enable the benefits of the delivery of the improvements to be tracked.

East Sussex Healthcare NHS Trust

Urgent and Emergency Care Project

Project Highlights: The main focus since the last report to the Committee has been the progression of activities and the transition of the patient flow project to BAU and the launch of this project to focus the improvements needed in urgent and emergency care. New KPIs are still being developed. Key highlights are:

- Improvement actions in A&E implemented - streaming protocols with medicine and paediatrics, Ambulatory Emergency Care, Rapid Access Treatment at EDGH and ENP rota partially implemented
- SAFER bundle pilot commenced on Hailsham 4 Urology and Jevington at EDGH and Benson and De Cham at Conquest
- In-reach trials into EDGH from Bowes House and Firwood House moved into business as usual
- Principles of Medical Model signed off by Urgent & Emergency Care Board
- ESHT Capacity/Surge Plan 2016/17 signed off
- System level priority actions agreed for winter 2016/17 at Hospital Flow & Discharge Group
- Emergency Care Improvement Programme (ECIP) support commissioned - diagnostic/ familiarisation visit to Conquest on 27.10.16

Milestone Name	Forecast Completion Date	Responsible	RAG	Comments for Unplanned/Red/Amber Status (In no more than 255 characters)
SRO - Joe Chadwick-Bell				
Project Plan in place		Trish Richardson	C	
Project Group Set Up		Trish Richardson	C	
Communications Plan in place		Simon Purkiss	G	
A&E Improvements				
Electronic breach analysis implemented	31-May-16		C	
Frailty practitioner service implemented	31-May-16		C	
Crisis response service implemented	31-May-16		C	
Workforce Capacity & Demand review	30-Jun-16		C	
Revised Service Manager structure	31-Jul-16		C	
A&E escalation protocols	30-Nov-16	Matt Hardwick	A	Protocols now in place in A&E but sign-up required from Divisions.
ENP service	30-Nov-16	Jenny Darwood	A	Short term sickness within teams. Funding agreed to raise teams to 5.5 FTE but being reviewed as not sufficient to allow for training requirements of teams.
A&E Initial assessment/streaming protocols	30-Nov-16	David Walker	A	Protocols agreed & working effectively for medicine & paeds. Still to be agreed with surgical specialities
Ambulatory emergency care model	30-Nov-16	Jenny Darwood	A	Implemented on EDGH site but issues with space and staffing at Conquest site
A&E enhanced co-ordinator role	31-Dec-16	Jenny Darwood	G	
Core hours Rapid Access Treatment service	30-Nov-16	Jenny Darwood	A	Implemented core hours at EDGH from 17.10.16 but only intermittently at CQ due to consultant concerns re staffing and space
Extension to HIT hours to 1800	31-Oct-16	Katy Lyne	G	
Implement new nursing rotas to match peaks in activity	31-Dec-16	Jenny Darwood	G	
Extension of HIT team hours to 2000 EDGH site	31 Feb 17	Katy Lyne	G	
Medical Model				
Principles signed off by Urgent & Emergency Care Board	30-Sep-16	Kate Murray	C	
Size requirement of AMUs agreed	30-Nov-16	Kate Murray	G	
Inter-professional standards approved	31-Dec-16	Kate Murray	G	
AMU location identified and agreed on each site	31-Dec-16	Matt Hardwick	G	
Hospital in-reach teams established for DME wards	31-Dec-16	Matt Hardwick	G	

Milestone Name	Forecast Completion Date	Responsible	RAG	Comments for Unplanned/Red/Amber Status (In no more than 255 characters)
Consultant job plans agreed for in-reach to AMUs	31-Jan-17	Divisional Chiefs	G	
New AMUs operational	28-Feb-17	Matt Hardwick	G	
Medical Model operational	31-Mar-17	Kate Murray	G	
Discharge Improvements				
4 exemplar sites identified for SAFER pilot	30-Sep-16	Matt Hardwick/ Heads of Nursing	C	
Analysis of top 20 presenting conditions LoS	30-Sep-16	Matt Hardwick/ Heads of Nursing	C	
Pilot of SAFER patient flow bundle on 4 wards completed	11-Nov-16	Kate Murray/ Matt Hardwick	G	
Plan for roll-out of SAFER bundle across Trust agreed	30-Nov-16	Matt Hardwick	G	
Discharge rate performance targets for top 20 presenting conditions issued	31-Dec-16	Matt Hardwick	G	
Trajectory performance for under-performing areas for top 20 presenting conditions agreed	31-Dec-16	Matt Hardwick	G	
Software for tracking discharge prescriptions introduced	31-Dec-16	Simon Badcott	G	
Roll-out of SAFER bundle and audit of 5 elements completed	28-Feb-16	Matt Hardwick	G	
Improved discharge medication information to GPs	31-Mar-17	Simon Badcott	G	
7 day pharmacy service to support weekend discharges	30-Jun-17	Simon Badcott	G	
Capacity				
Decision taken on information tools to be used to provide long range 'forward look'	31-Jul-16	Matt Hardwick/ Andy Bailey	C	
Ring-fencing of elective beds EDGH		Matt Hardwick	G	
Forward look for Nov16-Mar17 completed	31-Oct-16	Matt Hardwick/James Blake	C	
ESHT Capacity/Surge Plan 2016/17 approved	31-Oct-16	Matt Hardwick/ Pauline Butterworth	C	
System level priority actions agreed for winter 2016/17 at Hospital Flow & Discharge Group	31-Oct-16	Matt Hardwick	C	
Patient flow system dashboard developed for UEC Board	30-Nov-16	Matt Hardwick/ Andy Bailey	G	
Governance				
Clinical lead for Urgent & Emergency Care appointed	31-Aug-16	Pauline Butterworth	C	
Urgent & Emergency Care Board Terms of Reference agreed	30-Sep-16	Kate Murray	C	
UEC Board agree UEC priorities for 2017/18 business planning round	31-Jan-17	Kate Murray	G	

End of Life Care Project

Project Summary

This project was mandated by Adrian Bull at the Improvement sub-committee 10.9.16 following CQC inspection. Leadership, variation in practice and dynamics between specialist palliative care teams were raised as issues.

The aim of the East Sussex Healthcare Trust (ESHT) regarding End of Life Care is that:

- Adults, approaching end of life have access to consistent care that meets national best practice standards.
- Reduce unwarranted variation in care delivery across ESHT for people approaching end of life and/or requiring specialist palliative care.

The Project will ensure changes and improvements in clinical practice, governance and operational management are well co-ordinated; progress is monitored and reported to provide maximum contribution to the achievement of our 'high quality end of life aims'.

Project Status

Amber	The project is in early stages of scoping and integrating with existing plans to develop the PID. Project review meetings have been set up with the project lead and executive lead.

End of Life Care Project

Project Highlights: The main focus since the last report to the Committee has been the integration of current improvements into a project to include the new issues raised by the CQC. Following PID approval KPIs will be developed. Key highlights are:

- Commencement project with the lead Angela Colosi
- Away day for the specialist palliative care team externally facilitated on 6th December
- Monthly project review meetings set up
- PID drafted for agreement and EoLC for children excluded from scope
- Development of plan and logic model to completed by 12th December
- KPI's agreed by end of December
- Development of meridian audit for Quality of end of life care
- Review use of personalised care plan roll out due to resistance from staff.

End of Life Care Project

Milestone Name	Forecast Completion Date	Responsible	RAG	Comments for Unplanned/Red/Amber Status (In no more than 255 characters)
Project Start Up/Initiation Complete	14th Nov 2016	Jacky Thomas	G	-
PID approved	17th Nov 2016	David Walker	G	-
KPI's developed	20th Dec 2016	Angela Colosi	G	-
Agreed standard operating procedures for specialist palliative care teams	31st Dec 2016	Angela Colosi	G	-
Agreed clinical care pathways (inc handover and discharge) between SPCT and clinical care teams in place	31st Dec 2016	Angela Colosi	G	-
Implement/embed last days of life personalised care plan	31st March 2017	Jo Thorpe and Sarah Callaghan	A	Unexpected resistance has been found as the facilitators have tried to roll out use of the plan on the wards.
Advanced communication training for doctors in place			U	Activity not yet planned
80% Staff complete end of life care training	31st March 2017	Jo Thorpe and Sarah Callaghan	G	-
Project Complete	32nd March 2017	Jacky Thomas	G	-

Next Activities

Continue to progress projects to deliver the milestones. Key activities are:

- Meeting with Maternity and Obstetricians to discuss and agree the maternal sepsis tool.
- Agree maternity sepsis escalation and implementation plan
- Develop community sepsis tools and implementation plan with Out of Hospitals /Gateway areas
- Plan *Sock it to Sepsis* Community campaign
- Workshop to be held in December to further inform longer term aims for mortality governance reviews e.g. changing the model e.g. peer reviews, medical examiner in the bereavement office, reviews within 1 month.
- Agree PID for EOLC project
- Improvement actions in A&E – escalation protocols to be agreed with Divisions
- SAFER bundle to commence on Newington and Wellington at Conquest
- Review of SAFER bundle pilot and roll-out plan to rest of Trust agreed
- Size requirement of AMUs to be agreed
- Gap analysis of impact of medical model on elective work, eg RTT, cancer, completed
- Internal professional standards to be discussed at Divisional meetings
- ECIP - diagnostic/ familiarisation visit to EDGH on 11.11.16

Significant Risks:

- Risks to improvements due to staff recruitment of key senior clinical roles within Medical and Dental impacting service and capacity to lead on improvements
- Use of temporary staff impacts the delivery of robust sustainable change.
- Continued non-delivery of constitutional standards.

ESHT has launched NHS Elect Improvement Training Programme

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Theme of the week

Our improvement journey

ESHT 2020 sets out what we need to do to become an outstanding organisation within the next four years. To achieve this, we need to embark on an ambitious programme of change, using improvement and innovation to transform our services and the care we provide for patients.

How are we going to achieve this?

The improvements we need to make can't be achieved by a small group sat in a darkened room—we need as many colleagues as possible to become involved, taking forward improvement and innovation initiatives in their own area of work. To achieve this, we will be providing a range of opportunities and resources to support improvement capacity and capability right across the organisation.

What support will be available?

An Improvement Hub, led by our Director of Strategy, Catherine Ashton, is in development and will support service improvement across the organisation. The hub will be a virtual team, bringing together existing functions and new expertise to give those wanting to implement change access to a diverse set of skills. We have recruited an improvement lead for the hub and are planning to offer a number of fellowship/secondment opportunities for staff to come and work with the hub and be trained in improvement methodology so that they can embed this within the organisation.

To support and test small changes, we will be using the Plan, Do, Study, Act (PDSA) model. This circular model ensures that any improvement is planned, run and then any learning is taken into account before the cycle is repeated. Our Improvement Director, Sally Herne, has led workshops on the PDSA model and these will be repeated in the new year.

There is also support available to us from external organisations, such as the Kent, Surrey and Sussex Academic Health Sciences Network and NHS Elect. Through

How else can we make improvements?

A number of initiatives are already underway to take forward improvements in ESHT:

- The Programme Management Office (PMO), led by Lesley Walton, is supporting a number of improvement programmes and will continue to support larger change programmes, with progress monitored by the Improvement Sub-Committee.
- The Listening into Action programme will continue to support small projects to benefit patients and/or staff, facilitated by Jeanette Williams.
- We are planning to introduce 'improvement huddles' where colleagues meet briefly to assess how things are going and what could be done to make things better. Tina Lloyd is currently running a pilot programme for the huddles in Outpatients.

I have a great improvement idea, what should I do?

Speak to your line manager or any of the individuals mentioned above about your idea and keep an eye out for more resources which will be available on the extranet soon.

Working with NHS Elect, we are offering a programme for staff interested in service improvement, service redesign and improving quality of patient care. The course is initially being offered to clinical and operational staff at bands 7 and 8, closing date for expressions of interest is Friday 11th November. More information

East Sussex Healthcare NHS
NHS Trust

Month 7 – October 2016

TRUST INTEGRATED PERFORMANCE REPORT

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East Sussex Healthcare NHS
NHS Trust

Contents

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NHS Trust

October 2016

Key Issues

- **Three four of the key trajectories (A&E, RTT and Cancer 62 Days) failed to meet the planned level of performance and are under the national targets.**
- **Diagnostics met the national standard but was marginally below the planned trajectory**
- **FFT response rates remain low but have seen improvements in inpatients**
- **The Trust's overall RAG rating under the revised NHSI criteria is red in month 7**

Key Risks

- **Delivery against the agreed trajectories for improvement against the 4 key constitutional standards**
- **Delivery against the agreed financial plan**

Safety & Quality: Legal actions from unintentional harm to patients would normally be covered by negligence, an area of English tort (civil) law, providing the remedy of compensation. Case law is extensive. Criminal action could be pursued if investigation judged intentional harm and remedies will vary according to severity.
Staff safety: The Health and Safety at Work Act etc 1974 June apply in respect of employee health and safety or non clinical risk to patients (usually reported under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995).

The Care Quality Commission (CQC) regulates Safety & Quality and quality of care and the CQC register and therefore license care services under the Health and Social Care Act 2009 and associated regulations. The health and safety executive regulates compliance with health and safety law. A raft of other regulators deal with safety of medicines, medical devices and other aspects.

Action: The board are asked to note and accept this report.

Quality and Safety

QUALITY AND SAFETY

1. Indicators
2. Serious Incidents, Never Events and Incidents
3. Friends and Family Test
4. Complaints
5. Mortality
6. Safer Staffing

East Sussex Healthcare NHS
NHS Trust

Indicators

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Oct-15	Var	This Yr	Last Yr	Var	
Total patients safety incidents reported	M	969	880	924	916	956	978	1053	1078	1012	1499	1799	1787	1396	969	44.1%	9624	6214	35.4%	
% Patient safety incidents with no harm or near miss	70.0%	68.9%	67.6%	65.6%	67.0%	70.8%	67.8%	64.4%	66.8%	72.2%	84.1%	86.5%	84.4%	82.7%	68.9%	13.7%	79.1%	66.3%	12.8%	
% Patient safety incidents causing severe harm or death	0	0.3%	0.0%	0.4%	0.2%	0.1%	0.7%	0.2%	0.2%	0.1%	0.0%	0.1%	0.1%	0.1%	0.3%	-0.2%	0.1%	0.4%	-0.3%	
Total Non-ESHT patients safety incidents reported	M	122	104	73	122	110	84	319	242	148	168	145	164	136	122	11.5%	1322	828	37.4%	
No of never events reported	0	0	3	1	0	0	0	1	0	0	0	0	0	0	0	0	1	0	1	
No of serious incidents reported	M	6	12	15	7	6	14	7	0	3	8	9	4	3	6	-3	34	70	-36	
No of moderate incidents reported	M	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0		
Total Falls per 1000 beddays	7	7.0	5.8	7.3	6.7	6.8	6.1	6.0	6.0	6.0	6.3	6.3	6.2	6.4	7.0	-0.6	6.2	6.8	-0.6	
Total falls reported	M	172	140	181	183	178	169	152	149	144	152	156	153	160	172	-7.0%	1066	1130	-6.0%	
No of falls no harm	M	109	97	122	119	122	118	97	101	99	109	116	92	115	109	5.5%	729	724	0.7%	
No of falls minor/moderate	M	63	43	59	64	56	51	55	48	45	43	40	60	45	63	-28.6%	336	402	19.6%	
No of falls major/catastrophic	M	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	4	-3	
Falls Assessment Compliance	M				97.6%	99.3%	98.0%	92.2%	93.9%	89.6%	91.4%	92.5%	85.2%	90.3%			91.0%			
No of pressure ulcers grade 3 & 4 (trust acquired)	R	4	5	8	9	7	5	6	6	2	2	5	0	5	4	1	26	39	-13	
No of pressure ulcers grade 2 (trust acquired)	R	80	51	53	53	54	73	62	45	51	32	46	53	54	80	-26	343	413	0	
Pressure Ulcer Assessment Compliance	M				95.9%	93.0%	91.4%	93.4%	86.0%	87.5%	92.0%	86.7%	94.0%	91.2%			90.0%			
No of medication administration incidents	M	22	19	29	18	23	17	29	25	16	32	24	31	33	22	1	190	147	0	
Medication errors causing severe harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

East Sussex Healthcare NHS
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Indicators

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Oct-15	Var	This Yr	Last Yr	Var	
Observations completed on time (per protocol)	M	71.6%	73.5%	75.8%	76.3%	76.9%	76.8%	79.7%	80.7%	83.4%	82.5%	84.2%	83.2%	81.2%	71.6%	9.6%	82.2%	69.2%	12.9%	
No of Cardiac Arrest calls		0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	4	0	1	
No of MRSA cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	-4	
No of CDI cases	4	3	5	3	4	3	5	2	7	7	2	6	3	4	3	1	31	28	3	
No of MSSA cases	0	0	0	0	0	0	0	2	0	2	1	0	4	1	0	1	10	0	10	
Safety thermometer overall score	92.0%	94.0%	94.1%	94.6%	95.3%	93.0%	94.0%	93.0%	93.6%	94.0%	95.4%	93.0%	95.0%	93.3%	94.0%	-0.7%	6.1%	6.4%	-0.3%	
% of VTE risk assessments completed	95.0%	95.9%	96.7%	96.7%	96.5%	95.8%	94.8%	95.2%	97.9%	98.1%	97.9%	96.8%	97.0%	95.3%	95.9%	-0.7%	96.9%	96.0%	0.9%	
Emergency C-Section rate	9.0%	16.2%	14.4%	12.4%	16.0%	17.9%	12.8%	15.4%	13.4%	14.5%	12.6%	11.9%	17.4%	14.6%	16.2%	-1.5%	14.2%	16.2%	-2.0%	
Mixed sex accomodation breaches	0	23	16	3	27	29	0	0	0	0	0	0	0	0	23	-23	0	55	-55	
Inpatient FFT Response rate	45.0%							15.1%	16.2%	19.6%	18.5%	16.2%	15.0%	21.4%			16.6%			
Inpatient FFT Score (% positive)	96.0%							98.2%	98.3%	96.9%	98.1%	96.8%	96.7%	96.7%			16.6%			
A&E FFT Response rate	22.0%							9.2%	10.3%	8.9%	8.3%	6.2%	7.3%	8.6%			87.5%			
A&E FFT Score (% positive)	88.0%							91.0%	88.1%	87.7%	85.6%	86.3%	85.3%	85.9%			87.5%			
Maternity FFT Response rate	45.0%		28.7%	21.9%	27.8%	20.3%	24.2%	29.2%	30.7%	33.2%	25.4%	29.0%	14.0%	30.2%			29.3%			
Maternity FFT Score (% positive)	96.0%		96.6%	95.5%	95.9%	90.4%	95.2%	92.1%	93.0%	94.4%	97.2%	94.1%	95.1%	95.1%			94.2%			
No of complaints reported	R	68	47	42	41	56	55	75	55	58	46	55	53	53	68	-22.1%	395	462	17.0%	
All ward moves	M	2371	2377	2310	2254	2316	2331	2304	2345	2265	2314	2304	2286	2234	2371	-5.8%	16052	15952	0.6%	
Night ward moves	M	466	411	476	462	461	512	470	435	409	416	445	400	375	466	-19.5%	2950	3144	-6.6%	
Crude Mortality Rate	M	1.7%	1.9%	2.0%	2.1%	1.8%	2.3%	2.0%	1.7%	1.5%	1.4%	1.4%	1.4%	1.9%	1.7%	0.2%	1.6%	1.6%	0.0%	
HSMR (CHKS)	100	109	104	110	102	106	97	112	100	98										
SHMI (CHKS)	100	111	71	83	77	80	75	85	72	74	64									

Note: SHMI shown is month by month index score and not rolling 12 months.

East Sussex Healthcare NHS Trust

Quality Overview

There were 3 serious incidents reported as occurring in October. Two related to 12 hour trolley breaches and one to a diagnostic delay.

No new Never Events have been reported.

Infection control reported no incidents of MRSA in October but there was 1 MSSA and 4 reported cases of CDIFF

The emergency caesarean rate improved in October but is still above the target level.

No overnight mixed sex accommodation breaches were reported

FFT inpatient response rate improved by 8% for October following review of the system. This is hopefully the start of an improved picture.

There were 5 grade 3 Pressure Ulcers this month:

- 4 in patient's home (2 of this were patients on palliative care)
- 1 occurred whilst on Berwick ward and is currently being investigated by the Matron.

2. Serious Incidents and Never Events

There are 35 serious incidents within the system all of which are within the investigation timescale or have been submitted to the CCG for closure.

A review of the never events is has been undertaken to “close the loop” and determine if all actions have been completed and embedded in practice.

The review set out to examine whether the proposed actions had been taken forward/completed and the efficacy of these in terms of change in practice, reduction in risk and reduction of repeat/similar incidents.

The action plans for these Never Events contained 23 separate recommendations. The Trust has:

- Full assurance for 13 of these.
- Partial assurance for 4
- No assurance for 6.

One of the never events had no assurance on any recommendations although staff were fully aware of the incident and issues surrounding it which is positive, this has been raised and is being addressed.

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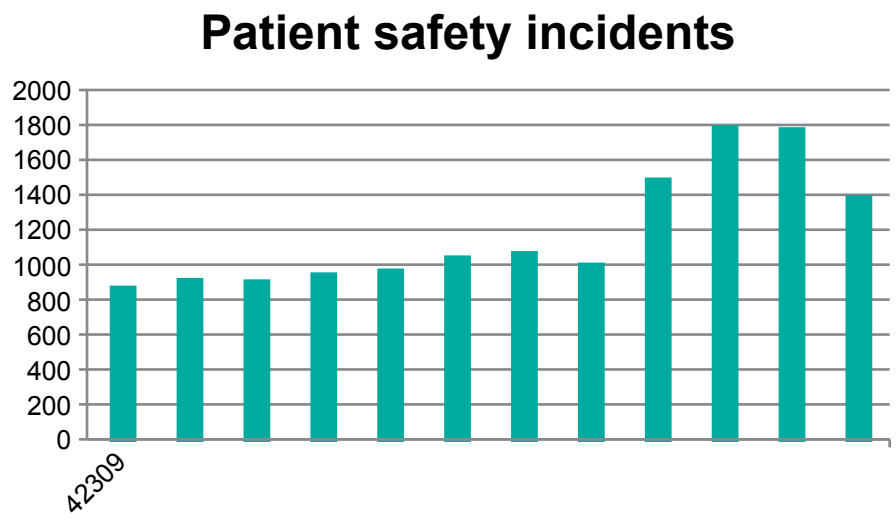
Incidents



The steep increase in incidents (per 1000 bed days) reported previously has now decreased.

- The prime category remains “no harm/near miss category”
- Health Records and missing or incomplete notes account for the largest number of incidents. The Health Records Improvement Programme is addressing the issues and improvements are being noted

3. FFT

A review and visit to the lowest wards to discuss the process and demonstrate the rich feedback it provides, and reconfiguring the data and reporting to ensure inpatient areas do not include areas where there is out-patient activity. Further work is on-going to improve with a league table shared with wards/departments, ensuring they use the data collected and developing the postcard system for A&E.

4. Complaints

The complaints backlog has increased slightly since August data. The number overdue is now at 47 in October (69 in March 2016) and there are 143 open complaints (lower than August).

100% of all complaints reported in September and October were acknowledged within 3 working days. There were 11(October) and 6 (September) re-opened cases by the Complaints Team where the complainant did not feel all original concerns were answered.

Since April 2016 there have been 10 cases referred to the Parliamentary and Health Service Ombudsman Enquiries (PHSO). One was returned in October as partially upheld. To date there has been 2 fully and 2 partially upheld.

The highest areas receiving complaints are Surgery and Urgent Care. Open complaints remain a challenge with Surgery and Medicine having the most overdue for responding to the Complaint team in time to produce the response letter.

Key themes / trends from complaints in October are:

- Overall standard of care
- Unhappy with attitude
- Lack of communication (verbal and written) specifically in Urgent Care and Surgery
- Missed diagnosis in Urgent Care and Surgery
- Delay/access to treatment
- Appointment issues mainly in Surgery and Specialist Medicine

5. Mortality

SHMI remains at 1.11. The next release is due in December 2016. The Trust is currently within the EXPECTED range.

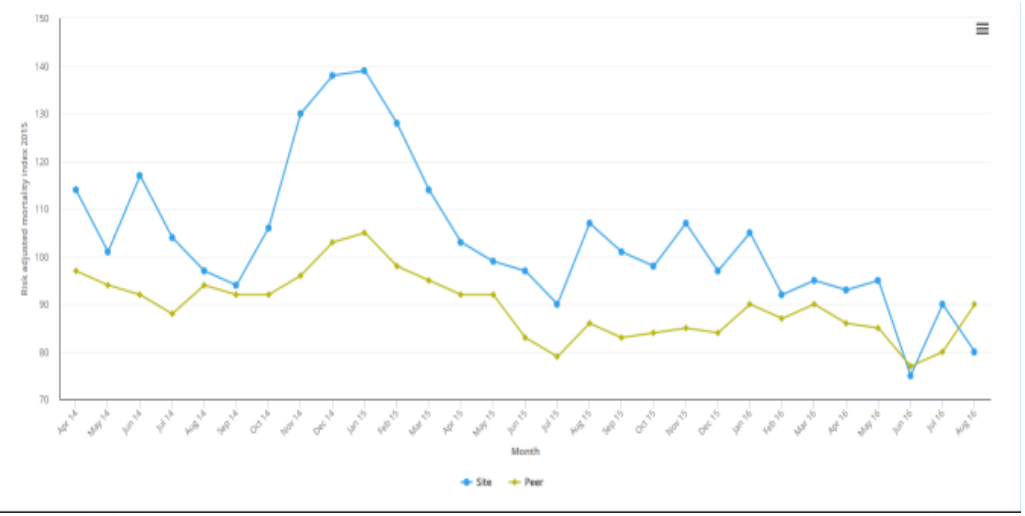
Targetted work continues to be undertaken on Mortality and Morbidity within the Quality Improvement Programme.

September 2015 to August 2016 RAMI (rolling 12 months) is 94 compared to 113 same period last year September 2014 to August 2015. This is down from 96 last month.

RAMI shows an August position of 80 compared to a peer position of 90. This has improved since the July position of 90 against a peer position of 91

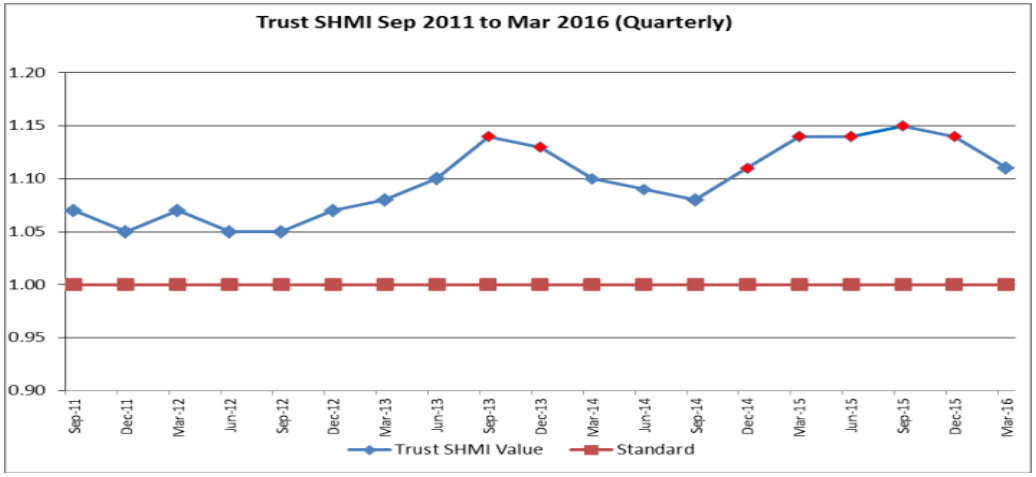
Crude mortality shows September 2015 to August 2016 at **1.85%** compared to September 2014 to August 2015 of **1.88%**

RAMI



Main causes of death during October 2016	
Pneumonia	36
Sepsis	19
Multi Organ Failure	6
Myocardial infarction	5

SHMI (Rolling 12 months)



Deaths reviewed within 3 months	Jan -16	Feb-16	Mar -16	Apr -16	May -16	Jun-16	Jul-16
TRUST	66%	57%	63%	64%	61%	78%	71 %

6. Safer Staffing

	Day		Night	
Site Name	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
BEXHILL HOSPITAL	85.1%	113.3%	90.3%	100.7%
CONQUEST HOSPITAL	93.9%	106.4%	95.4%	107.6%
CROWBOROUGH BIRTHING CENTRE	0.0%	0.0%	0.0%	0.0%
EASTBOURNE DISTRICT GENERAL HOSPITAL	94.9%	107.2%	94.9%	104.3%
MASTER'S HOUSE	0.0%	0.0%	0.0%	0.0%

Access & Delivery

ACCESS AND DELIVERY

1. Indicators
2. Elective Care
3. Emergency Care
4. Cancer

East Sussex Healthcare NHS
NHS Trust

Indicators

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Oct-15	Var	Yr	Last Yr	Var	
A&E Performance (4 hour wait)	95.0%	88.6%	88.4%	85.6%	84.2%	84.8%	79.0%	83.9%	85.0%	83.2%	82.6%	79.5%	80.5%	78.0%	88.6%	-10.5%	81.8%	90.8%	-9.0%	
A&E 12 Hour trolley waits	0	0	0	0	0	0	0	0	0	0	0	1	0	2	0	2	3	1	2	
A&E Unplanned re-attendance	5.0%	2.4%	2.9%	3.0%	3.0%	3.4%	3.0%	3.3%	3.3%	2.8%	3.0%	2.9%	3.0%	3.1%	2.4%	0.6%	3.1%	3.1%	-0.1%	
A&E Time to Initial Assessment (% Ambulance conveyan	M	95.7%	96.0%	95.0%	92.2%	92.1%	88.5%	94.3%	93.1%	90.7%	91.8%	90.1%	90.6%	89.6%	95.7%	-6.1%	91.4%	95.8%	-4.4%	
A&E Time to Treatment (% within 60 Minutes)	M	50.2%	53.9%	49.6%	52.4%	48.1%	42.0%	47.0%	40.1%	36.6%	36.7%	36.7%	38.8%	39.5%	50.2%	-10.7%	39.3%	49.9%	-10.7%	
A&E Left before seen	M	1.9%	1.3%	1.6%	2.1%	2.6%	2.7%	2.1%	2.2%	1.3%	1.4%	1.4%	1.2%	1.2%	1.9%	-0.7%	1.5%	1.9%	-0.3%	
Non Elective Conversion Rate	M	25.1%	26.7%	27.5%	27.5%	26.8%	24.8%	26.5%	24.6%	25.1%	23.5%	23.4%	23.1%	24.8%	25.1%	-0.3%			#VALUE!	
A&E Cubicle Waiters (average number per day)	M	49	49	50	51	51	51	48	51	50	51	52	53	46	51	-5	59	60	-1	
Number of zero LOS NEL Ambulatory admissions	R	465	437	433	435	454	461	524	464	467	431	433	299	370	465	-20.4%	2988	3801	-27.2%	
% Zero LOS NEL Ambulatory admissions	M	37.8%	38.4%	36.5%	38.4%	37.6%	37.1%	41.3%	37.3%	36.4%	35.1%	35.5%	27.3%	32.9%	37.8%	-13.0%	35.3%	40.0%	-4.7%	
Total Non Elective Beddays	M	22567	22360	23141	25732	24170	25700	23644	22663	21658	21959	23015	22693	22917	22567	1.6%	158549	152330	3.9%	
RTT Incomplete (%patients waiting over 18 weeks)	92.0%	92.7%	92.8%	92.1%	92.1%	92.2%	90.5%	90.2%	90.7%	89.5%	88.5%	87.5%	86.7%	85.7%	92.7%	-7.0%	88.3%	93.8%	-5.5%	
RTT Backlog (number of patients waiting over 18 weeks)	M	2009	2010	2198	2273	2268	2823	2936	2931	3399	3791	4239	4534	4809	2009	139.4%	201516	171990	14.7%	
RTT 52 Week waiters	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
RTT 35 week waiters	0	14	23	20	44	74	84	112	140	172	185	180	245	320	14	306	1354	36	1318	
Diagnostic performance (% patients waiting over 6 weeks	1.0%	1.9%	1.0%	2.0%	3.8%	2.4%	6.7%	2.9%	2.7%	2.6%	2.2%	3.0%	2.5%	0.9%	1.9%	-1.1%	97.6%	98.2%	-0.6%	

Indicators

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Oct-15	Var	Yr	Last Yr	Var	
Cancer 2WW standard	93.0%	91.3%	89.9%	91.9%	92.5%	94.9%	96.9%	96.0%	95.6%	96.5%	97.1%	97.3%	97.1%		91.3%		96.6%	90.5%	6.1%	
Cancer 2WW standard (Breast Symptoms)	93.0%	89.1%	88.5%	90.0%	99.1%	93.0%	90.0%	93.2%	98.5%	96.9%	95.8%	95.8%	96.9%		89.1%		96.3%	88.0%	8.3%	
Cancer 31 Day standard	96.0%	100.0%	97.4%	98.3%	96.9%	98.8%	99.3%	98.5%	99.4%	98.3%	97.7%	99.1%	98.8%		100.0%		98.7%	97.3%	1.3%	
Cancer 31 Day subsequent drug treatment	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100.0%	100.0%	0.0%	
Cancer 31 Day subsequent surgery	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%		100.0%		98.4%	100.0%	-1.6%	
Cancer 62 day urgent referral standard	85.0%	76.2%	75.4%	80.6%	73.0%	70.5%	79.4%	67.6%	68.3%	82.3%	75.3%	79.5%	72.6%		76.2%		74.8%	74.7%	0.1%	
Cancer 62 day screening standard	90.0%	84.6%	54.5%	60.0%	33.3%	100.0%	42.9%	100.0%	66.7%	62.5%	100.0%	88.9%	85.7%		84.6%		83.1%	84.4%	-1.3%	
Urgent operations cancelled for a 2nd time	0	0	1	1	1	2	1	0	0	0	0	0	0	0	0	0	0	0	0	
Proportion of patients not re-booked within 28 days of las	0.0%	6.1%	0.0%	0.0%	0.0%	5.7%	6.6%	0.0%	0.0%	0.0%	2.4%	0.0%	3.8%				1.6%	4.2%	-2.6%	
Delayed Transfer of Care	3.5%	7.8%	7.9%	7.5%	7.5%	10.8%	9.4%	5.3%	5.7%	7.0%	7.7%	8.0%	9.7%	9.7%	7.8%	2.0%	7.6%	6.8%	0.8%	
Outpatient appointment cancellations < 6 weeks	R	20	29	41	21	21	18	14	29	47	34	37	30	43	20	115.0%	234	241	-3.0%	
Outpatient appointment cancellations > 6 weeks	R	1196	977	1287	1064	1134	1554	1126	1018	1262	1411	1501	1278	1245	1196	4.1%	8841	8771	0.8%	
% Spending 90% time on Stroke Ward Monthly Monitorin	90.0%	92.5%	89.6%	89.6%	93.5%	98.0%	93.1%	100.0%	95.2%	90.9%	92.2%	93.9%	94.4%	92.3%	92.5%	-0.2%	94.1%	89.6%	4.5%	
Stroke:% to Stroke Unit <4hrs Monthly Monitoring	88.0%	76.3%	80.9%	83.3%	80.0%	77.6%	77.6%	81.1%	76.2%	80.5%	76.5%	93.9%	83.3%	76.9%	76.3%	0.6%	80.9%	79.7%	1.1%	
Stroke: % scanned <1hr of arrival Monthly Monitoring	95.0%	85.0%	85.4%	81.3%	84.8%	85.7%	84.5%	89.2%	78.6%	81.8%	86.3%	93.9%	88.9%	92.3%	85.0%	7.3%	86.1%	78.5%	7.7%	
Stroke: % scanned <12hr of arrival Monthly Monitoring	99.0%	100.0%	97.9%	100.0%	100.0%	100.0%	96.6%	100.0%	97.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	99.6%	97.8%	1.8%	

East Sussex Healthcare NHS Trust

Access and Delivery overview

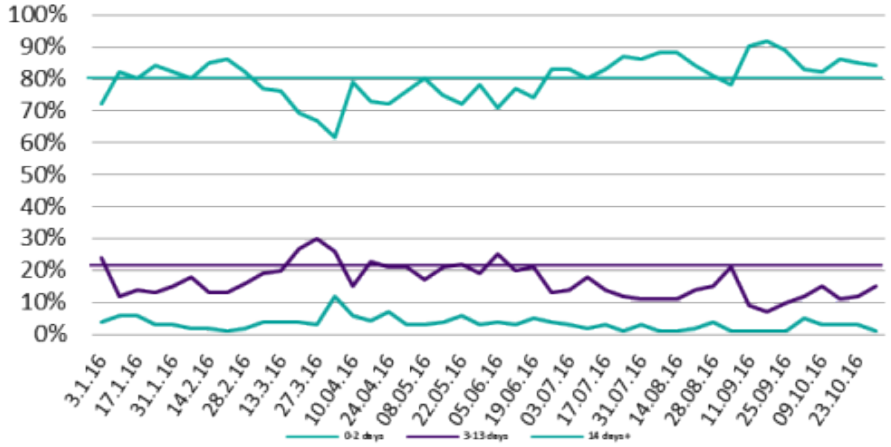
- The trust remains challenged against the key constitutional targets and trajectories
- A&E performance was 78% against the 95% standard
- RTT incompletes was 85.7% against the 92% standard
- Diagnostics achieved 0.88% against the 1% target
- Cancer 62 Days achieved 72.6% against the 85% standard (for September, one month in arrears)
- No urgent operations were cancelled for a second time
- Delayed transfers of care remain at 9.7%
- A&E attendances remain high (6.2% higher than October 2015 and 4.8% higher year to date

East Sussex Healthcare NHS
NHS Trust

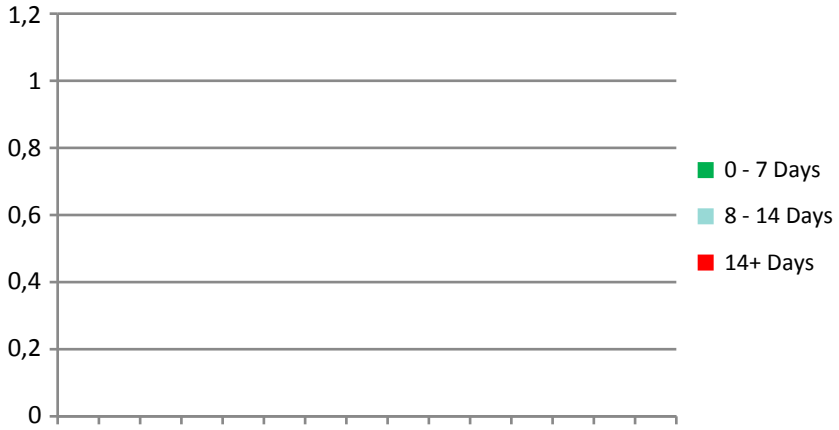
ELECTIVE CARE

Outpatients

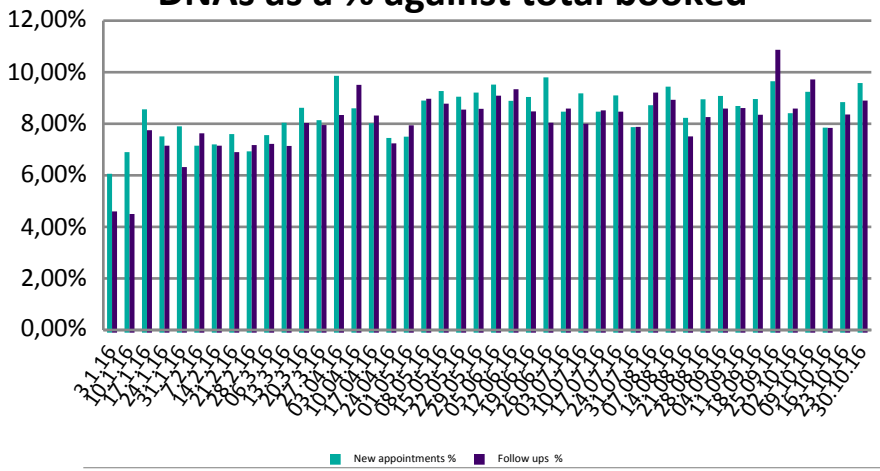
Referral Registration



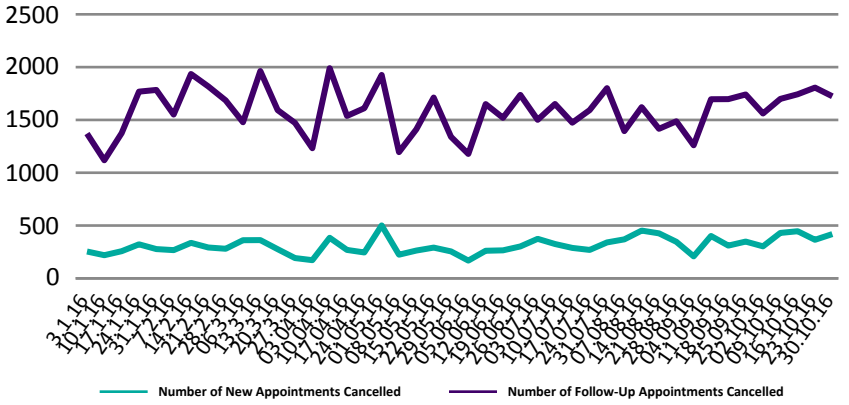
2ww Booking Performance



DNAs as a % against total booked



Number of Appointments Cancelled by Hospital



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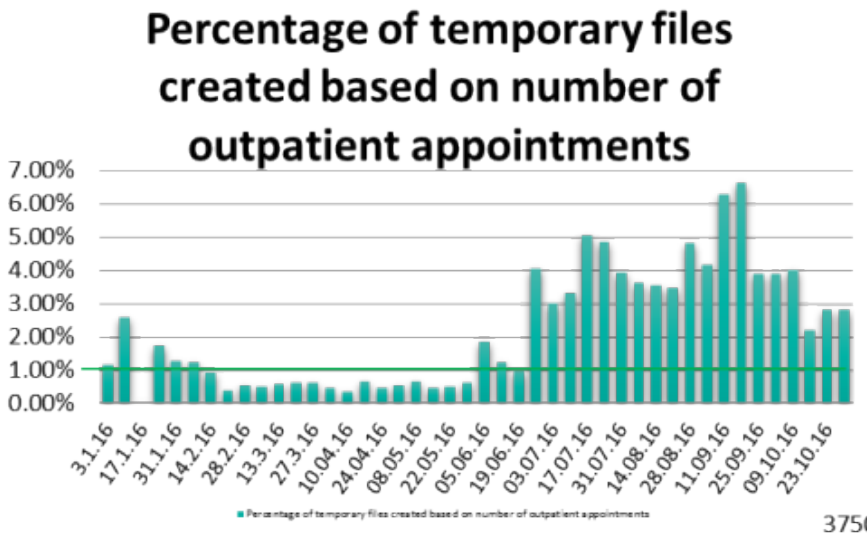
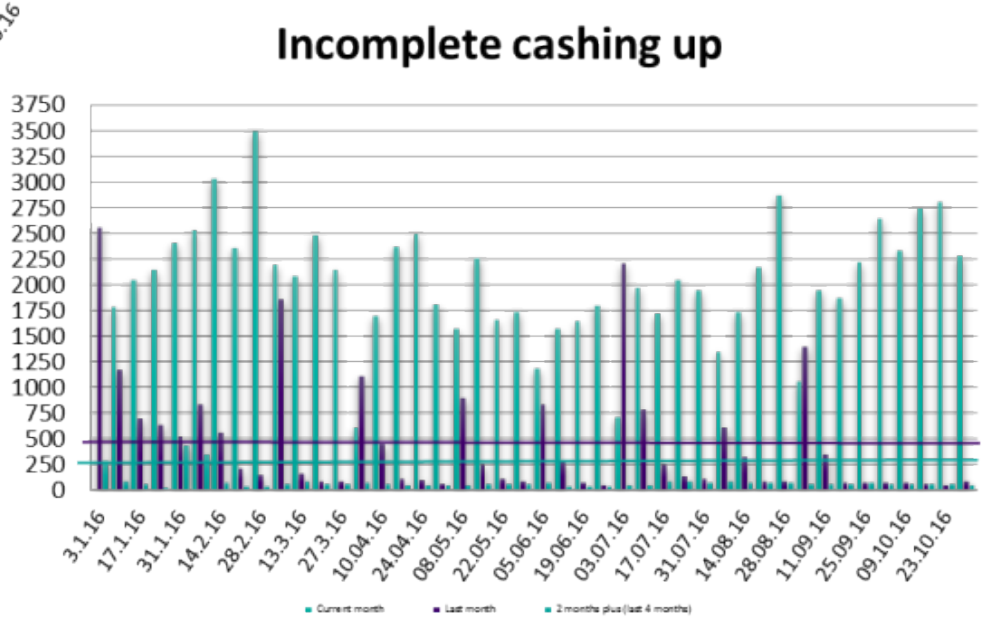


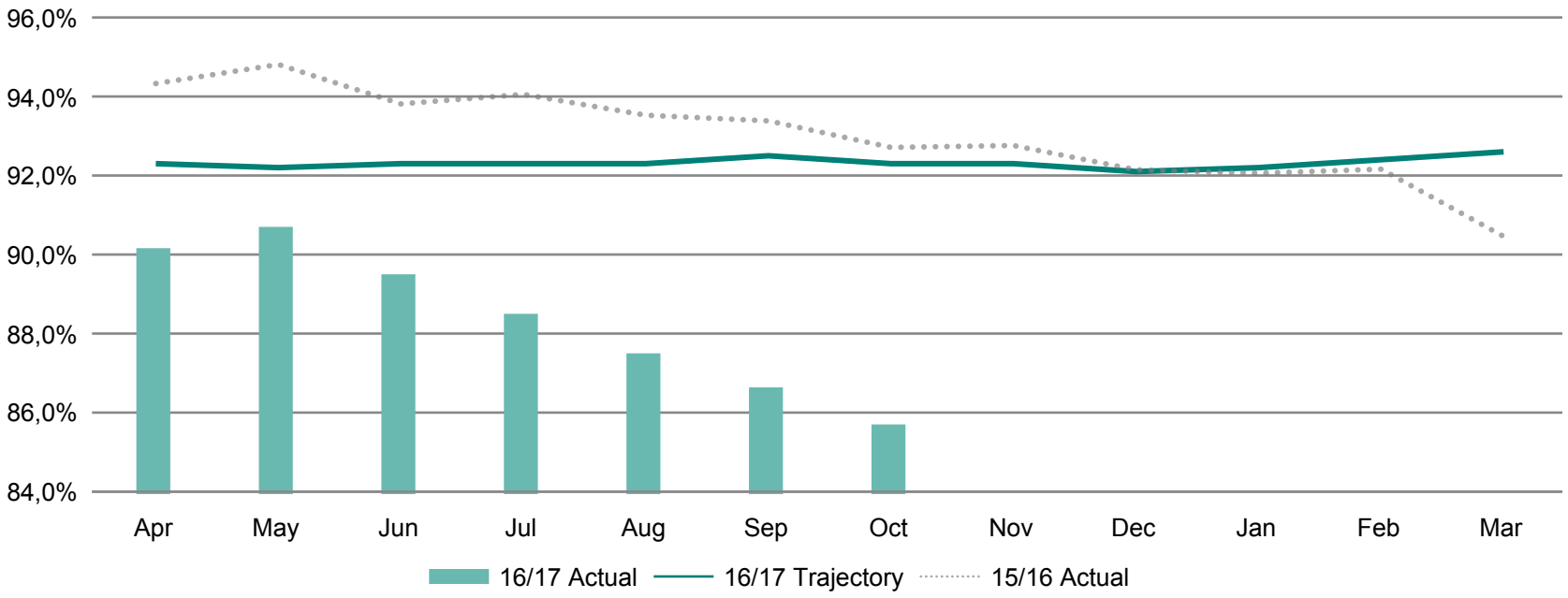
Temporary notes have begun to decrease as anticipated following the prolonged transfer of notes and reduction in temporary staff.

Incomplete cashing up is continuing to improve.



2. RTT

October performance was 85.7% against the trajectory of 92.3%. This represents a further decline in performance and a further widening of the gap against trajectory.



East Sussex Healthcare NHS Trust

RTT

The RTT position remains challenging and has further deteriorated during October.

Trust is currently projecting partial recovery to c88% by March '17 and full recovery to 92% by December '17. Recovery plans for full recovery still in development.

Weekly PTLs are now embedded in the Trust and are working on a specialty by specialty basis to highlight gaps in capacity, additional required to recover position and working with the services to develop recovery plans.

Ophthalmology - An external provider has begun work with the Trust to reduce patient waits. The initial phase has concentrated on new outpatients and will run for 8 weeks. Delivery is currently on target and waiting list has reduced by approximately 1000 patients. It is anticipated that collaboration with this provider will continue to manage the patients through their full pathway.

Gynaecology – Delivery against Outpatient recovery by November has not been realised. The service have identified additional clinics up to the end of March to see a further 950 outpatients. 600 additional IP/DC are required for full recovery, the service have currently identified capacity for 100.

Neurology – Capacity increased through appointment of consultant and use of locum. Recovery expected by late February

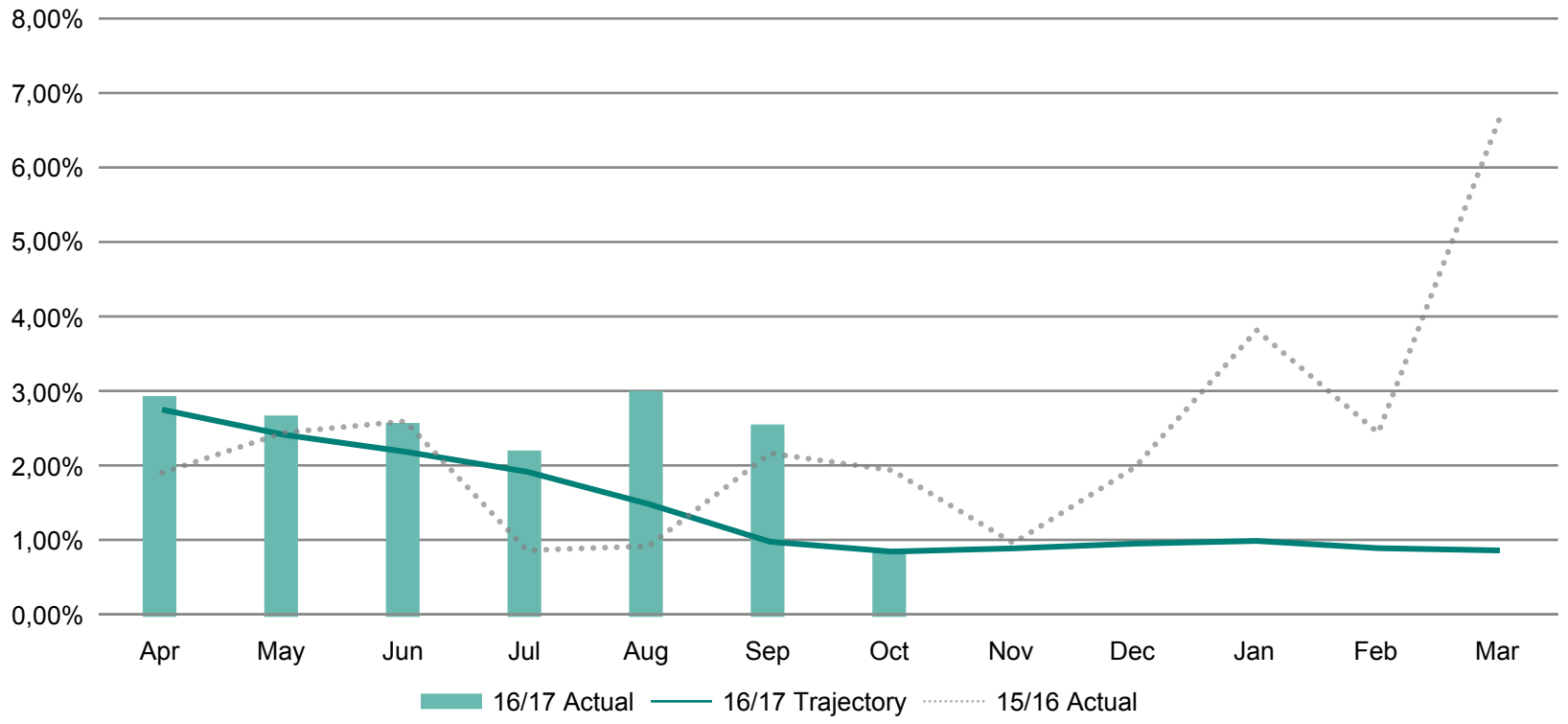
Gastroenterology and Thoracic Medicine waiting lists have grown and require further internal review to establish an appropriate recovery plan.

ENT, Surgery and Urology – Identifying and securing additional capacity for IP/DC continues to be a challenge both internally and through external providers. The Trust is beginning to scope capacity available from providers outside of area.

East Sussex Healthcare NHS Trust

Diagnostics

Diagnostics achieved the 1% standard with a performance of 0.88% in October. This was marginally short of the 0.84% trajectory. It is anticipated that the previous actions taken to improve performance are now embedded and that this will represent a sustainable position moving forwards.



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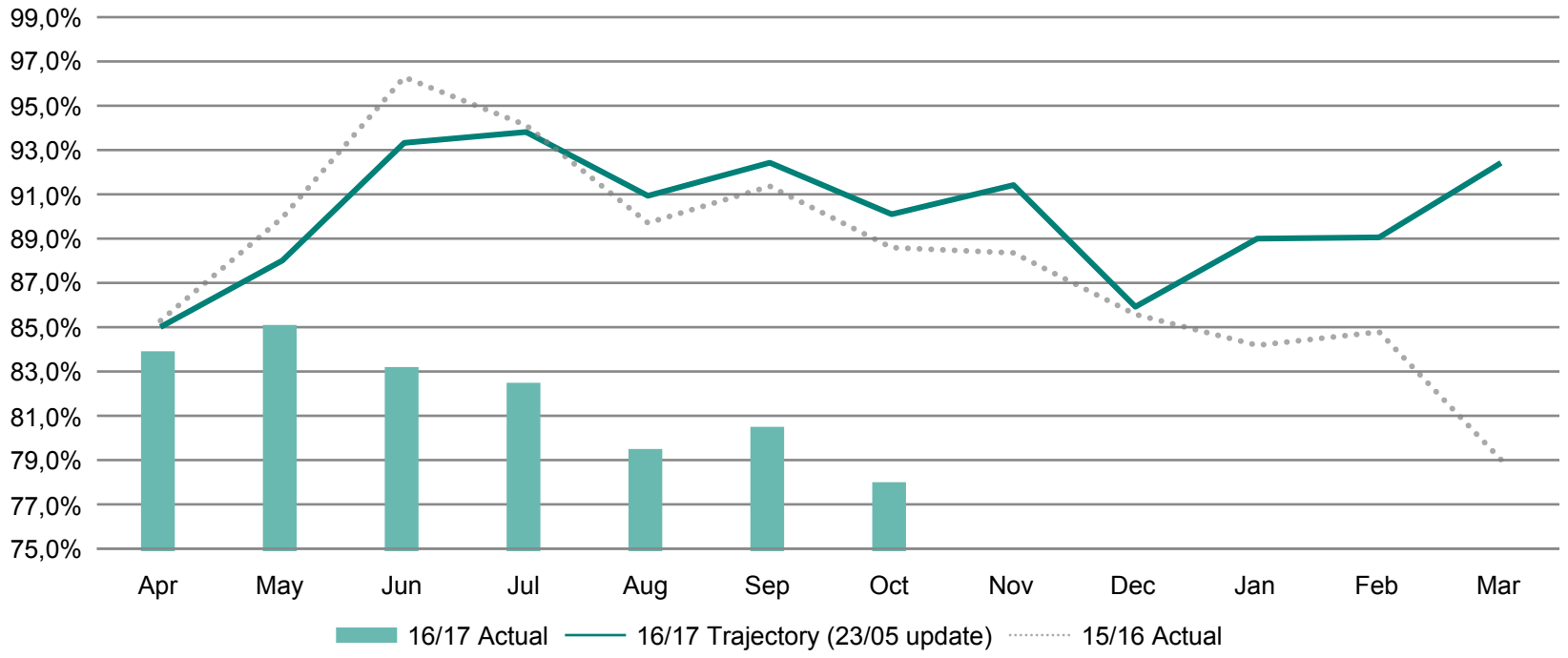
EMERGENCY CARE

East Sussex Healthcare NHS Trust

A&E Trajectory

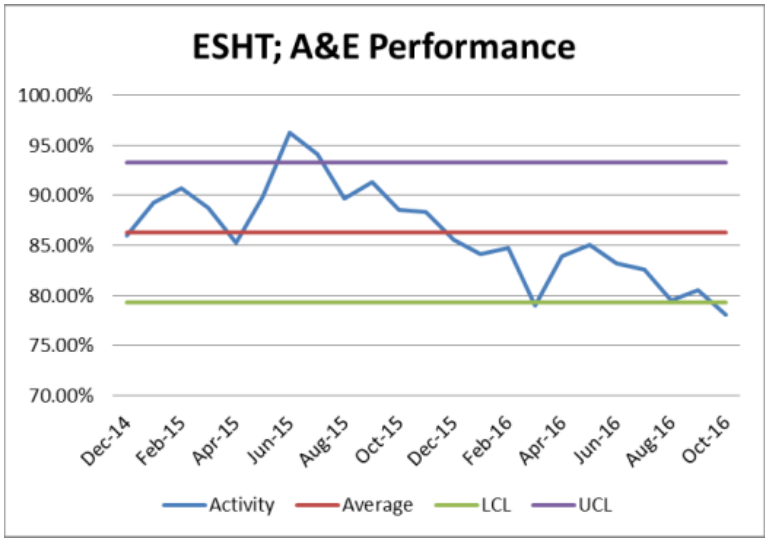


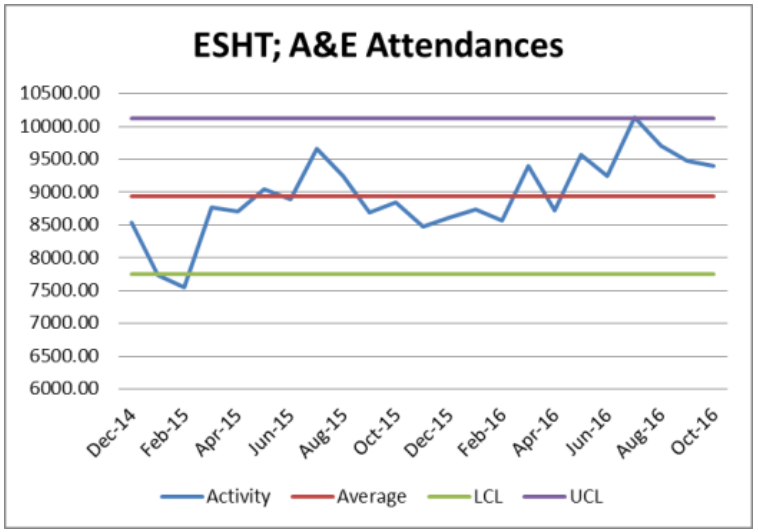
A&E

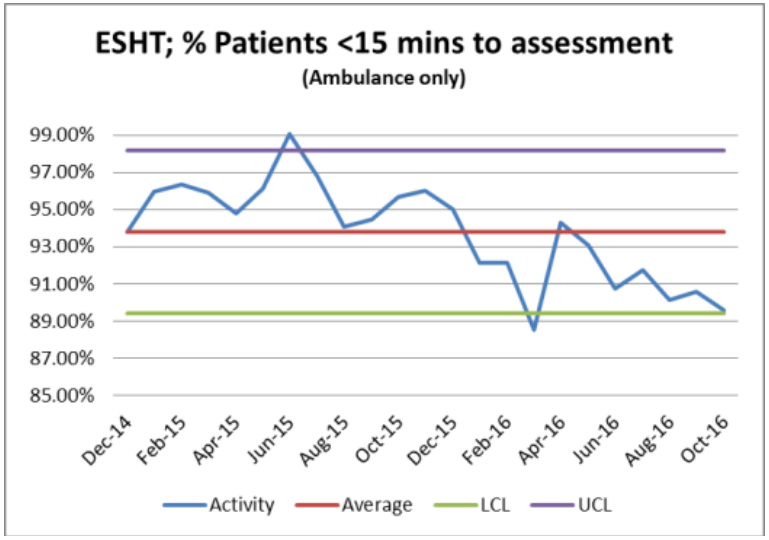
A&E performance showed a deterioration in October

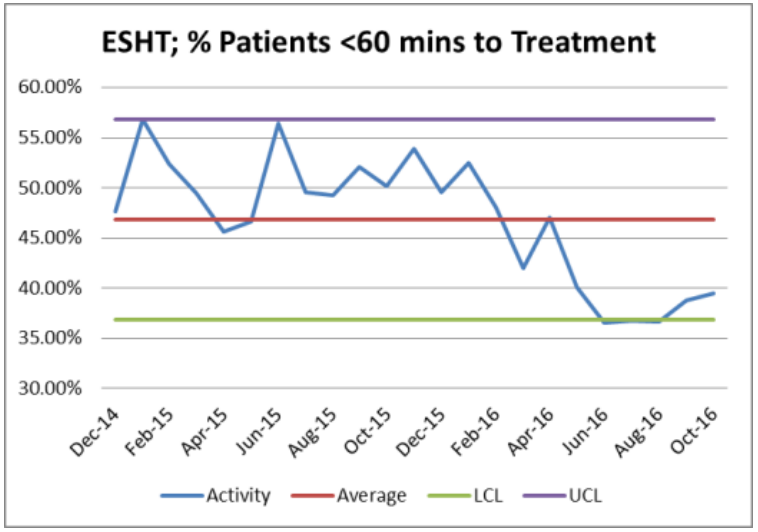
Attendances were up across both sites by 4% on the year to date figure and 9% against the same month last year.

An A&E Improvement Plan is in place and monitored weekly against the 9 improvement areas to ensure the anticipated impact is being realised. Streaming in particularly has shown a marked improvement in the number of breaches.


ESHT; A&E Performance
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
Dec-14
Feb-15
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Oct-16
Activity
Average
LCL
UCL


ESHT; A&E Attendances
10500.00
10000.00
9500.00
9000.00
8500.00
8000.00
7500.00
7000.00
6500.00
6000.00
Dec-14
Feb-15
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Oct-16
Activity
Average
LCL
UCL


ESHT; % Patients <15 mins to assessment
(Ambulance only)
99.00%
97.00%
95.00%
93.00%
91.00%
89.00%
87.00%
85.00%
Dec-14
Feb-15
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Oct-16
Activity
Average
LCL
UCL


ESHT; % Patients <60 mins to Treatment
60.00%
55.00%
50.00%
45.00%
40.00%
35.00%
30.00%
Dec-14
Feb-15
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Oct-16
Activity
Average
LCL
UCL

Progress against the 5 key work streams continues

A&E Process Improvements :

- Streaming out to other specialties has successfully been embedded within both EDs
- Ambulatory care facilities at EDGH are ringfenced and patient numbers managed via AEC have increased there
- Our minors performance has improved. IT work to improve our recording of minors patients on PAS-Oasis will be completed imminently.

Revised Medical Model:

- The model was signed off at October's UEC Board and the Chief of Medicine will work with Medicine's GM to timetable and operationalise the workforce changes required. Cardiology will provide specialist input at the "front end" in December 2016 with other specialities to follow in January 2017
- ECIP will support the Trust in right sizing the assessment areas

Patient Flow and discharge Planning

- SAFER bundle introduced on 4 pilot wards in October. ECIP have reviewed and agreed to undertake further education sessions on pilot wards to ensure correct process is followed consistently.

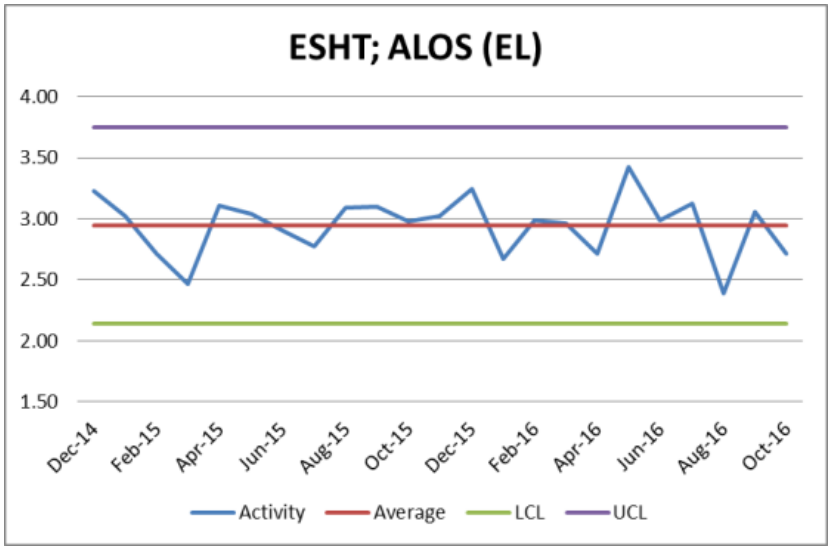
Develop Right Size Capacity

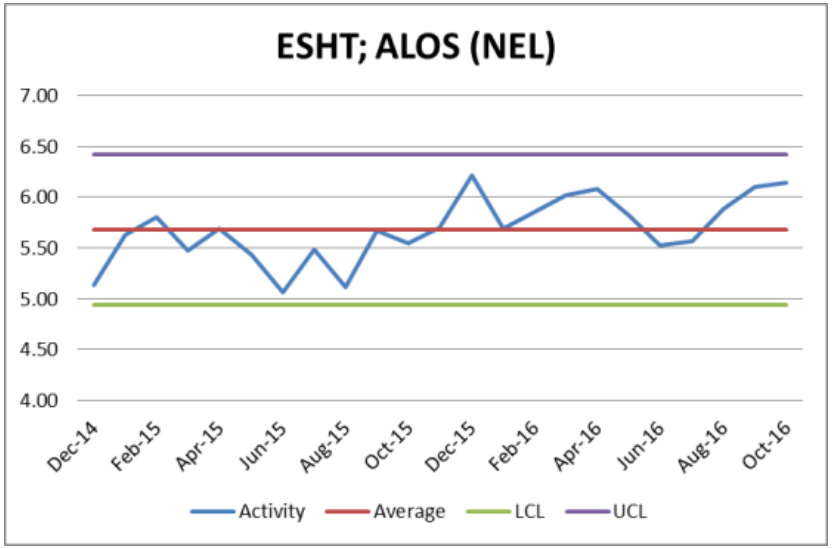
- 13 beds are now available and in use at Hastings Court Nursing Home. This will progress to 19 as resources become available
- Negotiations ongoing with other nursing home/hospice providers

Strengthen Governance

- Draft dashboard for programme improvements to be populated by BI
- Urgent & emergency Care Board established

East Sussex Healthcare NHS
NHS Trust





SYSTEM ACTIONS TO REDUCE LENGTH OF STAY

- Initially 15 rising to 30 care home plus beds for patients awaiting nursing home placements
- 2400 Additional homecare hours with JCR and Rapid response by January
- Ring fencing Ambulatory Care on both sites to increase use of pathways 20%
- Increased Adult Social Care workers in A&E and gateways
- Extension of Take Home and Settle
- Hospital Intervention team extended to cover till 10pm
- GP trial in A&E EDGH to reduce medical admissions who can be managed within primary care
- Frailty Team now in place to reduce attendances and expedite discharges
- Crisis response teams on both sites to in reach into A&E
- Expanding the liaison of the respiratory team to manage pneumonia pathways

East Sussex Healthcare NHS
NHS Trust

CANCER

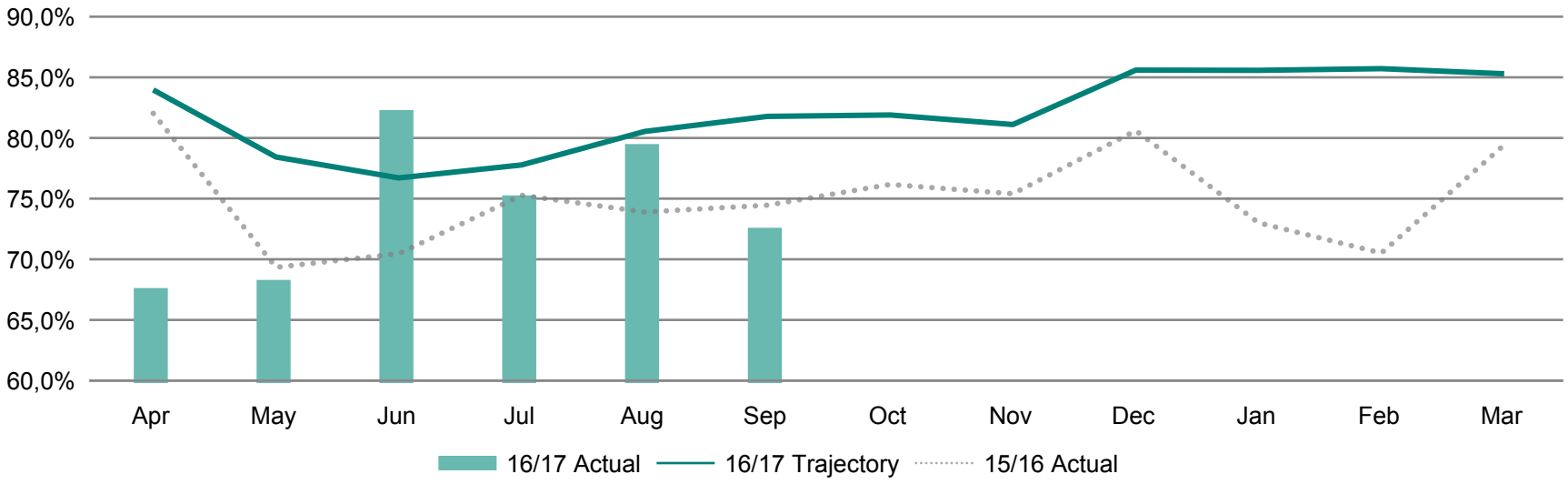
East Sussex Healthcare NHS Trust

CANCER

Achieved: 2 week wait

Achieved: 31 Day Standard

Did not achieve trajectory for 62 Day Standard. 72.6% against trajectory target of 81.8%



Completed Actions

Waiting times for Endoscopy now improved with additional capacity opened. Consultant staffing remains an issue and Locums are currently being appointed with substantive posts being finalised.

Bid to NHSI successful; funding stream into CCG currently being confirmed in order to commence appointment and purchase process for Radiology PPCs, Order Comms Project Manager and MPMRI Fusion imaging. Shared MPMRI imaging and reporting between BSUH and ESHT in planning.

New Prostate pathway being implemented by Clinical Unit and MDT. Initial improvements are now being noted in the diagnostic phase of the pathway in particular.

TWW Nurse Advisor has now commenced in post; she is working closely with the TWW Clerks and the Patient Pathway Co-ordinators.

Planned Actions

Head & Neck Deep Dive to take place in December or January dependent upon clinical commitments.

Joint PTLs being set up with BSUH and Guys and St Thomas's to run weekly in order to replicate the scrutiny on 38 day transfers currently in place with MTW.

The Diagnostic PTL has now been implemented and is being trialled.

Collaborative working on NG12 continues with CCG partners.

EBUS / EUS bid to be submitted to Business Case Board at the end of November.

Finance & Capital

FINANCE

East Sussex Healthcare NHS
NHS Trust

1. Financial Headlines
2. Financial Indicators
3. Income
4. Cash Flow
5. Activity and Contracts
6. Agency Expenditure
7. CIP
8. Year on Year
9. Capital
10. Financial Risks

East Sussex Healthcare NHS
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Financial Highlights – October 2016

- In month 7 the Trust made a deficit of £3.7m, which was £0.9m worse than plan; the cumulative deficit of £28.5m is £5.9m adrift of plan, of which £3.5m relates to a shortfall on Sustainability and Transformation Funding (STF)
- Total income was £1.3m better than plan in the month and is £4.8m ahead for the year to date
- The cumulative favourable position on income was achieved despite the shortfall on STF; contract income is £6.3m above plan, other non-clinical is £2.0m ahead and there is a £0.5m favourable variance on tariff exclusions; trading income is £0.5m adverse to plan
- The NHSI Use of Resources rating for the year to date remains at 4 (Red)
- The I&E forecast for the full year remains at £31.3m deficit, in line with plan, although a substantial level of risk remains, being addressed through the Financial Recovery Plan; the forecast assumes that STF will be recovered in full
- The operating cost run rate of £33.5m in month 7 is slightly ahead of the previous monthly average of £33.4m; the position after 7 months is £11.2m adverse to plan
- Pay costs to date are £5.7m above plan and non-pay nearly £5.0m above excluding £0.5m relating to tariff exclusions
- The year to date position has benefited from some mid-year non-pay adjustments, including a £0.4m stock adjustment and £0.9m release of accruals no longer required in respect of community property rentals
- Cost improvements fell short of plan by £0.9m in the month and delivery to date is £2.3m against the target of £5.5m
- Spend on agency staffing reached £14.3m after 7 months, £4.2m above plan; medical agency spend represented £5.3m of the total a and £2.4m of the adverse variance
- The Trust has drawn down £28.4m of its £31.3m Working Capital Facility to the end of month 7 and the full amount will have been drawn and utilised by the end of December; discussions are ongoing with NHSI regarding access to additional cash financing
- Cash management remains extremely challenging and the Trust is having to carefully prioritise its creditor payment runs; at the current expenditure run rate the Trust will continue to experience severe cash flow pressures pending any increase in availability of central financing
- Capital spend was £6m to the end of October against a full year programme of £11.0m; there is an 'over planning' margin of £1.3m, hence a need to prioritise the uncommitted expenditure plans
- No assumption has been made regarding additional capital funding in the current year.

East Sussex Healthcare NHS Trust

Financial Performance Indicators – October 2016

Financial Performance Indicators	Plan	Actual	Variance
NHSI Use of Resources Rating:			
Liquid Ratio	4	4	
Capital Servicing Capacity	4	4	
I&E Margin	4	4	
Distance from Financial Plan	4	4	
Agency Spend	1	3	
Overall Use of Resources	4	4	
I&E Surplus/(Deficit) - In Month	£-2.8m	£-3.7m	£-0.9m
I&E Surplus/(Deficit) - Year to Date	£-22.6m	£-28.5m	£-5.9m
I&E Surplus/(Deficit) - Forecast for Year	£-31.3m	£31.3m	£nil
Income per WTE (excluding STF) - Year to Date	£31.7k	£32.6k	£0.9K
Agency Costs - Month	£0.8m	£2.1m	£-1.3m
Agency Costs - Year to Date	£10.1m	£14.3m	£-4.2m
Agency Costs % of Total Pay - Year to Date	6.7%	9.1%	-2.4%
Cost Improvement Plans - Year to Date	£5.5m	£2.3m	£-3.2m
Cost Improvement Plans - % Green and Amber			
BPPC - Trade Invoices by Value (%)	95	41	
BPPC - NHS Invoices by Value (%)	95	76	
Overall Trade Creditor Balance	*	£25.3m	
Trade Debtors >90 days (%)	5%	12%	-7%
Current Cash Balance	£9.9m	£3.0m	£-6.9m
Capital Spend - Year to Date	£6.5m	£6.0m	£0.5m
Capital Spend - Forecast for Year (variance is over planning)	£11.0m	£12.3m	£-1.3m
* unspecified			

East Sussex Healthcare NHS
NHS Trust

Statement of Comprehensive Income – October 2016

£000s	Month Plan	Month Actual	Var	YTD Plan	YTD Actual	Var	Annual Plan
NHS Patient Income	23,677	25,832	2,155	165,820	172,115	6,295	286,487
Sustainability & Transformation Fund	867	0	-867	6,067	2,600	-3,467	10,400
Tariff-Excluded Drugs & Devices	2,608	2,453	-155	18,258	18,757	499	31,300
Private Patient/ ICR	243	189	-54	1,703	1,588	-115	2,919
Trading Income	483	427	-56	3,386	2,926	-460	3,631
Other Non Clinical Income	2,217	2,485	268	15,982	18,003	2,021	29,148
Total Income	**30,095**	**31,386**	**1,291**	**211,216**	**215,989**	**4,773**	**363,885**
Pay Costs	-21,036	-22,697	-1,661	-150,584	-156,293	-5,709	-254,517
Non Pay Costs	-7,681	-8,350	-669	-53,700	-58,654	-4,954	-90,076
Tariff-Excluded Drugs & Devices	-2,608	-2,453	155	-18,258	-18,757	-499	-31,300
Total Operating Costs	**-31,325**	**-33,500**	**-2,175**	**-222,542**	**-233,704**	**-11,162**	**-375,893**
Surplus/- Deficit from Operations	**-1,230**	**-2,114**	**-884**	**-11,326**	**-17,715**	**-6,389**	**-12,008**
Less: Donated Asset Income	-104	5	109	-829	-704	125	-1,243
EBITDA	**-1,334**	**-2,109**	**-775**	**-12,155**	**-18,419**	**-6,264**	**-13,251**
Depreciation	-1,043	-1,101	-58	-7,303	-7,277	26	-12,519
PDC Dividend	-430	-430	0	-3,011	-2,911	100	-5,162
Interest	-135	-157	-22	-940	-730	210	-1,611
Total Non Operating Costs	**-1,608**	**-1,688**	**-80**	**-11,254**	**-10,918**	**336**	**-19,292**
Total Costs	**-32,933**	**-35,188**	**-2,255**	**-233,796**	**-244,622**	**-10,826**	**-395,185**
Net Surplus/-Deficit	**-2,838**	**-3,802**	**-964**	**-22,580**	**-28,633**	**-6,053**	**-31,300**
Donated Asset/Impairment Adjustment	0	59	59	0	156	156	0
Adjusted Net Surplus/-Deficit	**-2,838**	**-3,743**	**-905**	**-22,580**	**-28,477**	**-5,897**	**-31,300**

SOCI by Division	Month Plan	Month Actual	Var	YTD Plan	YTD Actual	Var
	£000's	£000's	£000's	£000's	£000's	£000's
Urgent Care	-962	-980	-18	-6,613	-6,925	-312
Medicine	-4,479	-5,443	-964	-32,406	-37,202	-4,796
Surgery, Anaesthetics & Diagnostics	-8,948	-9,891	-943	-63,874	-70,408	-6,534
Women's, Children's & Sexual Health	-2,564	-2,627	-63	-17,904	-17,643	261
Out of Hospital Care	-3,553	-3,362	191	-22,704	-23,219	-515
Tariff-Excluded Drugs & Devices	-2,608	-2,453	155	-18,258	-18,757	-499
Total Divisions	**-23,114**	**-24,756**	**-1,642**	**-161,759**	**-174,154**	**-12,395**
Estates & Facilities	-1,964	-1,975	-11	-13,732	-14,602	-870
Corporate Services	-3,543	-3,998	-455	-25,069	-27,822	-2,753
Central Items	-1,154	-1,502	-348	-12,484	-7,531	4,953
Total Central Areas	**-6,661**	**-7,475**	**-814**	**-51,285**	**-49,955**	**1,330**
Contract Income	27,152	28,285	1,133	190,145	193,472	3,327
Non-contract Income	-215	144	359	319	2,004	1,685
Donated Asset/Impairment Adjustment	0	59	59	0	156	156
Adjusted Net Surplus/- Deficit	**-2,838**	**-3,743**	**-905**	**-22,580**	**-28,477**	**-5,897**

Workforce by Division			Month	Month	Var	YTD	YTD	Var
Plan	Actual	Pay Performance	Plan	Actual		Plan	Actual	
FTE	FTE		£000's	£000's	£000's	£000's	£000's	£000's
217	222	Urgent Care	-912	-915	-3	-6,247	-6,466	-219
1,171	1,239	Medicine	-4,121	-4,741	-620	-28,962	-32,052	-3,090
0	0	Cardiovascular	0	0	0	0	0	0
1,795	1,853	Surgery, Anaes & Diagnostics	-6,993	-7,422	-429	-49,117	-52,004	-2,887
615	602	Women's, Children's & Sexual Health	-2,365	-2,484	-119	-16,509	-16,198	311
918	888	Out of Hospital Care	-2,845	-2,647	198	-17,818	-18,184	-366
0	0	Clinical Support	0	0	0	0	0	0
0	0	COO Operations	0	0	0	0	0	0
4,716	**4,804**	**Total Clinical Units**	**-17,236**	**-18,209**	**-973**	**-118,653**	**-124,904**	**-6,251**
714	717	Estates & Facilities	-1,462	-1,454	8	-10,164	-10,499	-335
1,048	1,021	Corporate Services	-2,950	-3,021	-71	-20,705	-20,802	-97
1,761	**1,738**	**Total Non-Clinical Divisions**	**-4,412**	**-4,475**	**-63**	**-30,869**	**-31,301**	**-432**
0	**0**	Central Items	612	-13	-625	-1,062	-88	974
6,477	**6,542**	**Total Pay Analysis**	**-21,036**	**-22,697**	**-1,661**	**-150,584**	**-156,293**	**-5,709**

East Sussex Healthcare NHS
NHS Trust

Statement of Financial Position and Cash Flow – October 2016

Statement of Financial Position	Actual	Actual	F'cast
£000s	31/3/16	31/10/16	31/3/17
Non Current Assets			
Property plant and equipment	231,172	229,965	235,207
Intangible Assets	1,650	1,798	2,130
Trade and other Receivables	1,193	1,436	1,193
	234,015	**233,199**	**238,530**
Current Assets			
Inventories	6,472	6,314	6,341
Trade receivables	8,397	12,185	9,685
Other receivables	8,787	10,553	18,004
Cash and cash equivalents	2,100	3,014	2,100
	25,756	**32,066**	**36,130**
Current Liabilities			
Trade payables	-13,571	-25,264	-29,417
Other payables	-26,259	-20,720	-16,569
DH Capital investment Loan	-427	-427	-427
Provisions	-253	-364	-427
	-40,510	**-46,775**	**-46,840**
Non Current Liabilities			
DH Capital Investment Loan	-3,553	-3,339	-3,126
Borrowings - Revenue Support Facility	-35,218	-63,577	-72,296
Provisions	-2,709	-2,426	-2,900
	-41,480	**-69,342**	**-78,322**
Total Assets Employed	**177,781**	**149,148**	**149,498**
Financed by			
Public Dividend Capital (PDC)	153,562	153,562	153,562
Revaluation Reserve	98,247	98,247	101,264
Income & Expenditure Reserve	-74,028	-102,661	-105,328
Total Tax Payers Equity	**177,781**	**149,148**	**149,498**

Cash Flow Statement October 2016 to March 2017							
£000s	Oct	YTD	Nov	Dec	Jan	Feb	Mar
	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast
Cash Flow from Operations							
Deficit including Depreciation	-3,215	-24,993	-1,690	-1,769	-1,153	-1,230	6,308
Depreciation and Amortisation	1,101	7,277	828	1,048	1,048	1,048	1,050
Operating Surplus/(Deficit)	-2,114	-17,716	-862	-721	-105	-182	7,358
Net Interest (Paid) or Received	-157	-730	-178	-177	-178	-177	-171
Dividend Paid	0	-2,209	0	0	0	0	-2,953
(Increase)/Decrease in Trade and Other Receivables	-105	-6,279	500	500	500	500	500
Increase/(Decrease) in Trade and Other Payables	3,216	-6,460	-84	2,126	2,713	2,134	-2,736
Provisions Utilised	-46	-173	-40	-40	-40	-40	-139
Net Cash Inflow/(Outflow) from Operating Activities	**794**	**-33,567**	**-664**	**1,688**	**2,890**	**2,235**	**1,859**
Cash Flows from Investing Activities:							
Property, Plant and Equipment	-1,367	-5,664	-1,250	-1,250	-1,250	-1,250	-303
Net Cash Inflow/(Outflow) from Investing Activities	**-1,367**	**-5,664**	**-1,250**	**-1,250**	**-1,250**	**-1,250**	**-303**
Net Cash Inflow/(Outflow) before Financing	**-573**	**-39,231**	**-1,914**	**438**	**1,640**	**985**	**1,556**
Revolving Working Capital Facility	2,838	28,358	2,241	701	0	0	0
Temporary/Repayable CCG Funding	0	12,000		-3,000	-3,000	-3,000	-3,000
Uncommitted Term Loan	0	0	0	1,619	1,704	1,781	674
New and repaid Loans	0	-214	0	0	0	0	-338
Net Cash Inflow/(Outflow) from Financing Activities	**2,838**	**40,144**	**2,241**	**-680**	**-1,296**	**-1,219**	**-2,664**
Net Increase/(Decrease) in Cash	**2,265**	**913**	**327**	**-242**	**344**	**-234**	**-1,108**
Opening balance	748	2,100	3,013	3,340	3,098	3,442	3,208
Closing balance	3,013	3,013	3,340	3,098	3,442	3,208	2,100

East Sussex Healthcare NHS
NHS Trust

Activity & Contract Income – October 2016

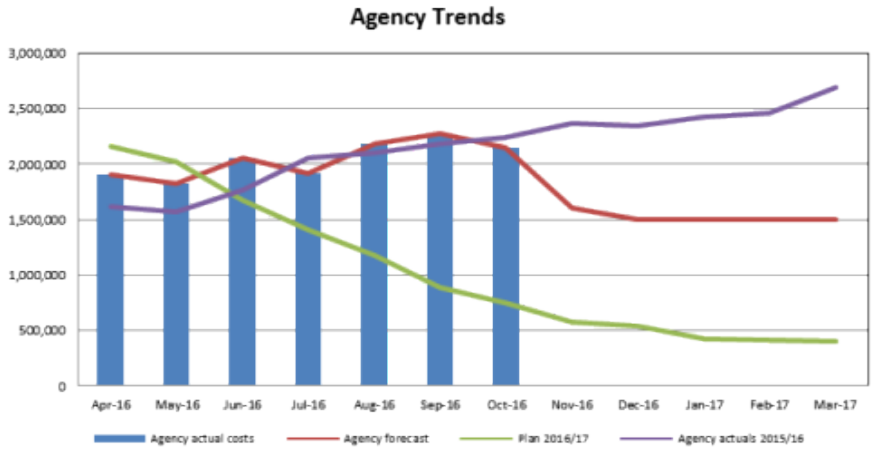
Activity	Current Month Plan	Current Month Actual	Current Month Var	YTD Plan	YTD Actual	YTD Var
Day Cases	3,589	3,102	-487	25,465	22,993	-2,472
Elective Inpatients	655	697	42	4,647	4,663	16
Emergency Inpatients	3,665	3,279	-386	25,301	24,091	-1,210
Total Inpatients	**7,909**	**7,078**	**-831**	**55,413**	**51,747**	**-3,666**
Excess Bed Days	2,229	4,190	1,961	15,415	17,476	2,061
Total Excess Bed Days	**2,229**	**4,190**	**1,961**	**15,415**	**17,476**	**2,061**
Consultant First Attendances	7,901	9,662	1,761	56,059	57,655	1,596
Consultant Follow Ups	12,346	12,140	-206	87,599	88,096	497
OP Procedures	4,504	5,302	798	31,960	31,935	-25
Other Outpatients inc WA & Nurse Led	12,124	13,341	1,217	86,022	91,154	5,132
Community Specialist	172	232	60	1,221	1,612	391
Total Outpatients	**37,047**	**40,677**	**3,630**	**262,861**	**270,452**	**7,591**
Chemotherapy Unbundled HRGs	617	1,804	1,187	4,374	9,126	4,752
Antenatal Pathways	311	274	-37	2,201	1,970	-231
Post-natal Pathways	285	317	32	2,023	2,089	66
A&E Attendances (excluding type 2's)	9,476	9,517	41	65,415	67,282	1,867
ITU Bed Days	517	566	49	3,572	3,687	115
SCBU Bed Days	309	175	-134	2,132	1,907	-225
Cardiology - Direct Access	68	68	0	481	486	5
Radiology - Direct Access	5,103	5,433	330	36,205	38,941	2,736
Pathology - Direct Access	276,561	287,815	11,254	1,962,270	1,962,473	203
Therapies - Direct Access	2,540	4,120	1,580	18,026	21,117	3,091
Audiology	1,013	614	-399	7,193	4,557	-2,636
Midwifery	13	10	-3	91	62	-29

Income £000's	Current Month Plan	Current Month Actual	Current Month Var	YTD Plan	YTD Actual	YTD Var
Inpatients - Electives	4,094	4,708	614	29,043	30,588	1,545
Inpatients - Emergency	6,310	6,272	-38	43,559	44,870	1,311
Excess Bed Days	493	903	410	3,405	3,784	379
Outpatients	3,993	4,527	534	28,340	29,473	1,133
Other Acute based Activity	2,805	2,749	-56	19,494	18,939	-555
Direct Access	771	889	118	5,476	5,830	354
Block Contract	5,381	5,549	168	37,664	36,705	-959
Fines & Penalties	0	0	0	0	-10	-10
Other	217	-377	-594	1,546	960	-586
CQUIN	480	612	132	3,360	3,576	216
Subtotal	24,544	25,832	1,288	171,887	174,715	2,828
Exclusions	2,608	2,453	-155	18,258	18,757	499
GRAND TOTAL	**27,152**	**28,285**	**1,133**	**190,145**	**193,472**	**3,327**

Commissioner	Month Plan £000	Month Actual £000	Var £000	YTD Plan £000	YTD Actual £000	Var £000
Eastbourne, Hailsham & Seaford	9,079	10,262	1,183	63,798	65,542	1,744
East Sussex County Council	728	1,143	415	5,097	5,728	631
Hastings & Rother	10,104	10,688	584	70,457	74,540	4,083
High Weald, Lewes & Havens	1,160	1,251	91	8,129	8,481	352
Musculoskeletal	1,200	1,312	112	8,487	8,657	170
NHS England	3,123	3,012	--111	21,888	21,790	--98
Other	1,758	617	-1,141	12,289	8,734	--3,555
Total	**27,152**	**28,285**	**1,133**	**190,145**	**193,472**	**003,327**

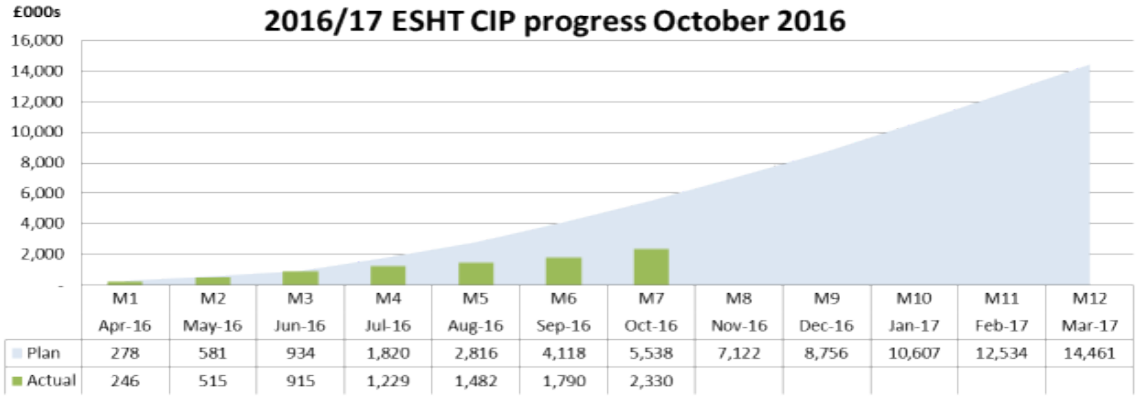
East Sussex Healthcare NHS Trust

Agency Expenditure – October 2016



Staff Group	M1	M2	M3	M4	M5	M6	M7
Nursing	826	689	693	658	633	705	600
Medical	593	547	666	706	904	952	1,020
Prof & Tech	275	369	404	346	350	370	252
Ancillary	121	102	127	116	162	168	145
Administrative & Clerical	90	115	170	92	140	87	168
Grand Total	**1,906**	**1,822**	**2,061**	**1,918**	**2,189**	**2,282**	**2,185**

2016/17 CIP Performance – October 2016



Theme	YTD Plan £000	YTD Actual £000	YTD Var £000
Clinical services productivity	343	353	-10
Corporate, administrative estates	634	332	302
Direct engagement	252	94	158
IM&T schemes	200	-	200
Income generation	167	212	-45
Lord Carter	2,117	-	2,117
Medicines Management	91	312	-221
Procurement	990	742	248
Redesign	144	285	-141
Stretched target	600	-	600
Total	**5,538**	**2,330**	**3,208**

Clinical Unit	YTD Plan £000	YTD Actual £000	YTD Var £000
Estates & Facilities	410	180	230
Operational COO	189	78	111
Corporate	664	292	372
Specialist Medicine	788	104	685
Surgery	1,393	766	627
Urgent	178	8	169
Women's & Children's	486	374	111
Out of Hospital	956	409	547
Trustwide	474	119	355
Total	**5,538**	**2,330**	**3,208**

East Sussex Healthcare NHS
NHS Trust

Year on Year Comparisons – October 2016

Activity	2016/17 YTD Actual	2015/16 YTD Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Day Cases	22,993	26,238	-3,245	-12.4%
Elective Inpatients	4,663	4845	-182	-3.8%
Emergency Inpatients	24,091	24,950	-859	-3.4%
Total Inpatients	**51,747**	**56,033**	**-4,286**	**-7.6%**
Elective Excess Bed Days	1,146	1,020	126	12.4%
Non elective Excess Bed Days	16,330	12,488	3,842	30.8%
Total Excess Bed Days	**17,476**	**13,508**	**3,968**	**29.4%**
Consultant First Attendances	57,655	55,217	2,438	4.4%
Consultant Follow Ups	88,096	86,358	1,738	2.0%
OP Procedures	31,935	31,621	314	1.0%
Other Outpatients (WA & Nurse Led)	91,154	86,115	5,039	5.9%
Community Specialist	1,612	1,150	462	40.2%
Total Outpatients	**270,452**	**260,461**	**9,991**	**3.8%**
Chemotherapy Unbundled HRGs	9,126	4,102	5,024	122.5%
Antenatal Pathways	1,970	2,171	-201	-9.3%
Post-natal Pathways	2,089	2,058	31	1.5%
A&E Attendances (excluding type 2's)	67,282	63,650	3,632	5.7%
ITU Bed Days	3,687	3,276	411	12.5%
SCBU Bed Days	1,907	2,149	-242	-11.3%
Cardiology - Direct Access	486	474	12	2.5%
Radiology - Direct Access	38,941	35,333	3,608	10.2%
Pathology - Direct Access	1,962,473	1,914,981	47,492	2.5%
Therapies - Direct Access	21,117	19,789	1,328	6.7%
Audiology	4,557	7,018	-2,461	-35.1%
Midwifery	62	89	-27	-30.3%

Statement of Comprehensive Income £000s	2016/17 YTD Actual	2015/16 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	193,472	187,632	5,840	3.1%
Private Patient/ RTA	1,588	1,686	-98	-5.8%
Trading Income	2,926	3,308	-382	-11.5%
Other Non Clinical Income	18,003	15,302	2,701	17.7%
Total Income	**215,989**	**207,928**	**8,061**	**3.9%**
Pay Costs	-156,293	-149,497	-6,796	-4.5%
Non Pay Costs	-78,936	-72,655	-6,281	-8.6%
Other	1,525	1,075	450	
Total Direct Costs	-233,704	-221,077	-12,627	-5.7%
Surplus/-Deficit from Operations	**-17,715**	**-13,149**	**-4,566**	**-34.7%**
Profit/Loss on Asset Disposal	0	14	-14	
Depreciation	-7,277	-7,702	425	5.5%
Impairment	0	0	0	
PDC Dividend	-2,911	-4,755	1,844	38.8%
Interest	-730	-552	-178	-32.2%
Total Indirect Costs	-10,918	-12,995	2,077	16.0%
Total Costs	**-244,622**	**-234,072**	**-10,550**	**-4.5%**
Net Surplus/-Deficit	**-28,633**	**-26,144**	**-2,489**	**-9.5%**
Donated Asset / Other Adjustment	156	347	-191	55.0%
Normalised Net Surplus/-Deficit	**-28,477**	**-25,797**	**-2,680**	**-10.4%**

East Sussex Healthcare NHS Trust

Capital Programme – October 2016

Capital Investment Programme £000s	Full Year Plan	YTD Actual	Forecast Outturn
Capital Resources			
Depreciation	11,519		
Interest Bearing Capital Loan Application £5m. (Not currently approved by the NHSI.)	0		
League of Friends Support	1,000		
Capital Investment Loan Principal Repayment	-552		
Gross Capital Resource	11,967		
Less Donated Income	-1,000		
Capital Resource Limit (CRL)	**10,967**	**-**	**-**
Capital Investment			
Medical Equipment *	881	145	1,145
IT Systems	2,187	821	2,180
Electronic Document Management	948	434	948
Estates Strategy	1,600	570	1,559
Backlog Maintenance	2,285	557	2,285
Minor Capital Schemes	1,000	1,525	1,525
Pathology CLD	797	735	1,047
Vital Pac	338	159	238
Project Management	106	51	106
Brought Forward Commitments - Various	1,183	900	1,236
Sub Total	**11,325**	**5,897**	**12,269**
Donated Asset Purchases	1,000	399	1,000
Donated Asset Funding	-1,000	-331	-1,000
Net Donated Assets	**0**	68	0
Sub Total Capital Schemes	**11,325**	**5,965**	**12,269**
Overplanning Margin (-) Underplanning (+)	-358	0	-1,302
Net Capital Charge against the CRL	**10,967**	**5,965**	**10,967**

East Sussex Healthcare NHS Trust

Financial Risks & Mitigating Actions – October 2016

Summary	
RISKS:-	**MITIGATING ACTIONS:-**
The following areas of risk have been identified in achieving the £31.3m deficit plan for the year: -	**The following opportunities for mitigation have been identified to offset the identified risks: -**
1) Increased activity and capacity cost pressures, e.g. access pressures, escalation wards, diagnostic capacity and scoping.	Reduction in expenditure through discretionary spend controls and additional cost improvement schemes. Capacity review of beds as part of the Urgent Care Board and Patient Flow project.
2) Unplanned operational cost pressures and reliance of agency staff at premium rates; failure to reduce agency costs as planned	Temporary Workforce Review; Executive approval process for authorisation of agency expenditure and recruitment to vacancies; further international recruitment drives; negotiation of agency rates within prescribed caps; extended use of Direct Engagement
3) Shortfall on delivery of CIPs.	Progress to be monitored through Integrated Performance Reviews and the Financial Improvement and Sustainability Committee. Identification of new savings opportunities through the FRP process with support from PA Consulting; support through NHSI Financial Special Measures and increased resources into the finance team to expedite CIP delivery. Increase pace on delivery of key work streams, notably Patient Flow and Theatre Efficiency
4) Failure to recover full contractual income entitlement.	Identification of lost opportunities with support from PA Consulting; drive forward the necessary changes and continue dialogue with commissioners regarding affordability of the Trust's income expectations
5) Technical adjustments made to improve the month 6 position carry a level of risk (Stock £0.4m, provision for a review non contract income accruals £0.7m, £0.9m properties accrual, and a review of the contract income reconciliation for Q1)	Ongoing review of the opportunities and risks with an emphasis on proactive delivery of the assumed values
6) STF funding is not secured as financial and operational targets are not met.	£31.3m assumes delivery of financial and operational targets are recovered by year end and £10.4m STF is received; ongoing discussion with NHSI as part of Financial Special Measures

Sustainability and Strategy

SUSTAINABILITY

1. STP
2. Developments

1. STP

The STP plan has been submitted to the Board for discussion.

Work is continuing with the local CCGs around the development of the model for Accountable Care

2. Developments

The Trust has negotiated 4 waves of improvement training with NHS Elect which is being rolled out across the Trust. This will be supported by the emerging Improvement Hub with a programme of improvement fellows.

The Trust has been working closely with colleagues in primary care to consider how we can support primary care resilience and delivery of the GP FYFV. We have been meeting with the GP Federation leads to discuss new ways of working and integrated pathways across primary and secondary care.

The Trust continues to work closely with the CGGs and Local Authority in the development of the Accountable Care model for East Sussex. This is a key part of our STP plan and will support our overall financial sustainability for the system.

Leadership & Culture

LEADERSHIP & CULTURE

1. Workforce Executive Summary
2. Overview
3. Recruitment
4. Turnover
5. Workforce Expenditure
6. Absence
7. Mandatory Training
8. Engagement

East Sussex Healthcare NHS
NHS Trust

1. WORKFORCE EXECUTIVE SUMMARY – KEY POINTS

Actual workforce usage of staff in October was 6542.43 full time equivalents (ftes), 64.99 ftes above budgeted establishment.

Temporary staff expenditure was £3,774K in October (16.63% of total pay expenditure). This comprised £1,593K bank expenditure, £2,134K agency expenditure and £47K overtime. This is a reduction of £114K overall compared to September.

There were 504.71 fte vacancies (a vacancy factor of 8.01%). This was a reduction of 12.50 fte vacancies compared to last month, achieved despite an increase in budgeted establishment of 60.66 ftes.

Annual turnover was 9.87% which represents 532.98 fte leavers in the last year. This is an increase of 0.21% compared to last month.

Monthly sickness was 4.68%, an increase of 0.67% from September. The annual sickness rate was 4.38%, an increase of 0.01%.

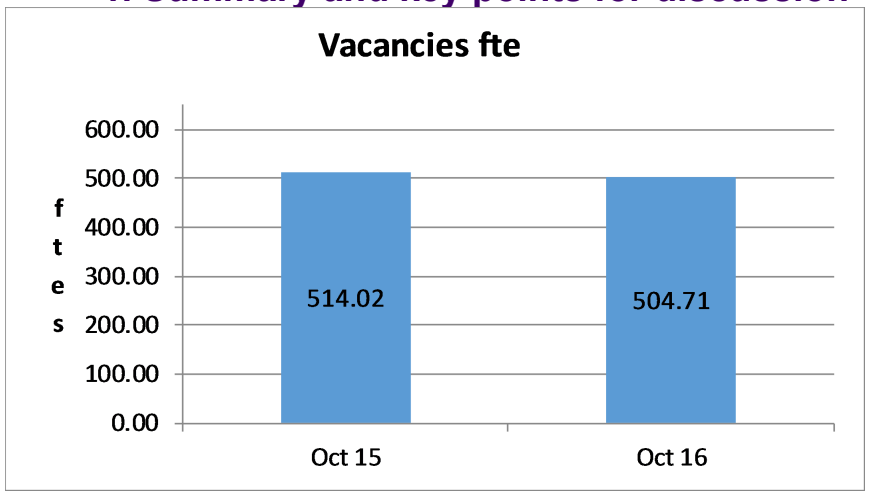
The overall mandatory training rate was virtually unchanged, just slightly down by 0.09% at 88.00%. Compliance rates were slightly down for Fire, Manual Handling, Induction, Infection Control and Information Governance but slightly higher for Health & Safety, Mental Capacity Act, Deprivation of Liberties and the Safeguarding courses..

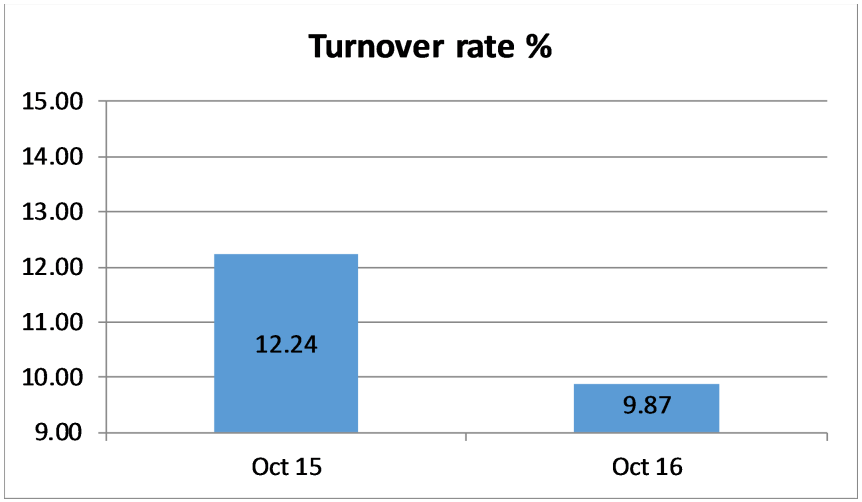
Appraisal compliance decreased by 1.53% to 81.61%

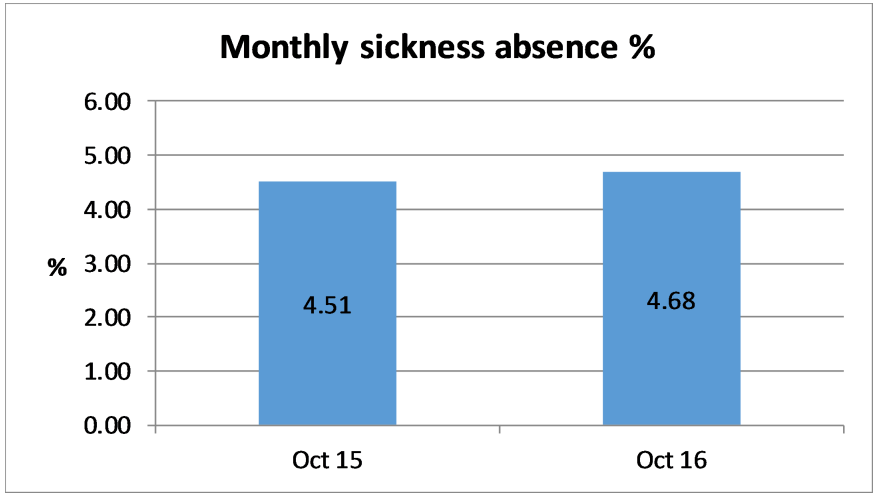
2. Overview

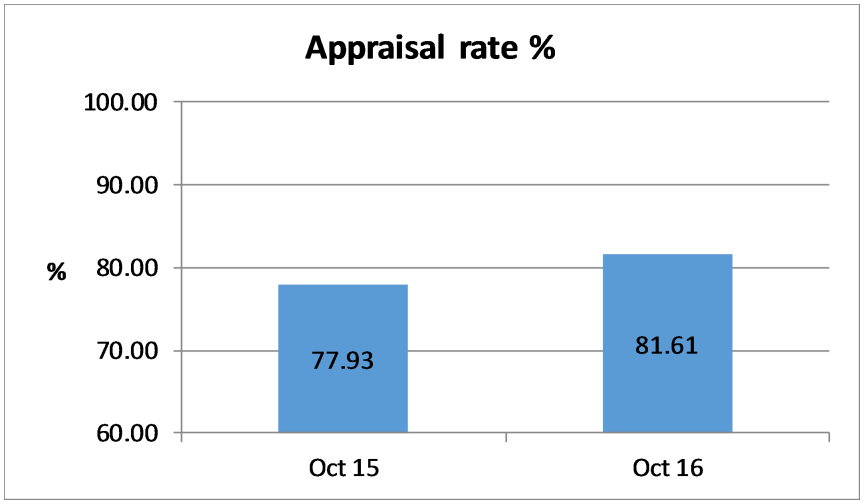
TRUST	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Trend line
WORKFORCE CAPACITY													
Budgeted fte	6028.97	6059.16	6057.38	6057.36	6057.39	6368.93	6381.23	6437.07	6328.78	6394.73	6416.78	6477.44	
Total fte usage	6236.91	6226.53	6282.89	6334.88	6492.33	6320.64	6340.02	6370.72	6380.32	6465.06	6516.26	6542.43	
Variance	-207.94	-167.37	-225.51	-277.52	-434.94	48.29	41.21	66.35	-51.54	-70.33	-99.48	-64.99	
Permanent vacancies	479.35	479.90	464.71	422.43	342.18	606.76	579.45	611.23	564.18	496.62	517.21	504.71	
Fill rate	91.83%	91.87%	92.12%	92.84%	94.20%	90.17%	90.66%	90.23%	90.94%	92.01%	91.71%	91.99%	
Bank fte usage (as % total fte usage)	6.75%	6.68%	6.27%	6.65%	6.58%	6.97%	6.23%	6.26%	6.40%	6.31%	7.42%	6.98%	
Agency fte usage (as % total fte usage)	6.94%	6.45%	7.35%	7.06%	8.09%	5.29%	5.37%	5.49%	5.32%	5.71%	5.33%	5.14%	
WORKFORCE EFFICIENCY													
Annual sickness rate	4.72%	4.61%	4.54%	4.53%	4.53%	4.50%	4.46%	4.42%	4.40%	4.39%	4.37%	4.38%	
Monthly sickness rate (%)	4.60%	4.48%	4.45%	5.10%	4.79%	4.18%	3.94%	3.77%	4.08%	4.10%	4.01%	4.68%	
Turnover rate	12.07%	11.97%	11.79%	11.28%	10.62%	10.25%	10.00%	10.03%	10.02%	9.76%	9.66%	9.87%	
TRAINING & APPRAISALS													
Appraisal rate	81.83%	81.85%	83.34%	85.29%	87.26%	88.47%	89.68%	88.07%	85.77%	87.01%	83.14%	81.61%	
Fire	84.49%	83.49%	83.96%	85.07%	85.31%	86.25%	87.01%	87.62%	86.91%	85.51%	86.28%	86.16%	
Moving & Handling	85.81%	85.76%	86.93%	88.09%	88.25%	89.43%	89.57%	89.91%	90.58%	90.09%	90.99%	90.12%	
Induction	93.66%	90.95%	91.97%	92.79%	93.83%	93.67%	94.69%	94.38%	94.50%	93.73%	94.09%	92.54%	
Infec Control	86.83%	86.53%	86.99%	87.86%	87.37%	87.92%	88.40%	89.24%	88.97%	87.95%	89.01%	88.92%	
Info Gov	87.40%	86.42%	86.81%	86.23%	85.49%	84.78%	84.48%	84.51%	83.86%	83.64%	84.79%	84.32%	
Health & Safety	82.88%	83.67%	84.42%	85.35%	85.94%	86.74%	87.42%	87.95%	88.05%	87.75%	88.42%	88.83%	
MCA	93.39%	93.36%	93.10%	93.40%	93.10%	93.92%	93.37%	94.13%	94.09%	93.83%	94.45%	94.68%	
DoLs	91.81%	92.29%	92.78%	93.29%	93.81%	94.06%	95.35%	95.04%	95.68%	95.64%	95.64%	95.97%	
Safeguarding Vulnerable Adults	77.64%	78.06%	78.28%	79.06%	79.71%	81.54%	81.37%	83.10%	83.82%	83.06%	83.90%	84.71%	
Safeguarding Children Level 2	81.42%	80.75%	81.45%	82.46%	82.12%	83.25%	83.35%	82.93%	82.35%	82.43%	83.32%	83.40%	

1. Summary and key points for discussion









3. Recruitment

The vacancy rates for medical staff and qualified nurses have reduced this month, whilst the rate for unqualified nurses has increased. The medical vacancy rate has reduced by 1.06% to 11.77% (67.97 fte vacancies, down by 5.40 ftes), for registered nursing & midwives the rate decreased by 0.31% to 7.14% (141.94 fte vacancies, down by 4.39 ftes) whilst for unqualified nurses it has increased by 1.06% to 5.35% (44.84 ftes, up by 9.28 ftes, though this can be accounted for by a 9.81 fte increase in the budgeted establishment, which is now being recruited to).

Urgent Care remains a key risk area for medical vacancies with a 50% vacancy fill factor for Consultants and 79% for non-Consultant grades. There is also continued focus on the specialities of Stroke, Gastroenterology, Histopathology, Paediatrics and Frailty. CVs have been requested from recruitment headhunters for high risk areas and are being forwarded as received to relevant stakeholders. Additional headhunters will be engaged to assist with vacancies in key areas.

Registered nurse vacancies decreased despite an increase in budgeted establishment this month. There are also 70.90 ftes in the pipeline (i.e. undergoing recruitment checks or awaiting a start date). The recent recruitment visit to the Philippines was successful with a further 80 candidates identified. A visit to Portugal has also been arranged for the end of November for a further 10 candidates. Recruitment open days for nurses are now taking place bi monthly with candidates having the option for substantive and/or temporary posts.

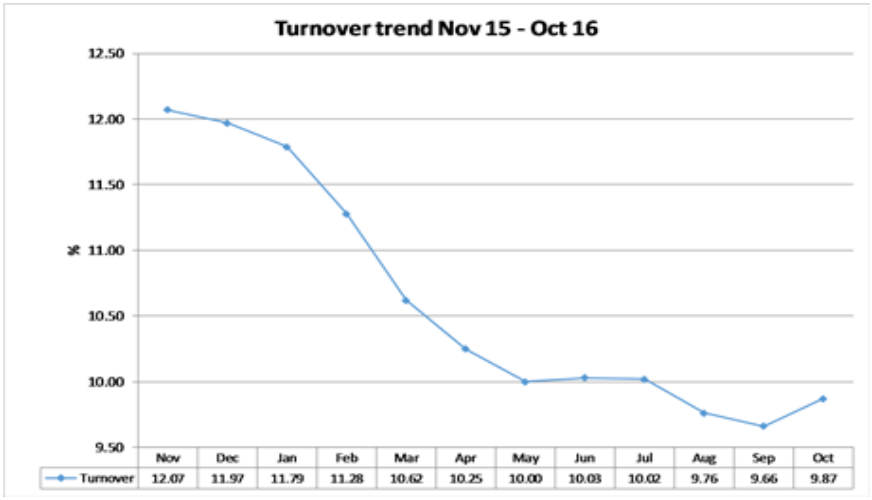
A major campaign to recruit Integrated Support Workers for East Sussex Better Together posts has commenced. 80 Band 1 and 2 staff are required by the end of January 2017. The Trust is advertising through social media and local media.

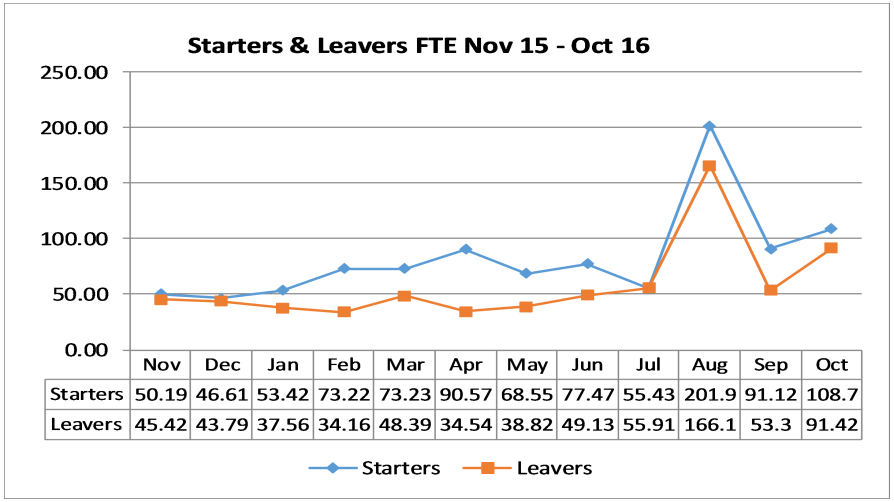
As part of Financial Special Measures, a weekly Vacancy Control Panel has now been established, which will review all vacancy requests except for Band 5 nurses and therapists and Band 2 healthcare assistants for which there is continuing demand. This scrutiny should streamline the demand for vacancies as well as highlighting any vacancies that have been ‘hidden’ by bank usage.

The Recruitment Department is hosting Recruitment process mapping meeting on 24th November to review areas for improvement with key stakeholders.

The Trust annual turnover rate slightly increased in October, up by 0.21% to 9.87%, which equates to 532.98 fte leavers in the last year.

4. Turnover





Starters & Leavers	Nov-15		Dec-15		Jan-16		Feb-16		Mar-16		Apr-16		May-16		Jun-16		Jul-16		Aug-16		Sep-16		Oct-16	
STAFF GROUP	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr
Add Prof Scientific and Technic	0.20	1.00	3.00	0.00	5.43	2.40	1.40	0.00	2.00	0.00	0.00	0.00	1.00	2.23	1.00	1.00	1.00	0.00	1.00	1.00	1.00	5.85	1.43	0.00
Additional Clinical Services	19.50	9.02	17.67	8.17	20.51	8.45	36.38	6.61	16.89	9.39	49.38	3.66	25.36	5.96	23.89	9.83	21.55	14.87	34.00	7.47	23.61	9.56	23.43	15.17
Administrative and Clerical	8.40	10.44	1.49	6.53	12.05	7.15	12.44	8.12	13.76	6.92	13.24	7.22	15.27	6.89	13.62	13.29	5.92	7.89	11.17	11.97	11.03	6.90	12.58	16.45
Allied Health Professionals	4.00	2.00	0.00	3.91	4.00	0.69	0.85	2.00	3.00	2.00	3.00	2.00	1.00	3.46	6.00	2.50	0.00	2.91	5.10	2.32	14.70	2.00	4.00	3.20
Estates & Ancillary	2.00	6.85	5.04	2.36	0.43	3.87	1.00	3.10	13.20	6.40	6.07	2.60	4.00	3.80	3.93	8.33	4.53	1.40	4.19	3.75	6.65	3.67	10.13	2.88
Healthcare Scientists	0.85	4.00	2.00	1.00	2.00	1.00	0.00	0.00	1.00	1.40	2.00	0.00	1.60	0.00	1.00	1.80	2.00	5.00	0.80	2.00	3.00	0.00	2.00	0.00
Medical and Dental	6.30	1.60	10.80	7.80	2.00	1.60	6.80	6.70	11.00	10.55	5.60	13.30	4.20	6.00	2.00	6.25	1.00	8.20	137.80	122.40	16.00	16.00	38.50	33.10
Nursing and Midwifery Registered	8.93	10.51	6.61	13.02	7.00	12.40	14.35	7.63	12.38	11.73	11.28	5.75	16.12	10.48	26.03	4.13	18.43	15.64	7.83	15.15	14.13	9.32	16.67	19.62
Students	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	1.00	0.00	0.00	0.00	1.00	0.00	0.00	1.00
Grand Total	**50.19**	**45.42**	**46.61**	**43.79**	**53.42**	**37.56**	**73.22**	**34.16**	**73.23**	**48.39**	**90.57**	**34.54**	**68.55**	**38.82**	**77.47**	**49.13**	**55.43**	**55.91**	**201.89**	**166.06**	**91.12**	**53.30**	**108.74**	**91.42**

East Sussex Healthcare NHS
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5. Workforce Expenditure

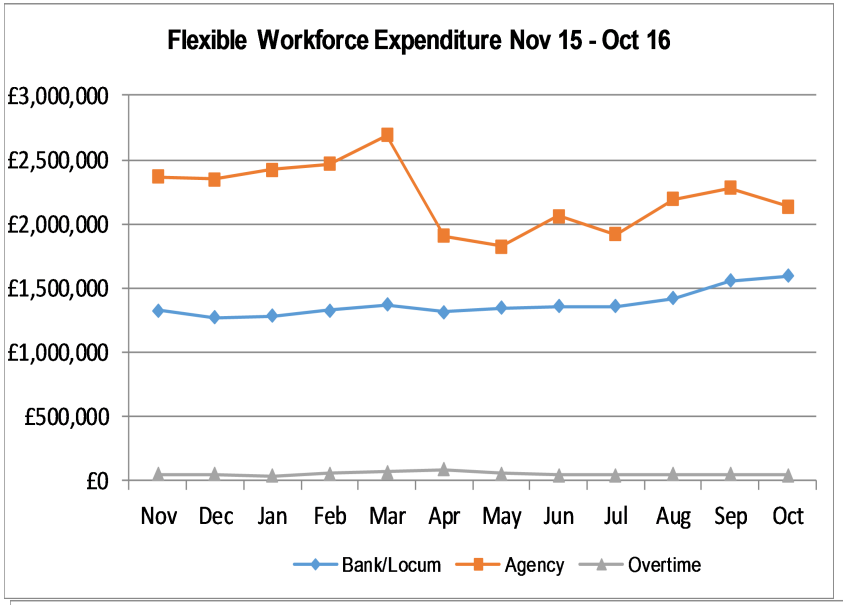
Budgeted establishment increased by 60.66 ftes. This is largely due to additional funding for East Sussex Better Together posts and additional budget for the Endoscopy units.

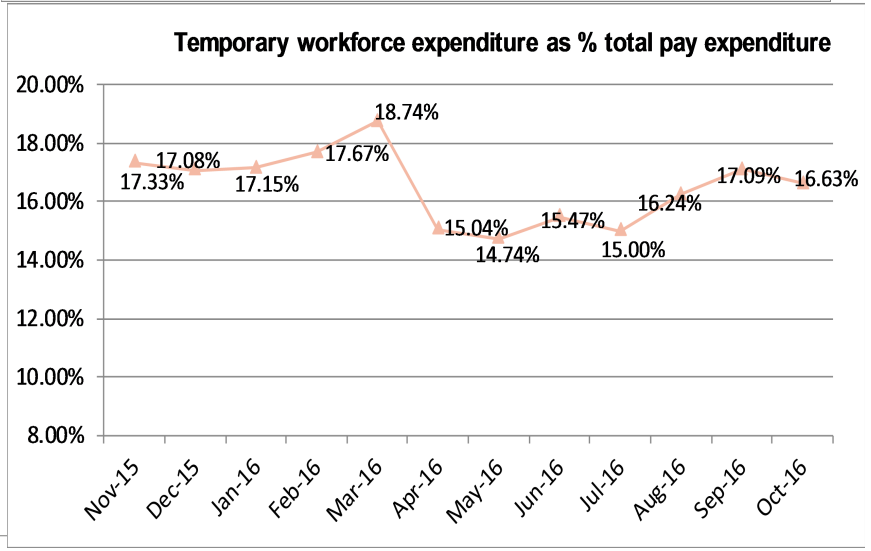
Temporary workforce expenditure has reduced by £114K compared to September. Bank expenditure actually increased by £37K, whilst agency expenditure reduced by £148K and overtime reduced by £3K.

There is some evidence of a switch from agency to bank usage in Pharmacy and on the Escalation wards. Bank expenditure also increased to cover vacancies (eg locums in Cardiology), maternity leave and to support safer working.

There have been reductions in agency expenditure in Radiology, Theatres and Facilties, due to successful recruitment. There has been as been a reduction in Community agency posts. Much of the reduction this month, however, relates to a correction in the coding of agency expenditure last month on EDGH Escalation ward and a one off adjustment in Pathology for previous agency accruals.

Agency expenditure this month could have been still lower, however, but backdated invoices for agency Specialist Registrars in Womens & Childrens Division were received and paid in this month.





6. Absence

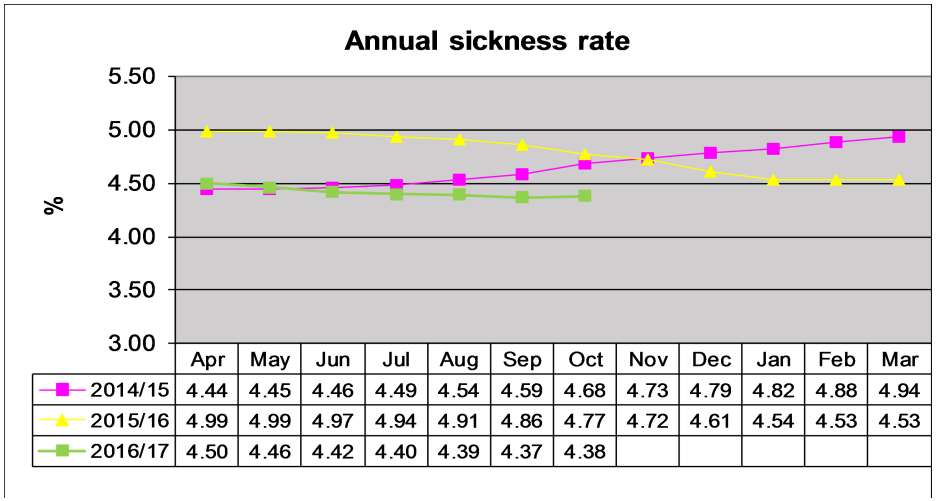
Monthly Sickness	2015	2016
March	4.77%	4.79%
April	4.65%	4.18%
May	4.24%	3.94%
June	4.30%	3.77%
July	4.21%	4.08%
August	4.26%	4.10%
September	4.36%	4.01%
October	4.51%	4.68%

Monthly sickness has increased this month by 0.67% to 4.68%. It is not unusual for there to be a seasonal increase in October, however, the monthly rate exceeds that for October 2015 which has resulted in a slight increase in the annual sickness rate by 0.01% to 4.38%. This is the first increase in the annual rate since April 2015.

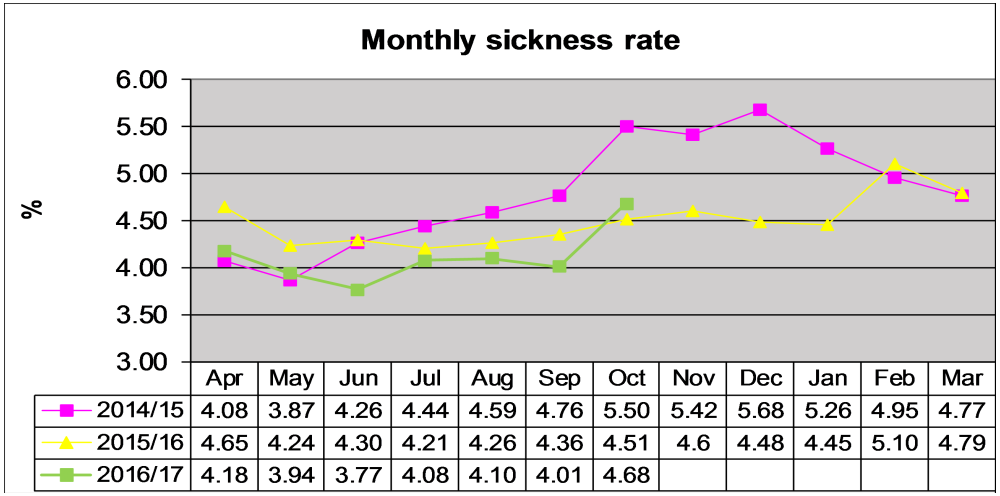
The highest rates of monthly sickness were amongst Additional Clinical Services staff (i.e. largely unqualified nurses and therapy helpers) at 6.65%, up 1.36% on last month; Estates & Ancillary staff at 5.48% (up by 0.61%) and Nursing & Midwifery staff at 5.18% (up by 0.57%).

HR teams continue to work with managers to ensure plans are in place to manage sickness and review meetings are held where required under the Attendance Management policy. There has been some success in resolving long term sickness cases though much of October's increase is due to short term sickness.

The latest available comparative figures from the Health & Social Care Information Centre show the monthly sickness rates for NHS Trusts, in July 2016, as 4.22%, at a time when the Trust's rate was 4.08%. The rate for large Acute Trusts was 4.25% and for Community Trusts it was 4.53%.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	4.44	4.45	4.46	4.49	4.54	4.59	4.68	4.73	4.79	4.82	4.88	4.94
2015/16	4.99	4.99	4.97	4.94	4.91	4.86	4.77	4.72	4.61	4.54	4.53	4.53
2016/17	4.50	4.46	4.42	4.40	4.39	4.37	4.38					



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	4.08	3.87	4.26	4.44	4.59	4.76	5.50	5.42	5.68	5.26	4.95	4.77
2015/16	4.65	4.24	4.30	4.21	4.26	4.36	4.51	4.6	4.48	4.45	5.10	4.79
2016/17	4.18	3.94	3.77	4.08	4.10	4.01	4.68					

East Sussex Healthcare NHS
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7. Mandatory Training

Mandatory training course	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	6 month trend
Induction %	94.69	94.38	94.50	93.73	94.09	92.54	
Fire %	87.01	87.62	86.91	85.51	86.28	86.13	
Manual Handling %	89.57	89.91	90.58	90.09	90.99	90.12	
Infection Control %	88.40	89.24	88.97	87.95	89.01	88.92	
Info Gov %	84.48	84.51	83.86	83.64	84.79	84.23	
Health & Safety %	87.42	87.95	88.05	87.75	88.42	88.83	
Mental Capacity Act %	93.37	94.13	94.09	93.83	94.45	94.68	
Depriv of Liberties %	95.35	95.04	95.68	95.64	95.64	95.97	
Safeguard Vuln Adults	81.37	83.10	83.82	83.06	83.90	84.71	
Safeguard Child Level 2	83.35	82.93	82.35	82.43	83.32	83.40	

Clinical Unit	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Health & Safety	Mental Capacity Act training	Depriv of Liberties training	Safeguard Vulnerable Adults	Safeguard Children Level 2	Appraisal compliance
Urgent Care	81.68%	85.15%	90.91%	83.17%	73.27%	81.68%	90.75%	86.52%	80.35%	84.97%	76.60%
Medicine Division	88.48%	89.92%	93.56%	88.57%	79.30%	86.32%	93.12%	95.38%	84.55%	81.84%	79.98%
Out of Hospital Care Division	89.91%	93.69%	95.30%	92.43%	86.12%	90.54%	97.27%	99.70%	86.09%	81.40%	84.27%
Surgery Anaesthetics & Diagnostic	84.91%	90.11%	90.76%	87.09%	86.25%	90.44%	94.48%	95.66%	83.35%	83.42%	85.63%
Womens Childrens & Sexual Health Division	82.42%	86.39%	95.06%	85.02%	78.29%	88.53%	94.96%	94.43%	86.37%	87.48%	77.80%
Estates & Facilites	80.18%	83.66%	87.27%	91.07%	85.02%	91.68%	n/a	n/a	n/a	n/a	78.87%
Corporate	89.67%	94.79%	91.96%	91.62%	90.59%	86.81%	98.06%	98.77%	92.16%	87.29%	84.79%
TRUST	**86.16%**	**90.12%**	**92.54%**	**88.92%**	**84.32%**	**88.83%**	**94.68%**	**95.97%**	**84.71%**	**83.40%**	**81.61%**

Currently, the mandatory training matrix, which shows compliance with each mandatory topic by individual, is sent out to the Clinical Unit Leads. Learning Development are proposing to break this down further and to send it out directly to matrons/service managers to assist them in planning and monitoring compliance. They will be working with the new Divisions to identify the correct leads for this distribution to maximise its effectiveness.

Unfortunately the appraisal rate continues to fall, by another 1.53% this month, as annual renewals this year have not kept pace with the big push on appraisals that took place in Autumn 2015. There are a further 427 appraisals due for renewal in November and the rate will fall further if these are not renewed.

(Green =85%+, Amber = 75-85% Red = <75%).

8. Engagement

The main focus for Staff Engagement in the past month has been encouraging all staff to complete the annual staff survey, The initial response has been slow, which is disappointing as the target is to have at least a 55% response rate by the end of November 2016. The Chief Executive has written to all staff, twice, emphasising the importance and relevance of completing the survey and reminder letters and a new survey have been sent to all colleagues who have so far not completed and returned their questionnaire.

The Staff Engagement and Wellbeing team are sharing work that has been undertaken as a result of feedback from last year's survey and also reassuring staff that all feedback is not identifiable to individuals. In the week commencing 14 November the team hosted two days when staff could come to a central point to complete their survey as well as take a break with tea and cake. Similar events have been arranged in the Community on request.

The Unsung Hero celebration week for Bands 1-4 was a great success with over 400 staff attending over the week. The staff who attended the final celebration day heard from two inspiring speakers on how all support staff make a difference to the lives of the people who use the Trust's services and on the importance of keeping motivated.

The Occupational Therapists hosted information sessions about the various aspects of their work and what it is like to work as an OT which was well received across the Trust

Theme of the Week continues to be sent out and shared by the ESHT Viners who are staff members from all levels of the Trust who have been nominated by their colleagues as excellent communicators. The Team will shortly contact the Viners to see what further information they require and how they would like to see this role develop.

Emotional resilience training continues to roll out across the organisation, with different wards/departments planning on how they can become more resilient under pressure

The "Walking in Your Shoes" programme, where the Executive Directors experience the work of various members of staff, has been well received across the Trust and given both the directors and staff members a greater understanding of each other's roles.

There have been a number of Leadership events this month. The managers and team leaders from Clinical Administration Services worked on their bespoke Leadership programme and several leaders have attended mentorship and coaching workshops

Activity

ACTIVITY

1. Activity overview

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Oct-15	Var	Yr	Last Yr	Var	
Primary Referrals	M	9145	8493	8195	8549	9363	9168	9246	9042	9551	8850	9145	9177	8925	9145	-2.4%	63936	62428	2.4%	
Cons to Cons Referrals	M	1523	1471	1224	1278	1279	1293	1404	1422	2007	1651	1451	1501	1426	1523	-6.4%	10862	10783	0.7%	
First OP Activity	M	11194	11525	10659	10297	11110	10990	10701	10880	11908	10799	11781	12089	12906	11194	15.3%	81064	80151	1.1%	
Subsequent OP Activity	M	26192	26429	24469	24746	25649	25842	25406	25678	26902	24145	25781	26392	25107	26192	-4.1%	179411	178177	0.7%	
New:FU Ratio	M	2.3	2.3	2.3	2.4	2.3	2.4	2.4	2.4	2.3	2.2	2.2	2.2	1.9	2.3	-0.4	2.2	2.2	0.0	
Elective IP Activity	M	696	621	567	511	604	627	596	697	656	715	649	670	682	696	-2.0%	4665	4957	-6.3%	
Elective DC Activity	M	3733	3821	3535	3629	3802	3781	3519	3836	4119	4033	4195	4203	3896	3733	4.4%	27801	26659	4.1%	
Non-Elective Activity	M	3866	3641	3827	3800	3920	4077	4038	3772	3791	3879	3801	3664	3721	3866	-3.8%	26666	27749	-4.1%	
A&E Attendances	M	8846	8476	8612	8731	8571	9398	8715	9573	9240	10144	9711	9470	9397	8846	6.2%	66250	63088	4.8%	
Admissions Via A&E	M	2239	2286	2407	2446	2357	2433	2357	2398	2363	2409	2302	2215	2380	2239	6.3%	16424	16076	2.1%	
Ambulance Conveyances	M	2875	2889	3060	3110	2879	3084	2848	3068	2996	3133	3092	3051	3138	2875	9.1%	21326	20348	4.6%	
Average LOS Elective	M	3.0	3.0	3.2	2.7	3.0	3.0	2.7	3.4	3.0	3.1	2.4	3.1	2.7	3.0	-0.3	2.93	2.99	-0.1	
Average LOS Non-Elective	M	5.5	5.7	6.2	5.7	5.9	6.0	6.1	5.8	5.5	5.6	5.9	6.1	6.1	5.5	0.6	5.87	5.43	0.4	

Community

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Oct-15	Var	Yr	Last Yr	Var	
Community Nursing Referrals	M	3382	3391	3577	3975	3765	3840	3900	3770	3963	3997	3976	4105	4154	3382	22.8%	27865	19928	28.5%	
Community Nursing Total Contacts	M	33493	32545	34110	34210	32702	34518	33652	35504	36021	33719	35003	32866	33521	33493	0.1%	240286	240078	0.1%	
Community Nursing Face to Face Contacts	M	18838	18468	19110	18851	18386	19536	19127	20064	19515	19058	19686	18744	19402	18838	3.0%	135596	138972	-2.5%	
% Patient Facing Time	60.0%	56.2%	56.7%	56.0%	55.1%	56.2%	56.6%	56.8%	56.5%	54.2%	56.5%	56.2%	57.0%	57.9%	56.2%	1.6%	56.4%	57.8%	-1.4%	
Community Nursing ALOS	42.0	27.6	26.3	27.0	26.6	25.6	23.4	21.2	19.0	16.0	14.6	13.4	10.1	5.7	27.6	-21.9	14.16	32.91	-18.8	
SALT WL <13 Weeks %	85.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100%	0	83.2%	100.0%	-0.16811	
Podiatry WL <13 Weeks %	85.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100%	0	83.8%	100.0%	-0.16218	
Dietetics WL <13 Weeks %	85.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100%	0	83.4%	100.0%	-0.16563	
MSK WL <13 Weeks %	85.0%	100.0%	100.0%	98.0%	96.4%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100%	0	99.2%	100.0%	-0.00789	
SALT Total WL	M	125	116	107	110	115	117	146	160	0	176	202	182	0	125	-125	866	125	741	
Podiatry WL Total WL	M	694	665	652	715	729	749	841	830	0	998	842	942	0	694	-694	4453	694	3759	
Dietetics WL Total WL	M	295	269	249	246	195	146	73	32	0	43	65	54	0	295	-295	267	295	-28	
MSK WL Total WL	M	290	400	1068	1089	1143	211	101	101	0	1922	1922	105	0	290	-290	4151	290	3861	
IP ALOS (including Irvine Stroke Unit)	M	22.3	30.7	30.0	27.5	32.5	31.1	30.6	33.3	25.8	30.9	36.0	28.5	27.0	22.3	4.8	30.37	24.12	6.3	
IP Activity (including Irvine Stroke Unit)	M	131	119	121	88	72	89	92	97	85	85	85	81	84	131	-35.9%	609	1061	-74.2%	

East Sussex Healthcare NHS
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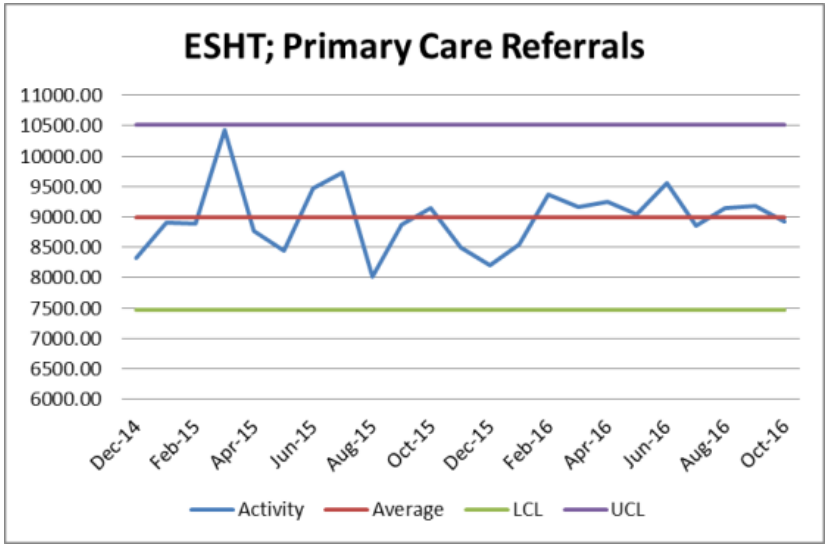
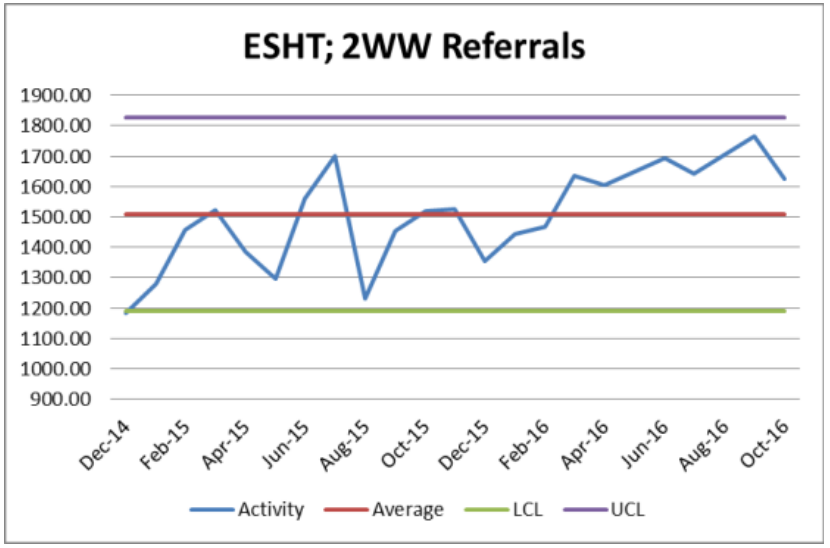
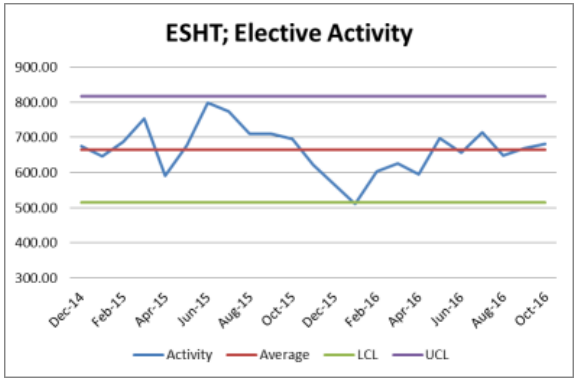
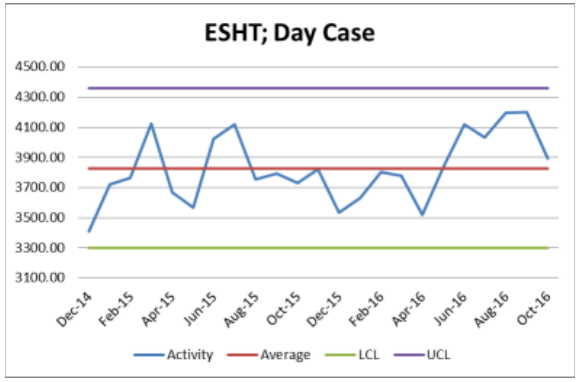
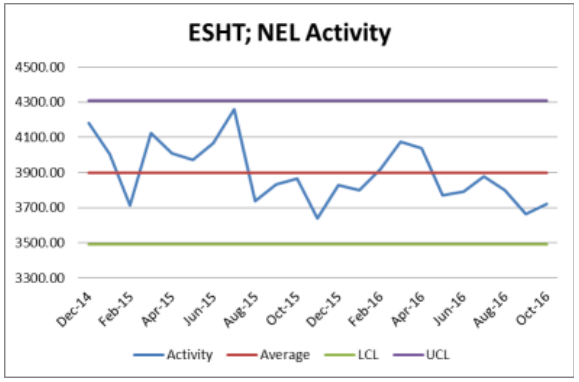










Community

East Sussex Healthcare NHS
NHS Trust

Community overview:

Intermediate Care:

Escalation beds maintained within BIU and Rye. Average length of stay decreased in all units for generic and Stroke rehabilitation Flow out of units remains challenging we continue to work with partner organisations to improve flow into and out of units. Continue to work with commissioners on longer term strategy for Intermediate care.

Joint Community Rehabilitation Teams:

Remains challenged for meeting targets on response rates. Working with commissioners on capacity demand and agreement for funding of locums at point when fully established.

Community Nursing:

Referrals rates continue to increase by 3.2% from August with a 215% increase above baseline target otherwise targets being maintained or improving with data accuracy and reporting initiatives. Hurst modelling for safe staffing – analysis being finalised.

Community AHPs:

Continue to maintain 13 week waiting time target although significant increase in referrals noted for SaLT and some pathways within Dietetics following changes in commissioned clinical pathways within Gastro.

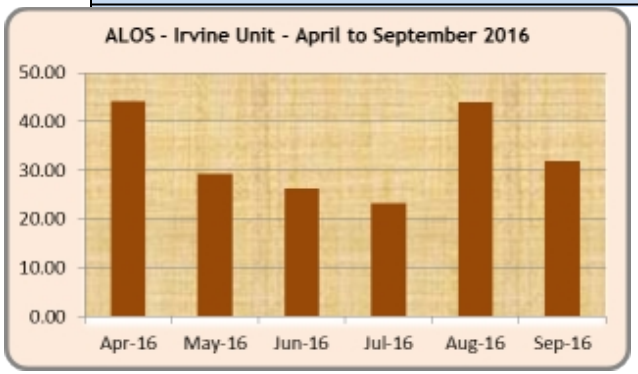
Acute AHPs:

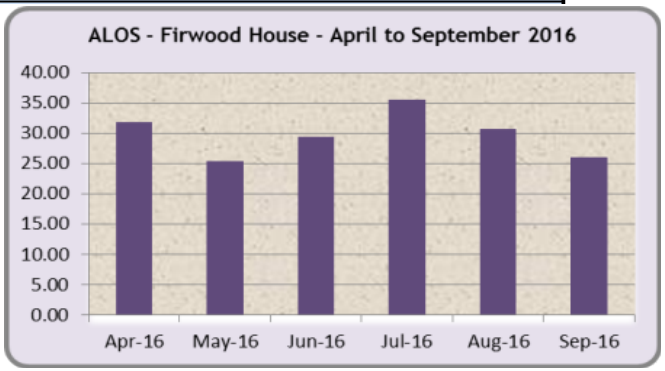
Acute SaLT SSNAP data improving, ongoing plans to improve OT data.

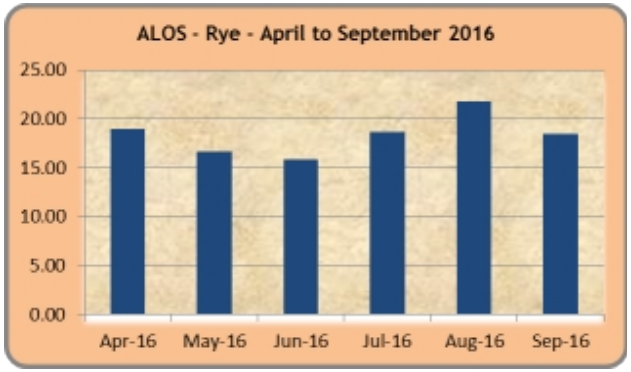
HIT reduction in conversion rated for discharge in September, currently recruiting to the enhanced HIT hours and working with commissioning.

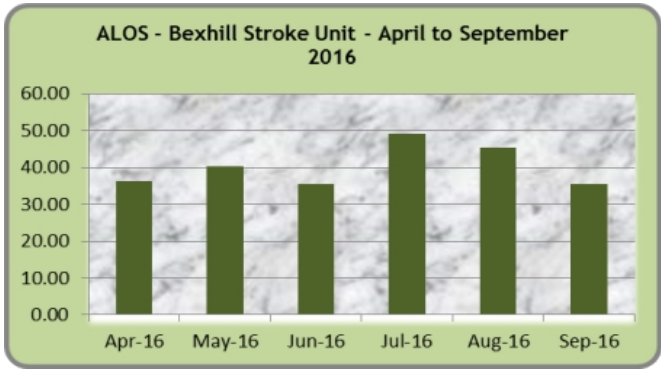
Intermediate Care

Total in Month Length of Stay (Days)	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Irvine Unit	44.20	29.43	26.36	23.32	43.93	31.84
Firwood House	31.88	25.41	29.47	35.47	30.76	26.00
Rye Memorial Care Centre	18.96	16.63	15.88	18.70	21.76	18.52
Bexhill Stroke Unit	36.44	40.33	35.50	49.00	45.46	35.60
Total YTD ALOS (average excludes Bexhill Stroke Unit)	**31.83**	**23.52**	**23.86**	**25.83**	**32.15**	**25.46**









East Sussex Healthcare NHS
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Acute Stroke (SSNAP)

Domain 4 – Specialist Assessments: 80% swallow screened within 4 hours – this has increased steadily over the last few months due to the training increase the number of nurses with this competency, however slight dip this month due to confusion over documentation of the first swallow screen if patients were too drowsy to be screened. Formal swallow screen within 72 hours maintained improvement at 100%

Domain 5 – OT: Increase in number of minutes of therapy delivered meeting target of 45 mins / day, however this is off set with a reduction in the frequency patients were seen. Updated action Plan attached to end of report.

Domain 6 – Physio: Slight reduction in number of days of therapy delivered, with minutes staying constant.

Domain 7 – SLT: Slight Increase in number of days of therapy delivered and an increase in the minutes of therapy delivered.

Domain 8 – MDT Working: 72 hour target was not met by OT, Physio or SLT attributed to reduced staffing in September and an increase in patients due to outliers in Berwick stroke beds. Rehab goals within 5 days remains at 100%.

Domain 9 – Standards by discharge: Remained at 100% for dietitian and continence and mood & cognition screening was similar to previous.

Domain 10 – Discharge process: 100% for all measured monthly.

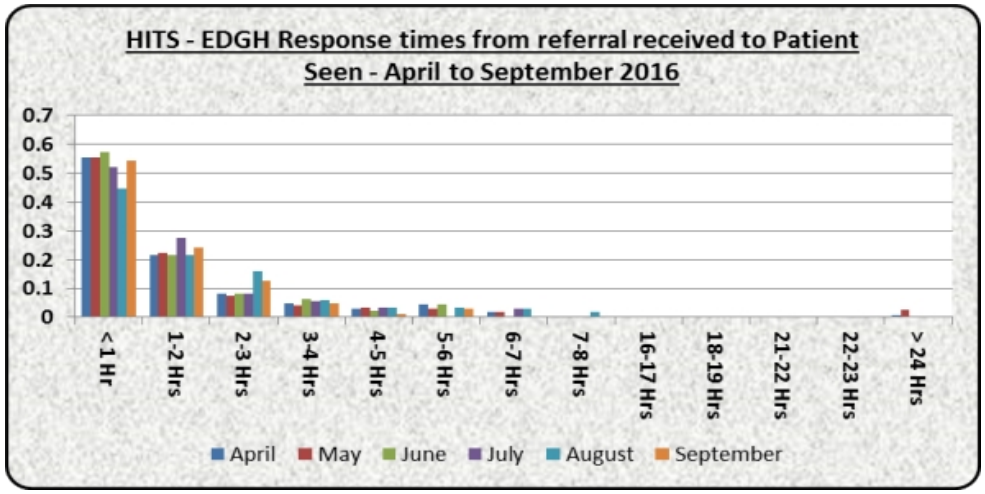
HIT DGH:

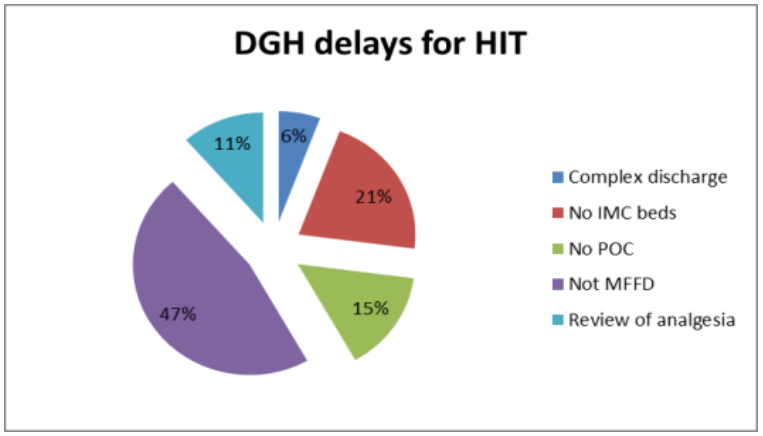
Eastbourne DGH						
	April	May	June	July	August	September
Total patients seen	245	246	215	247	251	258
Total discharged	147	180	154	186	165	162
Conversion rate	60%	73%	71%	75%	66%	63%

- Small increase in referral numbers at EDGH.
- Increasing referral numbers directly from A&E – team are proactively sourcing referrals
- Low number of patients admitted for complex discharge planning
- **DELAYS** due to:
- Transfer to intermediate care beds, no POC availability or patients who are not medically ready to leave hospital.
- Staffing has been challenged due to a high sickness rate within the service.

Response Data

- 78% of patients referred to HIT are assessed within 2 hours of referral
- 96% of patients are assessed by HIT within 4 hours of referral.

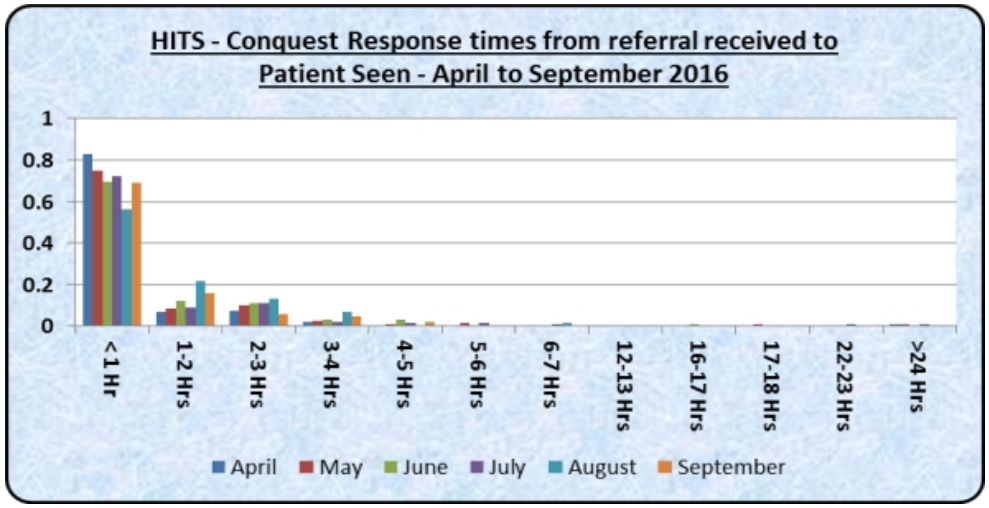




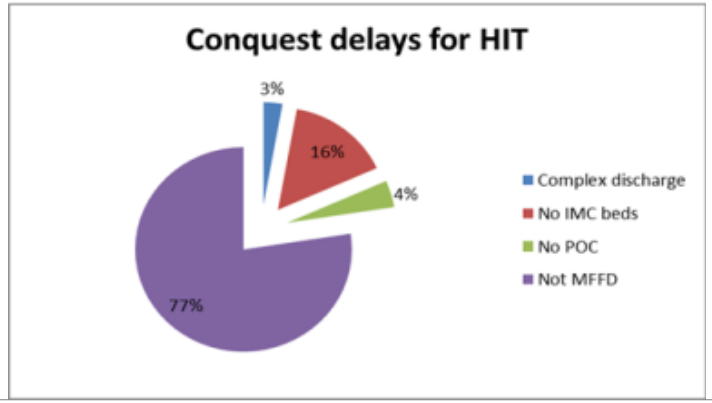
HIT Conquest:

Conquest						
	April	May	June	July	August	September
Total patients seen	134	113	110	134	119	149
Total discharged	97	83	77	98	79	96
Conversion rate	72%	73%	70%	73%	66%	64%

- September has been one of the busiest months for the Conquest team in 2016.
- Team have managed a higher caseload with absence within in the team.
- **DELAYS:** Patients who are waiting analgesia before their HIT assessment - shared in a A&E meeting.
- multiple contacts patients
- patients who become medically unwell during their assessment.
- **ACTION**: CQ team redistributing referral criteria. The Conquest team continue to assess over 50% of their patients in less than one hour of receiving a referral.



- Difference in team activity data across both sites .
- streamlining of the services cross-site.
- **ACTION**: Peer support for CQ to embed proactive approach.



2020 Metrics

2020 METRICS

East Sussex Healthcare NHS
NHS Trust

2020 Metrics: Safety & Quality

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Oct-15	Var	This Yr	Last Yr	Var	
Total patients safety incidents reported	M	969	880	924	916	956	978	1053	1078	1012	1499	1799	1787	1396	969	30.6%	9624	6214	35.4%	
Total Non-ESHT patients safety incidents reported	M	122	104	73	122	110	84	319	242	148	168	145	164	136	122	11.5%	1322	828	37.4%	
Falls Assessment Compliance	M							92.2%	93.9%	89.6%	91.4%	92.5%	85.2%	90.3%			91.0%			
Pressure Ulcer Assessment Compliance	M							93.4%	86.0%	87.5%	92.0%	86.7%	94.0%	91.2%			90.0%			
No of MRSA cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	-4	
No of CDI cases	4	3	5	3	4	3	5	2	7	7	2	6	3	4	3	1	31	28	3	
No of MSSA cases	0	0	0	0	0	0	0	2	0	2	1	0	4	1	0	1	10	0	10	
Mixed sex accomodation breaches	0	23	16	3	27	29	0	0	0	0	0	0	0	0	23	-23	0	55	-55	
No of complaints reported	R	68	47	42	41	56	55	75	55	58	46	55	53	53	68	-28.3%	395	462	-17.0%	
All ward moves	M	2371	2377	2310	2254	2316	2331	2304	2345	2265	2314	2304	2286	2234	2371	-6.1%	16052	15952	0.6%	
Night ward moves	M	466	411	476	462	461	512	470	435	409	416	445	400	375	466	-24.3%	2950	3144	-6.5%	
Crude Mortality Rate	M	1.7%	1.9%	2.0%	2.1%	1.8%	2.3%	2.0%	1.7%	1.5%	1.4%	1.4%	1.4%	1.9%	1.7%	0.2%	1.6%	1.6%	0.0%	
HSMR (CHKS)	100		109	104	110	102	106	97	112	100										
SHMI (CHKS)	100		111	71	83	77	80													

These metrics are planned to support the delivery of the Trust's 2020 strategy, which is available on the Trust website.

East Sussex Healthcare NHS
NHS Trust

2020 Metrics: Access & Delivery

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Oct-15	Var	Yr	Last Yr	Var	
A&E Performance (4 hour wait)	95.0%	88.6%	88.4%	85.6%	84.2%	84.8%	79.0%	83.9%	85.0%	83.2%	82.6%	79.5%	80.5%	78.0%	88.6%	-10.5%	81.8%	90.8%	-9.0%	
A&E 12 Hour trolley waits	0	0	0	0	0	0	0	0	0	0	0	1	0	2	0	2	3	1	2	
A&E Unplanned re-attendance	5.0%	2.4%	2.9%	3.0%	3.0%	3.4%	3.0%	3.3%	3.3%	2.8%	3.0%	2.9%	3.0%	3.1%	2.4%	0.6%	3.1%	3.1%	-0.1%	
A&E Time to Initial Assessment (% Ambulance conveyances within 15 minutes)	M	95.7%	96.0%	95.0%	92.2%	92.1%	88.5%	94.3%	93.1%	90.7%	91.8%	90.1%	90.6%	89.6%	95.7%	-6.1%	91.4%	95.8%	-4.4%	
A&E Time to Treatment (% within 60 Minutes)	M	50.2%	53.9%	49.6%	52.4%	48.1%	42.0%	47.0%	40.1%	36.6%	36.7%	36.7%	38.8%	39.5%	50.2%	-10.7%	39.3%	49.9%	-10.7%	
A&E Left before seen	5.0%	1.9%	1.3%	1.6%	2.1%	2.6%	2.7%	2.1%	2.2%	1.3%	1.4%	1.4%	1.2%	1.2%	1.9%	-0.7%	1.5%	1.9%	-0.3%	
Non Elective Conversion Rate	M	25.1%	26.7%	27.5%	27.5%	26.8%	24.8%	26.5%	24.6%	25.1%	23.5%	23.4%	23.1%	24.8%	25.1%	-0.3%				
A&E Cubicle Waiters (average number per day)	M	49	49	50	51	51	51	48	51	50	51	52	53	46	49	-3	59	60	-1	
Zero Length of Stay NEL admissions	R	465	437	433	435	454	461	524	464	467	431	433	299	370	465	-25.7%	2988	3801	-27.2%	
% Zero LOS NEL Ambulatory admissions	M	37.8%	38.4%	36.5%	38.4%	37.6%	37.1%	41.3%	37.3%	36.4%	35.1%	35.5%	27.3%	32.9%	37.8%	-13.0%	35.3%	40.0%	-4.7%	
Total Non Elective Beddays	M	22567	22360	23141	25732	24170	25700	23644	22663	21658	21959	23015	22693	22917	22567	1.5%	158549	152330	3.9%	
RTT Incomplete (%patients waiting over 18 weeks)	92.0%	92.7%	92.8%	92.1%	92.1%	92.2%	90.5%	90.2%	90.7%	89.5%	88.5%	87.5%	86.7%	85.7%	92.7%	-7.0%	88.3%	93.8%	-5.5%	
RTT 52 Week waiters	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Diagnostic performance (% patients waiting over 6 weeks)	1.0%	1.9%	1.0%	2.0%	3.8%	2.4%	6.7%	2.9%	2.7%	2.6%	2.2%	3.0%	2.5%	0.9%	1.9%	-1.1%	97.6%	98.2%	-0.6%	
Cancer 2WW standard	93.0%	91.3%	89.9%	91.9%	92.5%	94.9%	96.9%	96.0%	95.6%	96.5%	97.1%	97.3%	97.1%		91.3%	#VALUE!	96.6%	90.5%	6.1%	
Cancer 2WW standard (Breast Symptoms)	93.0%	89.1%	88.5%	90.0%	99.1%	93.0%	90.0%	93.2%	98.5%	96.9%	95.8%	95.8%	96.9%		89.1%	#VALUE!	96.3%	88.0%	8.3%	
Cancer 31 Day standard	96.0%	100.0%	97.4%	98.3%	96.9%	98.8%	99.3%	98.5%	99.4%	98.3%	97.7%	99.1%	98.8%		100.0%	#VALUE!	98.7%	97.3%	1.3%	
Cancer 31 Day subsequent drug treatment	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	#VALUE!	100.0%	100.0%	0.0%	
Cancer 31 Day subsequent surgery	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%		100.0%	#VALUE!	98.4%	100.0%	-1.6%	
Cancer 62 day urgent referral standard	85.0%	76.2%	75.4%	80.6%	73.0%	70.5%	79.4%	67.6%	68.3%	82.3%	75.3%	79.5%	72.6%		76.2%	#VALUE!	74.8%	74.7%	0.1%	
Cancer 62 day screening standard	90.0%	84.6%	54.5%	60.0%	33.3%	100.0%	42.9%	100.0%	66.7%	62.5%	100.0%	88.9%	85.7%		84.6%	#VALUE!	83.1%	84.4%	-1.3%	
Delayed Transfer of Care	3.5%	7.8%	7.9%	7.5%	7.5%	10.8%	9.4%	5.3%	5.7%	7.0%	7.7%	8.0%	9.7%	9.7%	7.8%	2.0%	7.6%	6.8%	0.8%	
Outpatient appointment cancellations < 6 weeks	R	20	29	41	21	21	18	14	29	47	34	37	30	43	20	53.5%	234	241	-3.0%	
Outpatient appointment cancellations > 6 weeks	R	1196	977	1287	1064	1134	1554	1126	1018	1262	1411	1501	1278	1245	1196	3.9%	8841	8771	0.8%	

East Sussex Healthcare NHS
NHS Trust

2020 Metrics: Leadership &Culture

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Oct-15	Var	Yr	Last Yr	Var	
Trust Turnover rate	10.0%	12.2%	12.1%	14.1%	11.8%	11.3%	10.6%	10.3%	10.0%	10.0%	10.0%	9.8%	9.7%	9.9%	12.2%	-2.4%	9.9%	12.4%	-2.4%	
Temporary costs and overtime as a % of total paybill	10.0%	16.1%	17.3%	17.1%	17.2%	17.7%	18.7%	15.0%	14.7%	15.5%	15.0%	16.2%	17.1%	16.6%	16.1%	0.5%	15.8%	16.4%	-0.7%	
Proportion of staff with up to date annual appraisal	85.0%	77.9%	81.8%	81.8%	83.2%	85.3%	87.3%	88.5%	89.8%	88.1%	86.3%	87.0%	83.2%	81.7%	77.9%	3.8%	86.3%	75.5%	10.8%	

2020 progress is reviewed on a regular basis by the Trust Board and the Improvement Committee


WHAT
MATTERS
TO YOU
MATTERS
TO US
ALL

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2016
Meeting:	Trust Board
Agenda item:	12
Subject:	Financial Recovery Plan
Reporting Officer:	Jonathan Reid, Director of Finance

Action: This paper is for **(please tick one only)**

Assurance		Approval	✓	Decision	

Purpose:

Through the Financial Special Measures regime, the Trust is required to develop a financial recovery plan for the delivery of the 2016/17 control total for presentation to NHS Improvement on 29th November 2016. The Trust entered financial special measures on 28th October 2016, and has made strong progress on the development of a robust and clearly articulated financial recovery plan, with the support of NHS Improvement and PA Consulting. The Trust Board approved the delegation of approval of the FSM FRP to the Finance and Investment Committee on 15th November 2016, and the Committee reviewed the plan in draft. This paper presents the submitted plan for improving the financial position of the Trust for review and discussion by the Committee. The plan will be presented in full to the next Trust Board and progress will be tracked on a weekly basis by the Executive Team and on a monthly basis by the Board.

The finance team and PA consulting are also working with operational leads to ensure that the pipeline of schemes is developed more fully and valued, to ensure that a FRP of above £16m – the identified risk – is in train.

Introduction:

The Trust entered financial special measures on 28th October 2016, and has made strong progress on the development of a robust and clearly articulated financial recovery plan, with the support of NHS Improvement and PA Consulting. The Trust Board approved the delegation of approval of the FSM FRP to the Finance and Investment Committee on 15th November 2016. This paper presents the submitted plan for improving the financial position of the Trust for review and discussion by the Committee.

Analysis of Key Issues and Discussion Points Raised by the Report:

The Trust has developed a financial recovery plan which builds on existing workstreams across the organisation, and existing recovery plans – but strengthens the deliverability of these plans. The Month 6 forecast identified £16m of risk to the financial position, and this paper sets out the actions in train to mitigate and manage these risks, with a series of key workstreams set up and supported by a refreshed and finance-focused PMO, and

a pipeline of new schemes in train. The Trust has worked with PA consulting to develop a clearer understanding of the drivers of the financial deficit and the opportunities for financial improvement. The paper is the submitted plan following positive and extensive feedback from NHS Improvement and members of the Executive Team.

Benefits:

The paper more clearly articulates the actions required to deliver the control total agreed by the Trust for 2016/17, and sets out the approach taken across the organisation over the remainder of the financial year.

Risks and Implications

The risks in the financial forecast are summarised in the attached paper.

Assurance Provided:

The paper has been developed in partnership with clinical and operational leaders, with additional support provided by the NHSI team and PA consulting. The paper describes in detail the Trust's financial recovery plan, and supporting work to ensure delivery of the planned control total for 2016/17. The paper provides assurance on the detail of the plan, and sets out the key risks, and further opportunities under development.

Review by other Committees/Groups (please state name and date)**:**

Executive Directors – 22nd November 2016
FIC – 23th November 2016
FIC – 30th November 2016

Proposals and/or Recommendations

The Trust Board is asked to ratify Financial Recovery Plan, and note that progress will be tracked weekly by the Executive Team and monthly by the Finance & Investment Committee.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)

What risk to Equality & Human Rights (if any) has been identified from the impact assessment?

No risks to equality and human rights have been identified from the impact assessment.

For further information or for any enquiries relating to this report please contact:

Name: Jonathan Reid	**Contact details: jonathan.reid@nhs.net**

East Sussex Healthcare NHS
NHS Trust

EAST SUSSEX HEALTHCARE

FINANCIAL RECOVERY PLAN 2016/17 - SUMMARY

29th November 2016

Objectives & Agenda

East Sussex Healthcare NHS
NHS Trust

Objectives

- ☐ Demonstrate the progress we have made since entering FSM
- ☐ Demonstrate that we have a robust understanding of our financial position
- ☐ Demonstrate that we have carefully considered how we will mobilise and deliver at pace

Agenda

1. Context & background
2. Drivers of the underlying deficit
3. From forecast to recovery
4. Immediate measures
5. Recovery plan
6. Exit run rate
7. Managing risk
8. Establishing a PMO
9. Summary and next steps

1. Context and background

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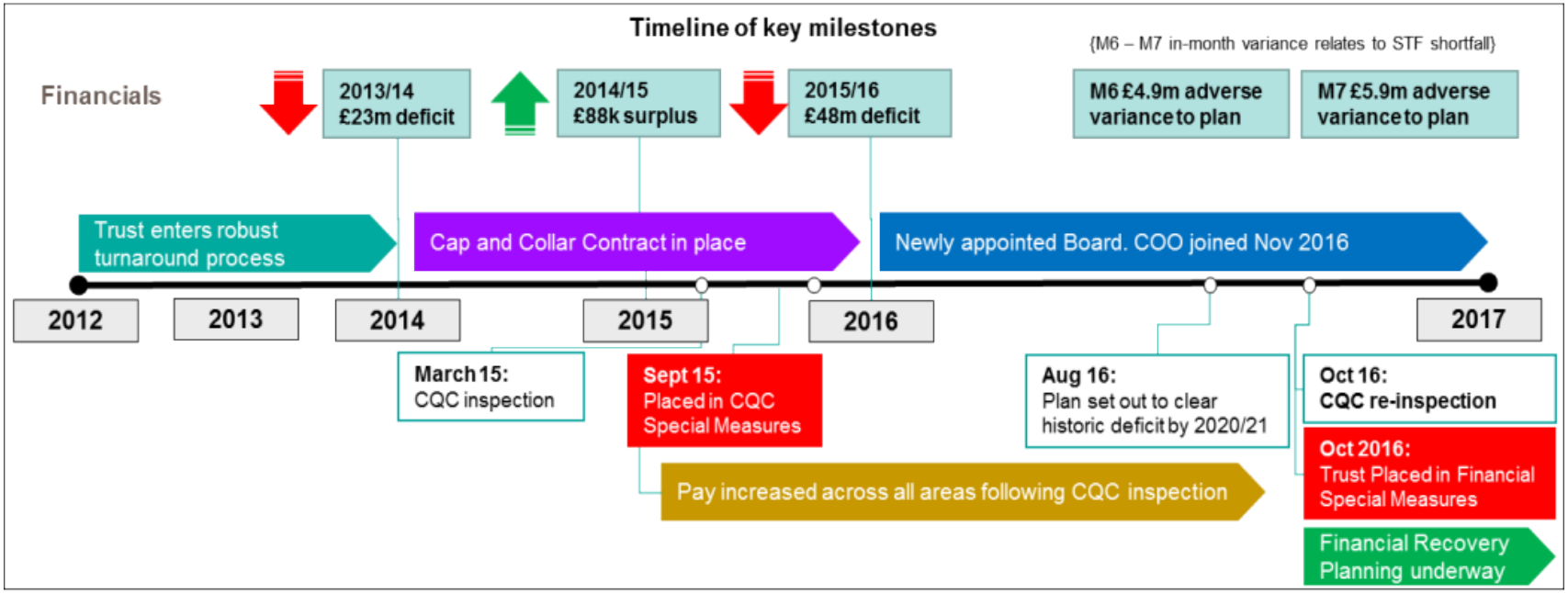


Focusing on finance

- The new Board have achieved significant improvements since April 2016
- Having stabilised the organisation, the focus of the Board is now on financial recovery
- The new Board accepted a stretch target in June 2016 and is committed to delivery of the £41.7m (excluding STF) control total by strengthening the delivery of the Trust plans

2. Drivers of the underlying deficit

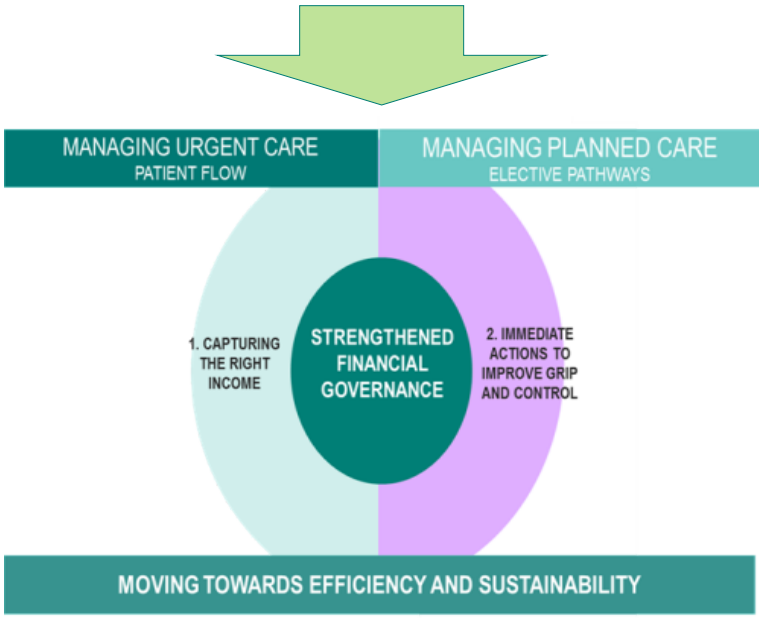
East Sussex Healthcare NHS
NHS Trust

- The Trust has a robust understanding of the drivers of the deficit
- This has informed the review of the forecast and the development of the financial recovery plan

Key Messages:

- The Trust has confirmed its view that there are **no structural issues** which are outside the control of the Trust, or the local health and care system, to resolve.
- The plan focuses in the short term on restoring financial discipline and improving capacity and ensuring financial recovery

Drivers of the underlying deficit	%
Workforce challenges and unsustainable services	33%
Reimbursement and financial discipline	22%
Delivery of efficiency / service change	20%
System capacity (primary care)	24%
Total	100%



3. Moving from forecast to recovery

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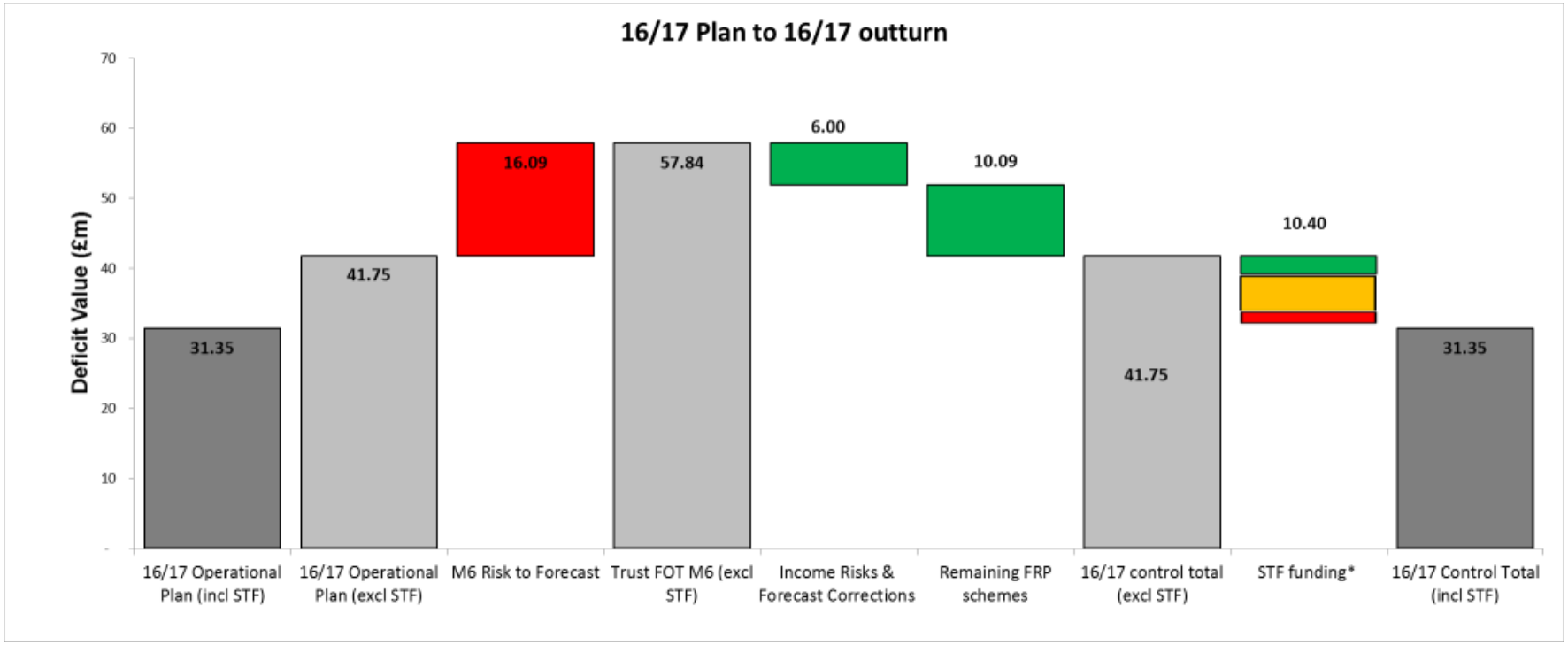

*STF funding of £10.4m:

- £2.60m Green – Q1 received
- £5.46m Amber – Q2-4 financial performance
- £2.34m Red – Q2-4 operational performance

4. Immediate measures taken

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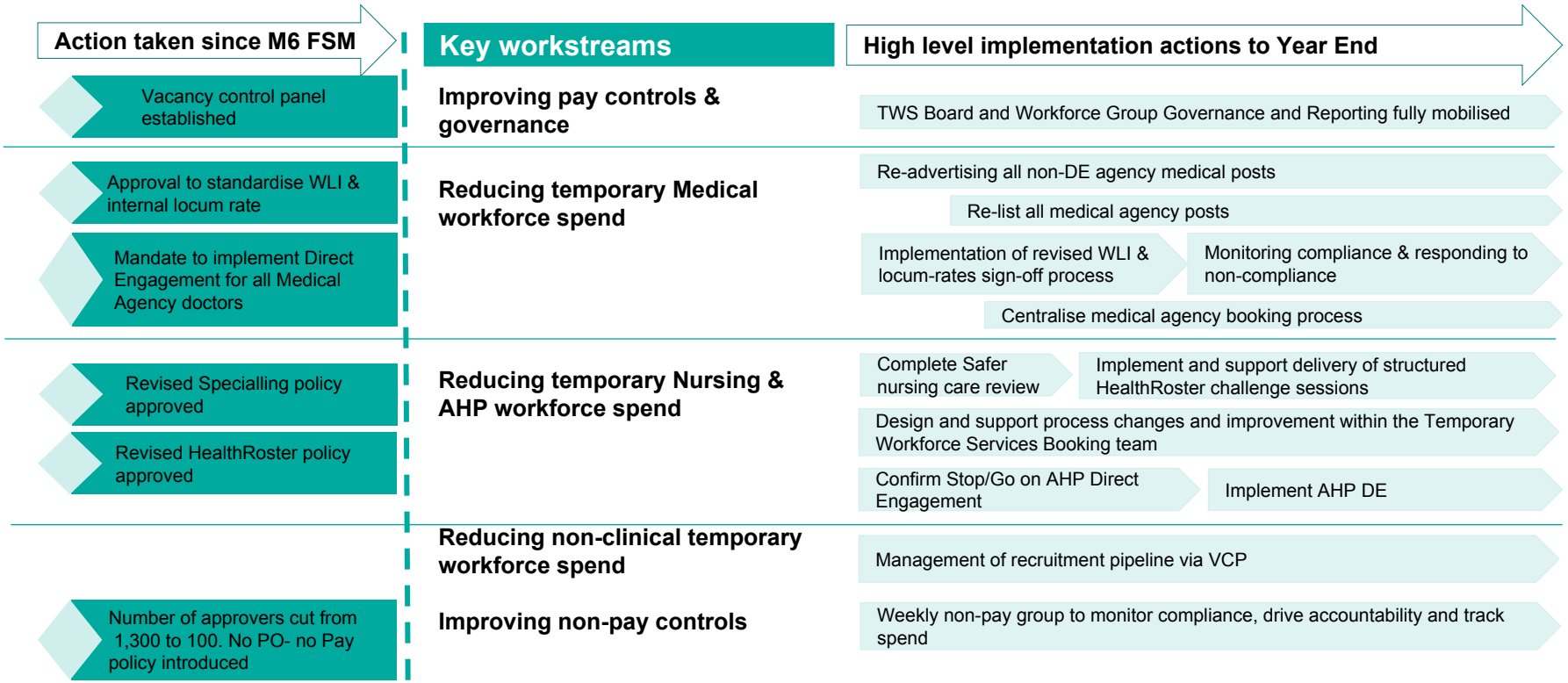
NHS Trust

- The Trust has taken immediate measures to increase grip and control on expenditure
- **Run-rate reduction of £120k** from M6 to M7 in temporary workforce demonstrates this programme of work is beginning to deliver benefit



5. Recovery plan

The Trust must deliver £16.1m to mitigate risk to the forecast position and deliver the control total.
The Trust recognises the need for a programme of £20m+ to achieve delivery of £16.1m in year.

Reduction in Income Risk & Forecast corrections:

£6m

PYE

- Income
- Clinical WIP
- Appropriate reimbursement from other sources
- Appropriate capitalisation
- Provider to provider

Efficiency:
£14.34m
PYE

Data Quality & Clinical Networks — £3.52m
- U-coded patients
- DTOC recharges
- T&O escalations
- Inpatient coding data quality

Patient Flow — £1.74m
- DTOC & LOS reduction
- Admission avoidance
- Recovery of activity plans

Elective Pathways — £2.72m
- Theatre productivity
- Outpatient activity
- Radiology
- Cath Lab & Endoscopy

Workforce — £1.55m
- Agency rate reduction
- Agency volume reduction
- Medical: WLI & internal locum reduction
- Nursing: non-patient facing time, specialling, rostering & recruitment

Non-pay — £0.57m
- Medical & surgical equipment
- Drugs
- Non-clinical non-pay

Pipeline: £4.24m

Workforce: Non-clinical agency, medical job planning, management role review, specialist nursing

Clinical Service Sustainability: private patient service redeployment, audiology service cessation, PMU review,

£6m income & forecast + £10.1m Efficiency + £4.24m Pipeline = £20.3m

6. Exit run rate

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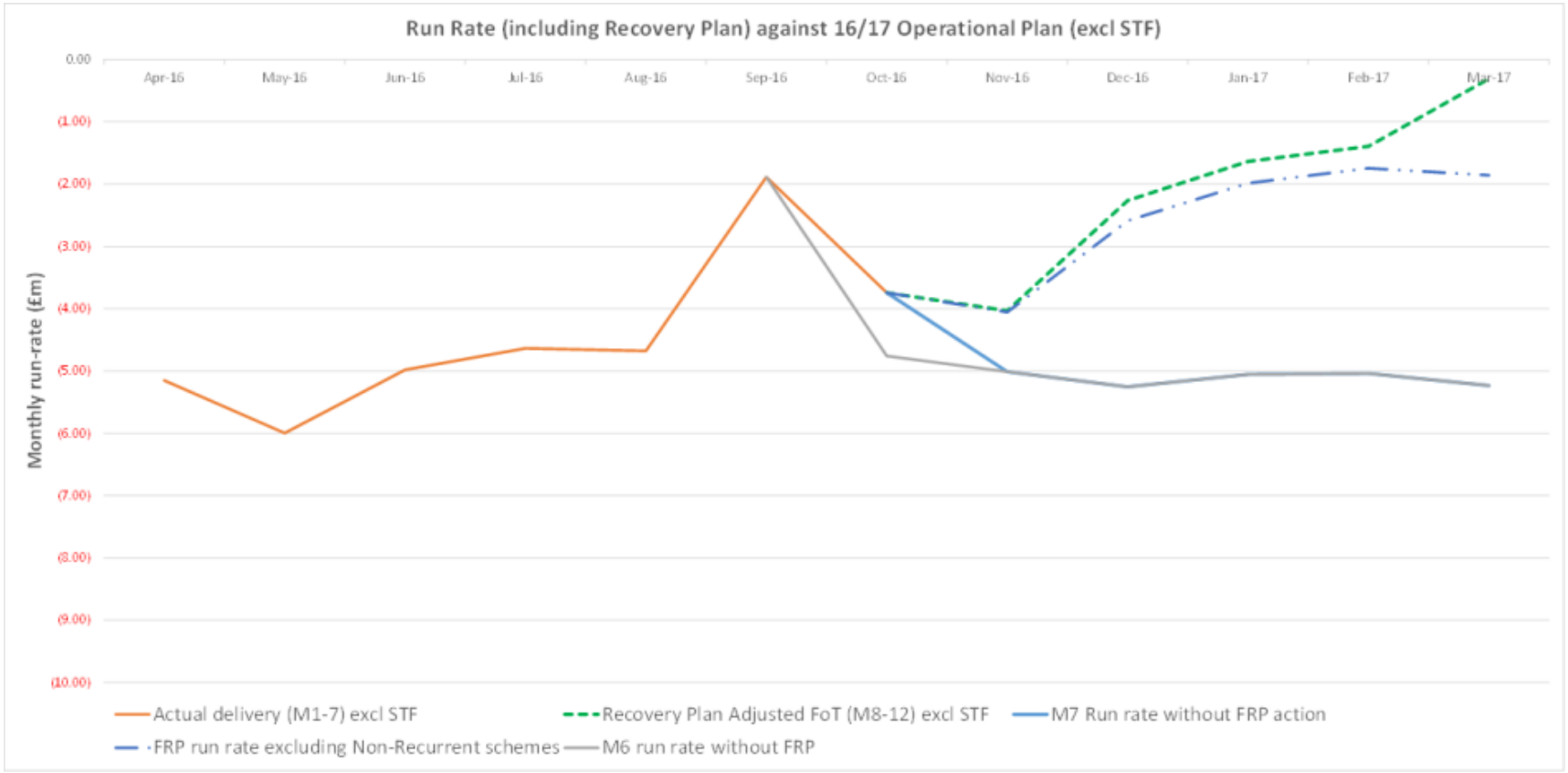

7. Managing risk

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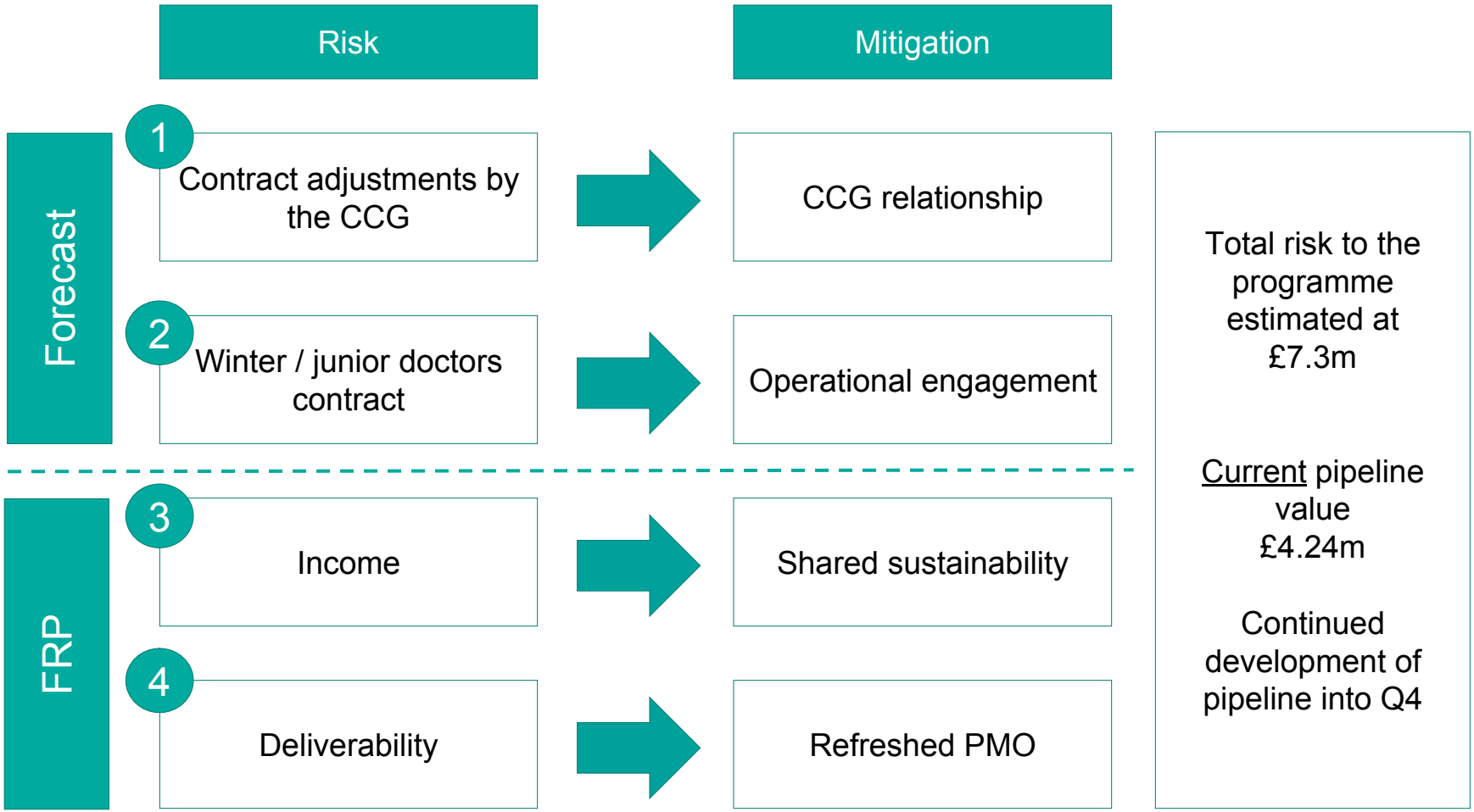
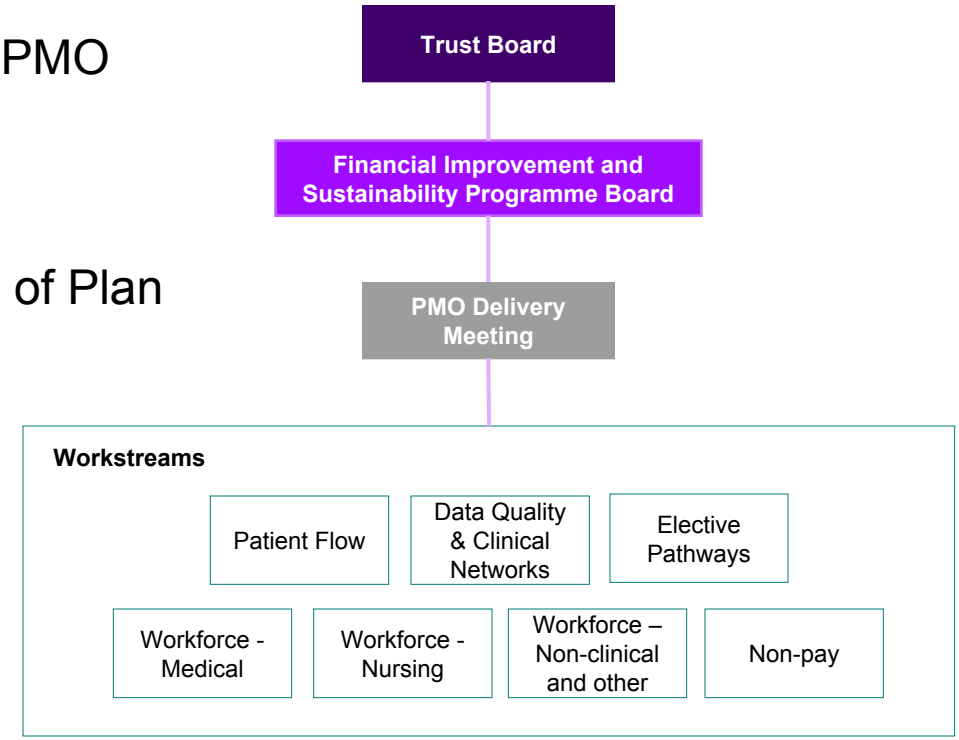


7.2 Managing risk - delivery

How is this risk being mitigated?

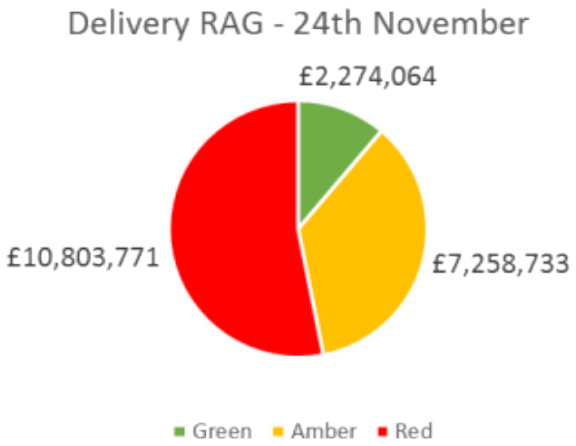
- New governance for financial delivery
- Mobilisation of financial efficiency PMO
- Robust programme management
- Rapid shift to divisional ownership of Plan
- Weekly progress checking
- Daily capacity model planned
- Targeted external support

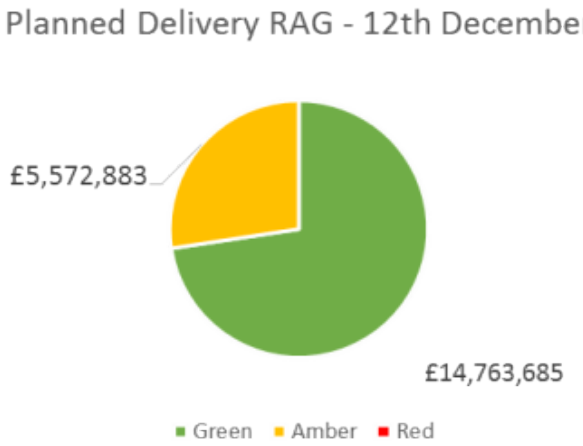


8. Establishing a PMO

The schemes within the FRP are at varying levels of maturity, but each scheme will have a signed-off PID and will be fully reflected in Clinical Unity plans by 12th December 2016.

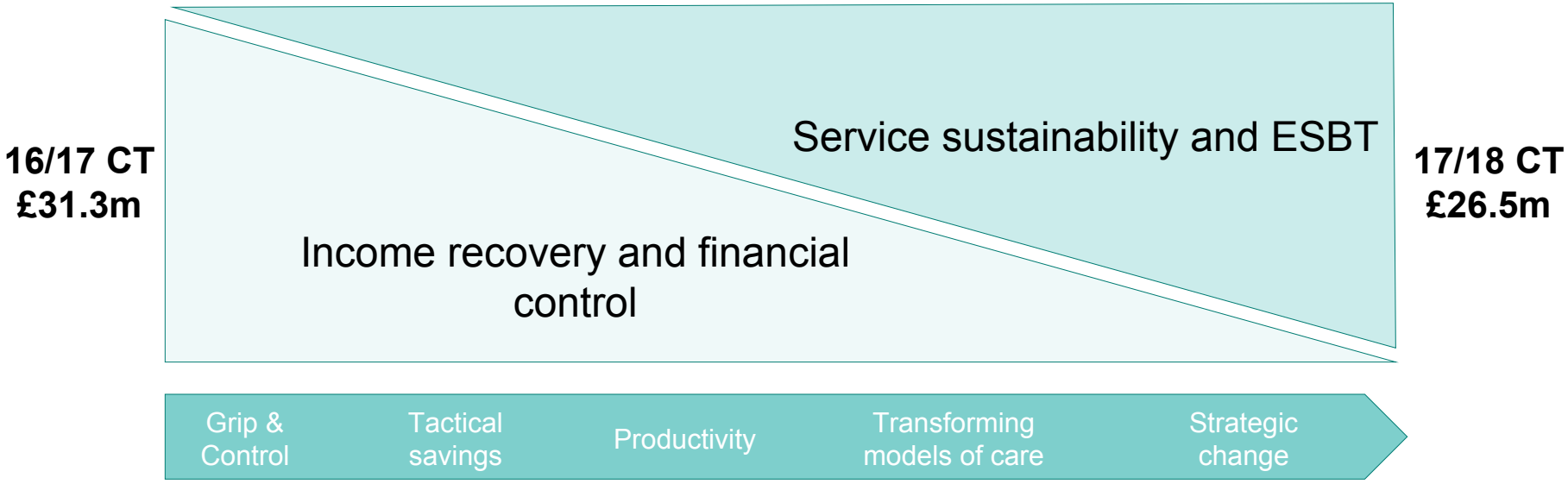
Workstream	Number of schemes	Total value
Reducing income risk & forecast corrections	9	£ 6,000,000
Patient Flow	6	£ 1,736,863
Data Quality & Clinical Networks	7	£ 3,524,213
Elective Pathways	13	£ 2,716,052
Workforce	14	£ 1,545,208
Non-pay	15	£ 569,732
Sub-total	**49**	**£ 16,092,068**
Pipeline	*13*	*£ 4,244,500*
Total	**77**	**£ 20,336,568**





9. Summary and next steps

- Delivery of the FRP at the pace required will necessitate a short term focus on measures to increase grip and control, deliver quick, tactical savings and measures to increase productivity
- Work must also be initiated on the longer term opportunities to support 17/18 CIP and the ESBT work



East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2016
Meeting:	Trust Board
Agenda item:	13
Subject:	New Junior Doctors Contract Implementation Update
Reporting Officer:	Monica Green

Action: This paper is for **(please tick)**					
Assurance	X	**Approval**		**Decision**	

Purpose:

This paper provides an update on the implementation of the New 2016 Junior Doctor Contract.

Introduction:

After two years of negotiation and recent industrial action the new Junior Doctors 2016 Contract came into effect on 3rd August 2016.

The Contract is being introduced in accordance with a phased National Implementation Timetable.

The BMA remains opposed to the introduction of the new Junior Doctor Contract which was rejected by their members in the June Referendum.

Industrial action has however now been suspended.

Analysis of Key Issues and Discussion Points Raised by the Report:

1. 76 Doctors will have transitioned to the new contract with effect from 7th December 2016. The remaining Doctors will transition by August 2017.
2. The impact of the new working hours rules on service delivery with the Emergency departments.
3. The implementation of exception reporting and the awarding of additional payments and fines.
4. Introduction of a Guardian of Safe Working Hours (GOSWH) and the Junior Doctors' Forum
5. Non-Engagement of Educational Supervisors (ES) due to the impact of exception reporting on their role and increased time commitment.

Benefits:

1. Safer working hours for all Junior Doctors
2. Newly created re-designed compliant rotas that will support 7 day service provision
3. Substantive appointment of two GOSWH cross-site
4. Engagement with Junior Doctors at local level
5. Greater cost control

Risks and Implications
1. The Impact of the new rules on service provision within the Emergency Depts. (A&E) 2. Total financial impact unknown as some rota's have yet to be designed 3. Financial risk due to the potential fines as a result of Exception Reporting 4. Non-engagement by Educational Supervisors who believe they have not been consulted about the change in their role and fear Exception Reporting will bring about increased workload.

Assurance Provided:
The new contract is being implemented according to the national guidance and within the national timescales laid down by NHS employers.

Proposals and/or Recommendations
• A Medical Work Force Plan to be created for each Clinical Unit that supports 7 Day Service Provision and identifies operational constraints • Finalise financial modelling as soon as rotas have been developed • Medical and service leaders to continue engagement with Junior Doctors during the implementation phase • First GOSWH report to be presented in April 2017.

For further information or for any enquiries relating to this report please contact:	
Name: Janis Boyd	**Contact details: HR Department EDGH**

East Sussex Healthcare NHS Trust

Implementation of the New Junior Doctor 2016 Contract

1. Introduction

The purpose of this paper is to update the Board on the implementation of the new 2016 Junior Doctor Contract. This is being introduced in accordance with the National Implementation Timetable issued by NHS Employers and monitored by NHS Improvement.

2. Background

After two years of negotiation and recent industrial action, the New Junior Doctors 2016 Contract came into effect on 3rd August 2016.

The contract is being introduced in accordance with a phased National Implementation Timetable and NHS Employers Guidance.

The BMA remains opposed to the introduction of the contract after it was rejected by a majority of their members in the June Referendum. Whilst the BMA have encouraged Junior Doctors to "work under protest", industrial action has now been suspended.

3.0 Regulatory Compliance

Underpinning the New 2016 Contract is a regulatory requirement for all Trusts to provide Trainees with the following:

- Contract of employment compliant with the new 2016 Terms & Conditions of Service
- Work Schedule (Learning outcomes achievable in the post)
- Work Pattern (Rota & pay breakdown for the hours worked)
- Mechanism by which to Exception Report variations to the work schedule and work pattern
- Appointment of a Guardian of Safe Working Hours (GOSWH)
- Establish Junior Doctors Forums

ESHT has fulfilled its regulatory compliance as above and on 5th October 2016 successfully transitioned 3 Obstetric and Gynaecology ST3 Trainees.

On 7th December 2016 ESHT will transition a further 40 x FY1 and 43 x FY2 Trainees to the New 2016 Contract.

4.0 Exception Reporting

Underpinning the new Junior Doctors Contract is a requirement for Trusts to provide Junior Doctors with a mechanism by which they can report exceptions to their work schedule and work pattern. Exception reports will be submitted to the Educational Supervisors to review and monitor and they will be responsible for authorising the exception for payment and imposing of fines.

All Trainees have been advised that ESHT will use the DRS4 System to exception report.

All Trainees have been sent:

1. Login IDs by DRS4 enabling them to Exception Report using DRS4
2. Provided details of their next rotation plus, Educational and Clinical Supervisors.

3. Have been informed of the Guardian of Safe Working Hours and the Director of Medical Education on their work schedules

To support the use of DRS4, ESHT have offered "Drop in Sessions" to both Junior Doctors and Educational Supervisors, enabling them to ask questions, to ensure they understand the system with regards to submitting and responding to Exception reports.

There is a national issue in relation to the non-engagement of Educational Supervisors who believe that they have not been consulted on the changes to their role and fear that exception reporting will bring about increased work load which is not supported in the time currently allocated to them. Educational Supervisors are currently allowed 2.5 SPA time per trainee per week. The impact on their role will be closely monitored and once the new rotas and exception reporting systems are embedded it is not anticipated that additional SPA time will be required.

5.0 Guardian of Safe Working Hours (GOSWH)

ESHT have now appointed substantively 2 GOSWH

Conquest site	Barry Phillips, Anaesthetic Consultant
Eastbourne site	Waleed Yousef, O & G Consultant

The Guardian of Safe Working Hours is a new feature of the 2016 Contract. The role of the guardian is to oversee the safety of doctors in training by providing assurance on compliance with safe working hours.

The GOSWH will report to the Board no less than once per quarter.

- The Report will show numbers of Exception Reports received and fines imposed and how the money derived from fines will be disbursed.

- The Report will identify where there are Departments that have safe working issues that cannot be remedied locally and inform the Board of such issues.

- This report will also be presented to LNC and will include data on all rota gaps and all Exception Reports

6.0 The Junior Doctors Forum (JDF)

Underpinning the appointment of the GOSWH is a requirement for Trusts to form and hold a Junior Doctors Forum (JDF). The JDF will represent all trainees at ESHT. The Forum will support and scrutinise the work of the GOSWH to ensure that the working hours of Junior Doctors are effectively monitored.

More specifically, the JDF will scrutinise the disbursement of fines (the parameters with which fines must be spent are set out in Schedule 5, Paragraph 14 of the of the TCS

ESHT held its first JDF on 28/11/16.

The Group confirmed Roles & Responsibilities but also the Quorate Membership as follows:

1 x Guardian of Safe Working Hours (GOSWH) (Chair of JDF)
1 x Director of Medical Education (DME)
1 x Local Negotiating Committee (LNC) Chair
1 x Junior Doctor Representatives appointed by the LNC
1 x Junior Doctor representing any speciality

1 x Medical Staffing and or HR Lead
1 x Executive Director (TBC)

7.0 Impact of the new contract to date

Compliant rotas have been developed for all FY1 and FY2 rotas, and the remaining rotas will be developed and in place by August 2017.

A&E is one of the specialties where rota pressure is at its most acute, particularly for FY2 Drs, the new Terms and Conditions of Service will have an immediately beneficial effect on the working lives of doctors in training however the impact of the new rota rules will have a major impact on service provision, as A&E Depts. nationally struggle to cover the hours previously worked by Junior Doctors under the 2002 Terms & Conditions of Service.

A Rota Gap Analysis has been undertaken and it indicates that an additional 3 Drs are required at each site to support service delivery. Mitigating actions have been put in place during the implementation period which includes offering additional hours to Drs who have already completed their A&E rotations.

Several rotations come close to the maximum weekly hours allowed increasing the risk of Exception Reporting and triggering additional payments and fines.

8.0 Financial Impact

The financial impact of the new contract will not be known until all of the rotas have been developed and finalised. Work is being undertaken by the HR lead and the finance department to model and monitor the impact as it is rolled out. The first estimates will be available in February 2017.

Salary Protection where applicable will be paid until 2022. FY1 Drs will be protected on the basis of their earnings at the point of transition. FY2 Drs are protected based on earnings received as at 31/10/15 and are required to provide documentary proof of earnings.

Salary protection costs for the Drs transitioned to date are estimated as follows:

3 ST3 doctors = £ 1,051
40 FY1 doctors = £43,826
43 FY2 doctors = £60,000

9.0 Conclusion

This is a major workforce change project, a number of the National processes have been developed at pace and 'just in time'. The programme to date has been delivered within ESHT on time and within the regulatory requirements.

It represents a significant change in the work scheduling, management and monitoring of Junior Drs hours and training delivery. The changes require the implementation of new roles, changes to current roles and the introduction of new governance arrangements. It has the potential to support changes in the delivery of services and provide a safer working environment for Junior Drs.

Junior Drs may require additional support during the change and it is essential that all medical leaders and senior managers liaise with Junior Doctors and their representatives during this period of change to ensure ways of working are fully embedded.

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2016
Meeting:	Trust Board
Agenda item:	14
Subject:	Quality Account Timetable
Reporting Officer:	Ashley Parrott

Action: This paper is for

Assurance	X	**Approval**		**Decision**	

Purpose:

The timetable for the Quality Account outlines the activity and sign off required to achieve the final submission deadline date.

Introduction:

The production of the Quality Account requires input from a large number of individuals across the organisation who all need to provide information within agreed timescales. The Governance Team are currently establishing specific outcome measures and the subsequent data for the 2016/17 priorities to ensure we have the majority of the information prior to April. This will ensure we only need to collect the March information to complete the document.

Analysis of Key Issues and Discussion Points Raised by the Report:

Key tasks between now and the end of April are to:

- Collect data to demonstrate the achievement of the 16/17 priorities;
- Identify 2017/18 priorities, through review of quality information, patient and public engagement and staff input and feedback;
- Collect information required from leads to meet the minimum requirements – Clinical Outcomes;
- External audit on data
- External review – CCG, HOSC and Healthwatch
- Presentation to core committees

Benefits:

Achieving the timescales will ensure the Quality Account is completed on time.

Risks and Implications

Failure to obtain the required information for the priorities and national audits and outcomes could result in missed submission deadline.

Assurance Provided:

Timetable in place, committee structure in place to support and Executive Lead in place – Director of Nursing.

Proposals and/or Recommendations

The Board is asked to receive assurance about the planning process for the 2017 Quality Account.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
None.

For further information or for any enquiries relating to this report please contact:	
Name: Ashley Parrott Associate Director of Governance	**Contact details:** ashley.parrott@nhs.net

Quality Accounts 2016 - 2017 ESHT Timetable

The following timetable may be subject to change if it is aligned with the annual report timetable

	Milestones	Actions	Timescales	Responsible Lead
1	Quality Engagement event (s)	Engagement events to be planned for Jan/Feb 15	Jan/Feb 17	DoN/Director of Corporate Affairs/Head of Governance
2	Prepare a timetable for Quality & Safety Committee.	Report to the QSC with the timetable for producing the 2016-2017 Quality Account. All parties likely to be involved will be informed of the timetable.	January 17	Head of Governance
3	Update Quality Account webpage on the ESHT Internet site.	The webpage explains what the Quality Accounts are and encourage service users and the public to contact us with ideas for our 2017-2018 QIPs. There is also a link to our 2015-2016 Quality Account.	January 17	Communications Manager.
4	Start production of the 2016/2017 Quality Account	Start work on the document's layout and content. To align with the layout of the annual report.	January 17	Head of Governance
5	Identify the 2017-2018 QIP options	Seek feedback from staff with proposed options and other ideas to consider. Analysis of all feedback received in order to identify the 2017-2018 QIP options.	January 17	Director of Nursing/Head of Governance/ Communications Manager
6	Consider imagery for the 2016/2017 Quality Account	Communications to take new pictures around the Trust for use in the Quality Account.	January 17	Communications Team
7	Public consultation – 2017/2018 QIPs	Send out the 2017/2018 QIP options for consultation through the ESHT Internet site, inviting feedback and comments.	End January 17	Head of Governance/ Communications Manager
8	Data to be requested for the QA from all necessary sources.	To collate and analyse the data for the QIPs with narrative on progress (data for Q1-Q3 should be collected by January 17)	February/ March 17	Head of Governance

Quality Accounts 2016 - 2017 ESHT Timetable

The following timetable may be subject to change if it is aligned with the annual report timetable

9	Prepare and present a report reviewing the 2017/2018 QIP options to the PS&QG for comment	To present options for the 2017-2018 QIPs – feedback is required.	February 17	Director of Nursing/Head of Governance
10	Prepare and present a report reviewing the 2017/2018 QIP options to the Q&SC and Trust Board for comment	To present options for the 2017-2018 QIPs – feedback is required.	March 2017	Director of Nursing/Head of Governance
11	Data Quality Assessment	Data quality to be continuously assessed by the relevant Lead and Internal Auditors.	February – March 17	Head of Governance /Auditors
12	A draft set of Quality Accounts	Using data and information, draft a set of quality accounts	March 17	Head of Governance
13	Circulate the draft set of the Quality Accounts to members of the Quality and Safety Committee and Board members for comment	The draft version of the quality accounts may still be missing information around last year's QIPs. The new 2017/2018 QIPs will now have been agreed. Feedback is required.	5th April 17	Director of Nursing /Head of Governance
14	Circulate the draft set of Quality Accounts electronically to the HOSC for comment	To provide 30 days for comments from date sent. Some data may still be missing at this stage.	By 28th April 2017	Head of Governance
15	Circulate the draft set of Quality Accounts electronically to the members of the public and all patients involved in development for comment	(Including HealthWatch and the CCG's). To provide 30 days for comments. Some sets will need to be printed and posted in hard copy. Some data may still be missing at this stage.	By 28th April 17	Head of Governance

Quality Accounts 2016 - 2017 ESHT Timetable

The following timetable may be subject to change if it is aligned with the annual report timetable

16	Update the draft Quality Account, to include any feedback or additional information received.	Comments to be added to the Quality Account from the HOSC, and the CCG's (alongside any internal feedback / information received). All data to be gathered and ready for an internal audit regarding the data quality.	End of May 2017	Head of Governance
17	Present the final set of Quality Accounts to the Q&S Committee	No data should be missing at this stage – but ratification will be required – electronic voting may be needed.	May 2017	Director of Nursing
18	Present the final set of Quality Accounts to the Audit Committee	No data should be missing at this stage – but ratification will be required – electronic voting may be needed.	May 2017	Director of Nursing
19	Present the final set of Quality Accounts to the Trust Board	The Quality Account should now be completed – awaiting final comments and ratification from the Trust Board - electronic voting may be needed.	June 2017	Director of Nursing
20	Publish the Quality Account on NHS Choices website and forward a copy on to the Secretary of State		**Before 30th June 2017**	Communications/Director of Corporate Affairs

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2016
Meeting:	Trust Board
Agenda item:	15
Subject:	Developing a New Model of Accountable Care
Reporting Officer:	Catherine Ashton

Action: This paper is for **(please tick)**

Assurance		**Approval**	x	**Decision**	

Purpose:

The Board are asked to approve:

- work to continue to develop a local fully integrated Accountable Care Model (ACM) across the East Sussex Better Together footprint, involving a test bed year in 2017/18
- work to establish a commissioner provider alliance to manage the health and social care system collectively with our ESBT partners in the 2017/ 18 test bed year

Following this approval we will then work towards :

- A draft agreement setting out the governance framework for the ESBT commissioner provider alliance by January 2017
- Detailed recommendations for future organisational arrangements for a full ACM, which would operate from 2018/19 at the earliest

Introduction:

The ESBT programme has created the partnership conditions to enable the testing of an ambitious, whole system model of care that has drawn from the best national and international exemplars. We are now developing a new model of care - we call this accountable care - that is right for East Sussex.

This report seeks Board endorsement of the work to develop a local ACM, setting out the case and plans to implement a test-bed year in 2017/18 as part of the process of deciding on the most effective organisational arrangements for our ACM, and moving to a full ACM from 2018/19 at the earliest.

This report outlines the cumulative position after an intensive period of engagement with local decision-makers and stakeholders and further discussion on the shape of the test bed year and likely organisation form beyond that. It describes activity to be undertaken during the transitional year to understand the best organisational arrangements and form for Accountable Care in East Sussex.

Analysis of Key Issues and Discussion Points Raised by the Report:

The report outlines:

- the emerging future state model;
- the potential governance and operating arrangements to enable the collective leadership

required to move forward to a test-bed year in 2017/18
- the emerging integrated operational management arrangements to support this.

This gives us the parameters for the new model of care we are building, the services we will be including within the model, and how we plan to test this during a test-bed year in 2017/18. We know that our model must enable us to achieve the triple aims as set out in the NHS Five Year Forward View: improve health and well-being outcomes; improve patient experience; and ensure financial sustainability, so we need to deliver a system that addresses these in a way that also reduces inequalities across the ESBT footprint, offering integrated, person centred care in a clinically and financially sustainable way.

In keeping with this, our model has a strong emphasis on population health promotion, prevention, early intervention and self-care and self-management to reduce demand for services and allow care to be delivered increasingly out of hospital and at the lowest level of effective care.

In addition to the international evidence and best practice we have drawn form, we know that ACMs are now under active development in a number of areas across England as a response to growing financial and service pressures. They are considered to be the best structure for delivering transformation; we are at the forefront of this change.

Benefits:

Improve health and well-being outcomes; improve patient experience;
and ensure financial sustainability

Risks and Implications

A change process of this kind and scale inevitably presents risks as well as opportunities and it is important that these are identified and managed in the same way risk is currently managed within the Trust and across the CCGs. The most significant ones will include:

- accountability and control
- the discharge of statutory responsibilities
- financial responsibilities and control
- management capacity to deliver change.

Assurance Provided:

We have made strong progress already through our ESBT programme to integrate services and redesign care pathways in line with best practice, however, we also need to transform the way services are organised and provided to fully deliver the triple aims:

- improve health and well-being outcomes
- improve patient experience
- Ensure financial sustainability.

The national and international evidence indicates that an ACM is the best structure for delivering transformational change.

Proposals and/or Recommendations
The Board are asked to approve: • work to continue to develop a local fully integrated Accountable Care Model9 ACM) across the East Sussex Better Together footprint, involving a test bed year in 2017/18 • work to establish a commissioner provider alliance to manage the health and social care system collectively with our ESBT partners in the 2017/ 18 test bed year

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
To be completed

For further information or for any enquiries relating to this report please contact:	
Name: Catherine Ashton	**Contact details: Catherineashton@nhs.net**

East Sussex Healthcare NHS
NHS Trust

Developing a new model of Accountable Care

1.0 Background

1.1 It was recognised three years ago that the scale of the quality and financial challenge facing the NHS, Adult Social Care, Public Health and Children's Services across East Sussex required a fundamentally different approach to our joint work. In response the East Sussex Better Together (ESBT) Programme was initiated in August 2014 to deliver fully integrated health and social care services and a sustainable local health and social care economy for future generations. The key challenges faced by our local health and social care economy and the case for change have been fully discussed and noted previously; this has been brought together in a summary document and is available to read on the ESBT website.

1.2 As a result of the ESBT Programme a strong partnership between commissioners and providers of health and social care has enabled us to make significant progress with redesigning care pathways and integrating health and social care in East Sussex. However this will not be enough to create a fully integrated, clinically and financially sustainable health and social care economy for the future and to do this we need to embed transformation through changing the way services are organised and provided. The international and national evidence and best practice shows that Accountable Care offers us the best opportunity to address the triple aims as set out in the NHS Five Year Forward View:

- improve health and well-being outcomes
- improve patient experience
- ensure financial sustainability alongside ensuring provider sustainability across local primary, acute hospital, community, social care and mental health services in East Sussex

1.3 Following on from detailed discussion regarding the case for change and national and international evidence base, it was agreed by the ESBT Programme Board that a new model of Accountable Care could be the best mechanism for fully delivering our ambition as part of ESBT. Over the past two months a multiagency group has been developing an Accountable Care Model that we hope to run in a test bed year (shadow form) in 2017/18. It is hoped that a final model will emerge from this test phase for implementation from 2018/19 at the earliest.

2.0 Local engagement to develop our model of Accountable Care Model (ACM)

2.1 Research and discussions have taken place to shape the development plans for an ACM, and continue to inform our work and the arrangements for the test-bed year in 2017/18. This has included:

- System wide seminars and workshops, including representation from the Local Medical Committee (LMC) and Healthwatch East Sussex on the impact of future models on health and social care in East Sussex.
- Multi-agency Steering Group discussions between statutory partners.
- ESBT Strategic Investment Plan discussions, as part of budget-setting processes focussing on the activity and capacity changes needed to effect a move to community based prevention and proactive care.
- Discussions at GP Locality Meetings, Membership Engagement and Learning Events (MELEs) and a well-attended evening meeting with GPs to fully explore the relationship between resilient and sustainable primary care and the ACM.
- Partnership engagement events and meetings, such as Shaping Health and Care events and provider forums, meetings of the ESBT Communications and Advisory Group and other workshop sessions and discussions.
- Staff engagement commissioned through Healthwatch across partners to test understanding and inform future communications and engagement.
- Transparent and open communications about Accountable Care including explanatory videos and other material uploaded to the ESBT website to grow understanding and engagement.
- In addition Accountable Care has featured as part of regular updates on the ESBT Programme at the meetings of the East Sussex Health and Wellbeing Board in 2016.

2.2 All of these discussions were, and continue to be, informed and underpinned by everything the public has told us since the inception of ESBT Programme in August 2014 and before, about their experience of health and care services locally and the need for transformation to fully integrated preventive and proactive care in community settings as the appropriate response to population health and care needs in the 21st century.

3.0 The East Sussex Accountable Care model

3.1 There is a clear consensus on the need to build a whole system model of Accountable Care that incorporates primary prevention, primary and community care, social care, mental health, and acute and specialist care. In line with this ESHT and SPFT formally joined the ESBT Programme Board in September 2016 enabling a full alliance between commissioners and providers. A new ESBT Clinical Leadership Forum has also been formed whose purpose is to act as the primary resource for primary and acute care pathway, service specific and medical workforce advice to the ESBT Board and constituent organisations. A summary of the evidence base and main local considerations for moving to a local ACM is brought together in 'Developing the Evidence Base Further for Accountable Care in East Sussex' which is available on the ESBT website.

3.2 The new model will involve changing the local system from one of separate organisations to managing the way we pay for and deliver health and social care on an integrated, system-wide basis, based on delivering the outcomes that matter to local people rather than, as currently, based on activity. The features emerging from dialogue and engagement so far about the future model for Accountable Care in East Sussex is describing a model that lends itself to a single overarching alliance or organisation that is responsible for directly or indirectly (by sub contract) delivering all health and care services to the population. This builds on the principles and characteristics previously agreed as

referenced earlier in this paper and available on the ESBT website, and includes commitment to ensuring local people are at the heart of our health and care system. Previous discussion noting mechanisms such as outcomes based capitation used to drive improvement, reduce variation in practice and deliver a comprehensive programme of primary prevention will underpin our work as we develop further.

3.3 There are different options for establishing an ACM, including a virtual partnership arrangement, partial integration of specified elements of service and full integration. These were explored as part of the series of system-wide seminars and have been further examined as this work has progressed. More detail about these options is available in 'Developing the Evidence Base Further for ESBT Accountable Care.' Under any of these scenarios, the CCGs and the County Council will remain the accountable strategic commissioning bodies for health and social care services, exercised through democratic accountability to the Council and accountability of the CCG Governing Bodies. The CCGs and the Council will continue to set outcomes and oversee their delivery, as well as ensuring service user voice and choice are maintained. ESHT will remain an independent NHS organisation and as such will continue to be held accountable for delivery of its regulatory requirements.

3.4 The ACM will mean evolving the working arrangements of commissioners and providers and other partners. This will be important to ensure that any new integrated model has the freedom to define the detail of the service model and how providers would work together to deliver this, as well as determining the operating model and partnership arrangements. The freedom would however be dependent on delivery of the outcomes specified by the Council and CCGs.

3.5 In order to encourage more coordinated care between health and care providers an ACM will have to bring together a range of services that currently sit across a number of different organisations. Local discussions have taken account of the need to develop and agree an organisational form and also decide how the prospective ACM will relate to GP Practices and Federations, other staff groups, and providers in the independent and voluntary sector, as well as the communities where they provide services.

3.6 The 2017/18 year will allow us the opportunity to test and evaluate the options available to us on organisational form, in addition to undertaking more detailed work on governance and support arrangements. The suggested options to explore during the test-bed year include:

- using NHS legislation to establish a new NHS Trust Board, to include social care and Public Health provision;
- partners on the ESBT Programme Board forming a limited company or limited liability partnership (LLP) e.g. forming a corporate joint venture vehicle to deliver the single contract for the whole population
- Other organisational models such as Community Interest Companies and Mutual Companies.

This is not an exhaustive list but offers some sense of options to explore.

4.0 2017/18 Test-bed Year

4.1 It is considered that the best way to decide on the most appropriate organisational arrangements for our ACM in East Sussex is to have a test-bed year of Accountable Care through forming a commissioner provider alliance. This would be made explicit through an agreement that sets out the operating arrangements between the ESBT Programme partners and allows us to test and develop:

- the optimum population base for capitation and the devolution of budgets to localities
- the phasing of the introduction of a capitation payment mechanism
- the methodologies for organisational and individual incentives to deliver the outcomes
- What the menu of options for funding and contracting should be with primary care, voluntary and community organisations and the independent care sector.

4.2 Local determination on the preferred organisational form would also form a key part of the deliberations in early 2017/18, in order that recommendations can be made to the ESHT Board and CCG Governing Bodies in July 2017 regarding preferred models to consider moving forward.

4.3 The HOSC and the ESBT Scrutiny Board would have an ongoing role in all of these considerations. It should be noted that these are indicative timescales.

4.4 During the test-bed year all organisational accountabilities will remain unchanged, with partners joining up funding and activity through the delivery of the Strategic Investment Plan, creating integrated and aligned budgets and a governance agreement regarding the commissioner and provider alliance. The year will also help us determine how ESHT, the CCGs, Council and other providers will fulfil their ongoing statutory responsibilities, financial control and governance requirements following the test-bed period.

4.5 The CCGs and the Council will continue to set priorities for the local population and make investment decisions, as well as scrutinising the delivery of health and care services. ESHT will continue to provide healthcare services to our population.

4.6 The agreement will describe how the governance of the health and social care economy will take place through single system leadership, with accountability to the ESHT Board, CCG Governing Bodies and the Council, and overarching local whole system leadership and decision-making through the following mechanisms:

- the development of an integrated single budget covering collective health and social care investment;
- an integrated Strategic Investment Plan to prioritise investment, to be considered
- through the organisational budget-setting processes; and
- A unified outcomes framework and a single performance management process.

4.7 A draft outline structure is contained in Appendix 1 of this report showing the potential arrangements for the governance and leadership of the ESBT health and social care system in the test-bed year, with accountability back to the ESHT Board, CCG Governing Bodies, and the Council Further work and information on this will be brought back to the ESHT Board as it emerges.

5.0 Clinical leadership and engagement

5.1 There has been discussion on the different ways that GPs could relate to or be part of the new ACM, with a specific session for GPs taking place on 27 October 2016, to explore Accountable Care and test out what matters most to our local GPs, to inform how we develop the relationship and menu of options for primary care. The session reflected a range of views on the appetite for change and how this can best be achieved. The ambition is to create a menu of options that can help support the significant primary care workforce challenges we have locally and contribute meaningfully to a sustainable and resilient primary care workforce in the future, as well as accommodate different preferences for individual GP Partnerships. All solutions sit within the context of ensuring high quality services for our local populations that meet the needs of today.

5.2 Although all options would be voluntary some early stage thinking suggests that some options might be:

- GPs being sub-contractors or independent contractors with the ACM;
- GPs becoming partners or stakeholders in the ACM;
- GPs being direct employees of the ACM; and
- Practices tapping into the infrastructure of the ACM for back office support for example around workforce and recruitment, IT and estates.

5.3 In addition to the organisational and contractual arrangements for GPs and primary care discussions about the primary and acute care pathway have begun to be taken forward by the ESBT Clinical Leadership Forum, a body of experts drawn initially from our locally employed medical workforce. At a high level these discussions have covered potential action needed to support better outcomes for patients and reducing variation across all care, including:

- reducing barriers between primary and acute and mental health care for the benefit of patients, for example introducing virtual clinics for some specialties in Practices
- improving direct day-to-day liaison between GPs and consultants;
- establishing universal principles for all care pathways to reduce waits and improve patient experience and outcome
- Providing the forum for developing the collective clinical leadership (approximately 400 GPs and Consultants) of the health and care system in East Sussex.

5.4 It is anticipated that we will grow the Clinical Leadership Forum to encompass other professional groups from across the clinical and care spectrum.

5.5 Moving forward this work will need to link with the discussions taking place about the development of emerging GP Federations to create a successful partnership between acute care and the collective voice of primary care providers, to ultimately deliver an expanded primary and community care offer in conjunction with the Integrated Health and Social Care Locality Teams as part of a single system geared towards prevention and proactive care in community settings.

6.0 Citizen, patient and client engagement and leadership

6.1 A comprehensive stakeholder engagement plan has been in place to support Accountable Care development. This has incorporated stakeholder analysis and the development of tools and resources designed to grow understanding and facilitate wide and deep engagement about the benefits of moving to Accountable Care, and the considerations for designing a local model.

6.2 Work is also underway to develop an Accountable Care Outcomes Framework that will encompass a range of outcome measures across experience, quality and safe services, population health and wellbeing and transformed models of care (including use of resources). This will be aligned with the outcomes that matter to local people to arrive at a public-facing balanced scorecard that we can use to measure performance in the testbed year of Accountable Care. An action plan has been developed with Healthwatch East Sussex outlining the co-design process to support a publicly owned outcomes framework for 2017/18. It includes:

- Undertaking a desk top analysis of existing local intelligence to identify common themes across the range of outcome measures and grouping this against four categories population health and wellbeing, the experience of local people, quality care and services, and transformed services leading to better use of resources.
- Undertaking a co-design process involving key groups of people to test out and describe in more detail the outcomes and goals within each theme that matter to local people. Some of these might be new and some would be based on the things people have already told us.
- Testing (via survey methodology) more widely with local people and further sense checking against existing knowledge about what is important.
- Identifying suggested measures or indicators for capturing progress.

6.3 This will be incorporated alongside work with our commissioner provider alliance and the Kent Surrey and Sussex Academic Health Science Network to arrive at a comprehensive outcomes framework that can be used to measure performance in priority areas for the 2017/18 year, so that we know that the action we are taking is having the impact desired.

7.0 Risk Management

7.1 It is recognised that, as ESHT and the CCGs enter into the new ACM arrangements, they will continue to need to meet their statutory responsibilities, financial control and governance requirements. The partnership will bring organisations together and in these circumstances there are a range of additional risks due to a proposed shared accountability for health and social care.

7.2 A change process of this kind and scale inevitably presents risks as well as opportunities and it is important that these are identified and managed in the same way risk is currently managed within the Trust and across the CCGs. The most significant ones will include:

- accountability and control;
- the discharge of statutory responsibilities
- financial responsibilities and control
- Management capacity to deliver change.

7.3 These will be addressed through the agreement proposed for the test-bed year and any subsequent formal agreements. Expert advice will be taken to guard against unintended financial consequences. To support the change management, integrated management arrangements are also developing in order to reduce duplication and maximise opportunities for system-wide working.

7.4 In considering risk management, it is important to recognise that we are already managing risk in a way that we know is not clinically and financially sustainable. The risks associated with the programme of change need to be understood within the context of the risk the ESBT partner organisations are already exposed to in staying as we are.

8.0 Conclusion

8.1 We have made strong progress already through our ESBT programme to integrate services and redesign care pathways in line with best practice, however, we also need to transform the way services are organised and provided to fully deliver the triple aims:

- improve health and well-being outcomes
- improve patient experience
- Ensure financial sustainability.

8.2 Taking account of international and national best practice and after extensive local engagement, moving to a fully integrated model of Accountable Care offers the best opportunity to achieve the full benefits of an integrated system. This is also in line with the national direction of travel as set out in the NHS Five Year Forward View.

8.3 A number of practical arrangements need to be worked through in order to decide on the most effective organisational arrangements for our Accountable Care model in East Sussex, and therefore a test-bed year would provide the basis for taking this forward within frameworks enabled by NHS England and national Government in order to achieve our aims and objectives.

8.4 A test-bed year of Accountable Care, under an alliance arrangement, would also allow for the collaborative learning and evaluation to take place between the ESBT Programme partners and other stakeholders to further develop the evidence base locally for increased levels of formal integration and designing the appropriate contractual and funding arrangements to suit local preferences.

8.5 It is recommended that work continues towards developing a local ACM and to implement a commissioner provider alliance for 2017/18. This will include agreeing the services included, and entering into the necessary contractual arrangements, such as those related to integrated budgets, and an agreement which will govern the alliance.

9.0 Recommendation

9.1 As a result of the work that has been undertaken since May 2016 to inform and shape developing a local ACM, the Board are recommended to approve:

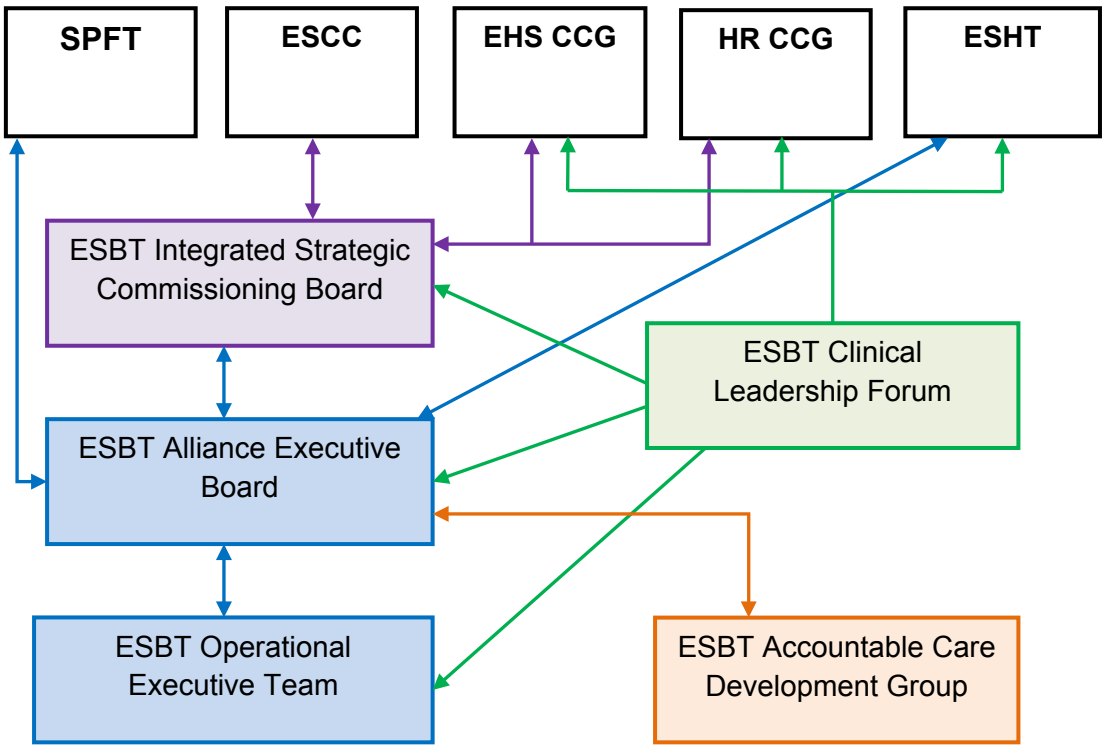
- work to continue to develop a local fully integrated ACM across the ESBT footprint, involving a test-bed year in 2017/18
- Work to establish a commissioner provider alliance to manage the health and social care system collectively with our ESBT partners in the 2017/18 year.

9.2 Following this approval, we will then work towards:

- a draft agreement setting out the governance framework for the ESBT commissioner provider alliance by January 2017
- Detailed recommendations for future organisational arrangements for a full ACM which would operate from 2018/19 at the earliest.

Appendix 1

DRAFT East Sussex Better Together (ESBT) Alliance Governance Structure 2017/18 Test-Bed Year



Draft ESBT Alliance Arrangements 2017/18 Test-Bed Year

Further detail will be worked up on the proposed governance arrangements for the shadow Accountable Care commissioner-provider alliance, based on the following starting assumptions (which may be subject to change as understanding evolves):

- The Accountable Care arrangements **for the test-bed 2017/18** will be subject to an Agreement to cover the Strategic Investment Plan requirements between local authority and NHS commissioners and the alliance between commissioners and providers.
- All current organisational duties, accountability arrangements and management reporting will remain in place **in 2017/18**, unless specified by agreement of all parties.
- All existing reporting arrangements to the Health and Wellbeing Board and Health Overview and Scrutiny Committee (HOSC), as well as single organisational audit and scrutiny processes, remain the same.

East Sussex Better Together (ESBT) Integrated Strategic Commissioning Board:

- Statutory accountability for commissioning health and social care continues to be held by the CCGs and County Council.

- The Board's duties will be set out in the Agreement and will include oversight of the 2017/18 Strategic Investment Plan and any responsibilities delegated by the statutory commissioning bodies.

East Sussex Better Together (ESBT) Alliance Executive Board:

- Will report to the ESBT Integrated Strategic Commissioning Board and to East Sussex Healthcare NHS Trust (ESHT) and Sussex Partnership NHS Foundation Trust (SPFT).
- Will take executive responsibility for the delivery of the Strategic Investment Plan and operation of the alliance Agreement.
- Will lead the development of proposals for the full Accountable Care Model.
- Will hold to account the ESBT Operational Executive for the delivery of agreed plans, including the strategic management of risk and any changes to proposed service arrangements, performance and resource allocation.

East Sussex Better Together (ESBT) Operational Executive Team:

- Will report to the ESBT Alliance Executive Board.
- Will oversee the delivery of our agreed plans and escalate as required risks, proposals for service developments or budget changes, needing executive authorisation.
- Will manage operational delivery of all specified health and social care services.

East Sussex Better Together (ESBT) Accountable Care Development Group:

- Will report to the ESBT Alliance Executive Board.
- Will oversee the development of proposals for the full Accountable Care Model.
- Will lead on programmes and projects for the delivery of the full Accountable Care Model.

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2016
Meeting:	Trust Board
Agenda item:	16
Subject:	Fire Safety Policy
Reporting Officer:	Tony Humphries, Operational Property Manager

Action: This paper is for **(please tick)**					
Assurance		**Approval**	✓	**Decision**	

Purpose:

The purpose of this paper is to present the revised Trust wide Fire Safety Policy for final Trust rafification.

Introduction:

It is mandatory that all NHS organisations (excluding foundation trusts):

- comply with legislation relating to fire safety;
- follow evidence-based best practice guidance where reasonably practicable;
- ensure that suitable and sufficient governance and assurance arrangements are in place to manage fire-related matters and demonstrate due diligence;
- have in place a clearly defined management structure for the delivery, control and monitoring of fire safety measures, which is shared across the organisation;
- provide appropriate levels of investment in the estate and personnel to facilitate the implementation of suitable fire safety precautions;
- facilitate the development of partnership initiatives with stakeholders and other appropriate bodies in the provision of fire safety where reasonably practicable.

Analysis of Key Issues and Discussion Points Raised by the Report:

The first Trust Fire Policy was ratified in February 2013 and updated in March 2014 to meet the published Second Edition of the Health Technical Memorandum 05-01: managing healthcare fire safety. As required by HTM 05-01 procedures and protocols are to be developed separately to the trust Policy. The 2016 version has been updated to confirm organisation changes, but no significant technical changes.

Benefits:

Compliance with statutory legislation and DOH Policy.

Risks and Implications

The document provides for Policy for producing Protocols for Risk Assessment and controls.

Assurance Provided:

This Policy has been written and reviewed to comply with Health Technical Memorandum 05-01: managing healthcare fire safety (Second edition: April 2013)

Board Assurance Framework (please tick)	
Strategic Objective 1 - Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	✓
Strategic Objective 2 - Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences	
Strategic Objective 3 - Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.	✓

Review by other Committees/Groups (please state name and date)**:**

Trust Health & Safety Steering Group (September 2016).

Proposals and/or Recommendations

The author, on behalf of the Estates Management Team, requests approval of the Fire Policy to be ratified for trust wide implementation.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)

What risk to Equality & Human Rights (if any) has been identified from the impact assessment?

The Equality Act 2010 requires the adjustment of policies, practices and procedures and, where necessary, the building fabric, so as not to discriminate against disabled people. Site Risk Assessments and Operating procedures (including Emergency Action Plans and PEEPS) must take account of the requirements of the act.

The main principle of fire safety is that all people should be evacuated from a building in the event of fire. In terms of healthcare premises, this may not necessarily be the case for all situations. In hospitals, the concept of progressive horizontal evacuation is the norm. Existing fire legislation requires suitable evacuation procedures to be in place for all people using the building. The Fire Safety Manager must ensure that any staff required to assist with evacuation are adequately trained.

For further information or for any enquiries relating to this report please contact:

Name: Tony Humphries	**Contact details:** t.humphries@nhs.net 07780 956238

East Sussex Healthcare NHS
NHS Trust

Trust Fire Safety Policy

Version:	3.0
Ratified by:	Trust Policy Group
Date ratified:	
Name of author and title:	Tony Humphries, Operational Property Manager
Date Written:	August 2013 (updated March 2016)
Name of responsible committee/individual:	Trust Health & Safety Steering Group Alice Webster (Chair)
Date issued:	
Issue number:	
Review date:	3 years from ratified date
Target audience:	All Trust staff, agents and contractors
Compliance with CQC regulations:	Regulation 15 – 'Premises and Equipment'
Compliance with NHSLA/CNST:	
Compliance with any other external requirements (e.g. Information Governance):	The Regulatory Reform (Fire Safety) Order 2005 (RRO) DOH Policy The Health and Safety Management Regulations 1999
Associated Documents:	ESHT Health and Safety Policy ESHT Major Incident Plan ESHT Induction Policy ESHT Learning and Development Policy ESHT Mandatory Training Policy ESHT Risk Management Policy ESHT Incident Reporting and Management Policy ESHT Trust Security Policy ESHT Waste Policy

Did you print this yourself?
Please be advised the Trust discourages retention of hard copies of the policies and can only guarantee that the policy on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
2.0	November 2015	Tony Humphries	Revision to comply with HTM 05-01 (second edition) April 2013	Details of management procedures removed. To be provided in separate management “Fire Safety Protocols”
3.0	November 2015	Tony Humphries	Updated for organisational changes	Amend the Clinical Site Managers response to an incident. Reporting to the Switchboard removed.
3.0	November 2015	Tony Humphries	Updated for organisational changes	Amended the Job role of Fire Trainer to Fire Trainer /Fire Risk Assessor as from 1st August 2015.
3.0	November 2015	Tony Humphries	Updated for organisational changes	Amended the term Fire Safety Committee to Estates Fire Safety Management Group.
3.0	November 2015	Tony Humphries	Updated for organisational changes	Added and completed - Due Regard EQ&HR Analysis in Appendix C.

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Jan Ingram	Senior Fire Safety Advisor	August 2013
Estates SMT	Mark Paice, Mike Chewter, Mark Neal, Tony Humphries, Simeon Beaumont	September 2013
Commercial DMG	George Melling, Mark Paice, Stuart Barnhill, Vicki Rose, John Kirk	September 2013
Health & Safety Steering Group	All members and advisors	September 2013
Fire Safety Strategy Group	All Members and Advisors	December 2015
Health & Safety Steering Group	All members and advisors	January 2016

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. INTRODUCTION

East Sussex Healthcare NHS Trust (ESHT) is committed to the health, safety and welfare of all relevant persons in premises owned, occupied or the responsibility of ESHT.
ESHT will ensure that the risk of fire is reduced to the lowest possible level. When fires do occur, ESHT will ensure that they are rapidly detected and effectively contained.

The Trust fire safety management system comprises of the following:

- **Fire Safety Policy;**
- **Fire Safety Protocols:**
  - Fire prevention;
  - Risk assessments;
  - Fire strategies;
  - Emergency planning and procedures;
  - Fire safety training;
  - Construction and refurbishments;
  - Fire detection and alarm systems;
  - False alarms and unwanted fire signals;
  - Fire extinguishers;
  - Security;
  - Arson;
  - Hot works;
  - Maintenance of fire equipment;
  - Fire stopping;
  - Portable appliance testing;
  - Medical gases;
  - Purchasing;
  - Laundry;
  - Information for the fire and rescue service;
  - Salvage and continuity planning.
- **Fire safety information manuals;**
  - A description of the ward/department/area.
  - A brief description of the area, its extent, location and use.
  - A fire safety plan of the ward/department/area.
  - A fire safety checklist.
  - Emergency action plan specific to the ward/department/area.
  - Staff fire safety training records.
  - Records of fire drills and emergency fire action plan rehearsals.
- **Fire audit**

1.1. FireCode (HTM 05-02 & 05-03)

Firecode is a suite of guidance specifically covering fire safety in the NHS in England. It considers management, functional requirements, and operational provisions.
Whilst Firecode provides a means of achieving an acceptable standard of fire safety, the Department of Health recognises that alternative ways of achieving the same objectives may be possible. Where an alternative solution to Firecode is proposed, the designer must demonstrate that the approach does not result in a lower standard of fire safety than if Firecode had been applied.

1.2. Arson

Arson is a significant cause of fire in all types of premises. It is a cause for concern to those who are required to meet the costs of such fires, especially trusts because of the inherent life risk in most of the premises they occupy and the impact that fire damage may have on the wider provision of healthcare.

Key to the prevention of fire because of arson is effective security measures and housekeeping practices relating, in particular, to waste materials.

Trust Security and Waste Policies and Procedures will address the issues of arson as described in *Firecode – fire safety in the NHS Health Technical Memorandum 05-03: Operational Provisions, Part F: The prevention and control of arson in NHS healthcare premises.*

2. PURPOSE

Purpose
To provide an unambiguous statement of fire safety policy applicable to East Sussex Healthcare NHS Trust and to premises where patients of East Sussex Healthcare NHS Trust receive treatment or care, excluding a single private dwelling.

2.1. Rationale

Policy aims
This fire safety policy aims to minimise the incidence of fire throughout all activities provided by, or on behalf of, East Sussex Healthcare NHS Trust.
Where fire occurs, this policy aims to minimise the impact of such occurrence on life safety, the delivery of patient care, the environment and property.

2.2. Principles

Application
This policy applies wherever East Sussex Healthcare NHS Trust owes a duty of care to service users, staff or other individuals.

2.3. Scope

All East Sussex Healthcare NHS Trust staff and properties (leased or owned) fall within the scope of this policy.

All staff and properties must comply with legislation relating to fire safety.

ESHT must be satisfied that all new buildings, leased, or occupied under a PPP/PFI contract must comply with legislation relating to fire safety.

East Sussex Healthcare NHS Trust will ensure that appropriate and competent advice and guidance on all matters related to fire safety is available.

3. DEFINITIONS

Assembly point: a pre-determined area of safety where persons should assemble in the event of an emergency.

Authorising Engineer (Fire): a chartered fire engineer, or a chartered member of an appropriate professional body, with extensive experience in healthcare fire safety.

Child: a person who is not over the compulsory school age.

Compartmentation: the fire-resisting elements including walls, floors, and where applicable, roofs and/or other structures used in the separation of one fire compartment from another.

Competence: where a person is required to be competent, he/she must be able to demonstrate through training and experience or knowledge and other qualities that they have the ability to properly assist in undertaking the preventative and protective measures.

Competent Person (Fire): a person who can provide skilled installation and/or maintenance of fire-related services (both passive and active fire safety systems).

Complex healthcare organisations: hospitals or other healthcare premises that perform invasive procedures and other treatments that place a dependence on staff for evacuation.

Fire emergency action plan: the pre-determined plan that describes the actions necessary in the event of a fire to protect relevant persons and facilitate their safe evacuation.

A fire safety checklist: A schedule of the fire safety checks that should be undertaken on commencement of work by the person in charge of the area during that work period, including for example:

- check that the nearest fire alarm repeat panel displays a healthy condition;
- check that the manual call points are unobstructed;
- check that the fire extinguishers are in place and readily accessible;
- check that escape routes are clear and unobstructed;
- check that the fire doors that should be kept shut are fully closed;

Fire engineering: the application of scientific and engineering principles to the protection of people, property and the environment from fire.

Fire-fighting equipment: the fire extinguishers, fire blankets and other equipment made available to trained personnel for the purpose of fighting fire.

Fire resistance: the ability of an element of building construction, component or structure to fulfil, for a stated period of time, the required load-bearing capacity, fire integrity and/or thermal insulation and/or other expected duty in a standard fire resistance test.

Fire risk assessment: the process of identifying fire hazards and evaluating the risks to people, property, assets and the environment arising from them, taking into account the adequacy of existing fire precautions, and deciding whether the fire risk is acceptable without further fire precautions.

Fire Safety Adviser (Authorised Person: Fire): a person who has sufficient training and experience or knowledge and other qualities to enable them to properly assist in undertaking preventative and protective measures.

Fire safety management system: a robust framework of protocols and processes used to ensure that an organisation can fulfil all tasks required to achieve the fire safety objectives set out in the fire safety policy.

Fire Safety Manager: the person within the organisation tasked with coordinating fire safety issues throughout the organisation's activities.

Fire Safety Order: The Regulatory Reform (Fire Safety) Order 2005.

Fire safety policy: a high level statement of intent, as expressed by the board, partners, or equivalent controlling body, setting out clear fire safety objectives for the organisation.

Fire safety procedure: a detailed document setting out each step of a process intended to prevent fire, maintain fire precautions, minimise fire hazards or effectively respond to a fire incident.

Fire safety protocols: a set of organisation-specific guidelines that set the fire safety parameters of any activity that may impact on fire risk.

Healthcare building: a hospital, treatment centre, health centre, clinic, surgery, walk-in centre or other building where patients are provided with medical care, diagnostics or other associated treatment.

Hot works: Operations involving the use of open flames or the local application of heat or friction such as welding, soldering, cutting or brazing.

Material change: A change in arrangements or circumstances that may have an impact on the validity of fire risk assessments, fire precautions, fire emergency action plans etc.

Management level: standard or quality of the organisational fire risk management system.

Occupant dependency: the categorisation of occupants on the basis of their likely need for assistance to effect their safe evacuation in an emergency. The following categories are referred to in this Health Technical Memorandum:

- Independent: occupants will be defined as being independent: if their mobility is not impaired in any way and they are able to physically leave the premises without staff
    - if their mobility is not impaired in any way and they are able to physically leave the premises without staff assistance; or
    - if they experience some mobility impairment and rely on another person to offer minimal assistance. This would include being sufficiently able to negotiate stairs unaided or with minimal assistance, as well as being able to comprehend the emergency wayfinding signage around the facility.
- **Dependent**: all occupants except those classified as "independent" or "very high dependency".
- **Very high dependency**: those whose clinical treatment and/or condition creates a high dependency on staff. This will include those in critical care areas, operating theatres, coronary care etc and those for whom evacuation would prove potentially life-threatening.

Place of relative safety: an initial place away from the immediate danger of fire and from which further evacuation is possible to a place of safety.

Place of safety: a place where persons are in no danger from fire.

Premises: the land, building, or part of a building which is owned, occupied or managed by the organisation.

Preventative and protective measures: the measures which have been identified by the responsible person in consequence of a risk assessment as the general fire precautions necessary to comply with the requirements and prohibitions imposed by the Fire Safety Order.

Progressive horizontal evacuation: evacuation of patients away from a fire into an adjacent fire-free compartment on the same level.

Relevant person: any person who may be lawfully on, or in the immediate vicinity of, the premises and who is at risk from a fire on the premises.

Responsible person: the employer of persons working at the premises, a person who has control of the premises, or the owner of the premises.

4. Accountabilities and Responsibilities

Refer to Fire Safety Management Structure in appendix A

4.1. The "Responsible Person": Organisational Interpretation

The Regulatory Reform (Fire Safety) Order 2005 (RRFSO) states that the 'Responsible Person' is the Employer if the Workplace is to any extent under his control. Or

Any person who has control of a premise (occupier or otherwise) for the purpose of carrying on by him a trade, business or other undertaking (profit or not).Or

The owner where the person in control of the premises does not have control in connection with carrying on by that person a trade, business or other undertaking.

Article 5.3 RRFSO refers:

Duties on persons other than responsible persons to comply with the RRFSO to the extent they have control over the premises.

Article 5.4 RRFSO refers:

When a person has by virtue any contract or tenancy an obligation for the maintenance or repair of premises or the safety of premises they will be treated as the person who has control of the premises to the extent that their obligation so extends.

It is important to identify the 'Responsible Person(s) for each premises on the relevant Fire Risk Assessment and that their responsibilities are clearly defined in any Operating Procedures and Emergency Plans for that premises.

4.2. Executive Management

The Chief Executive has overall responsibility for the health, safety and welfare of all staff, service users, visitors and others within ESHT and is responsible for monitoring and reviewing health and safety in the Trust. This includes fire safety. The Trust Board will be informed of fire safety matters on a regular basis and ensure adequate resources are

made available to provide and maintain the necessary standards of fire safety in the Trust.

Members of the Executive Management Team have full responsibility for the health, safety and welfare of all staff, visitors and others within the wards, offices etc. under their specific management and will support the Chief Executive in fulfilling their responsibility.

All Directors have a corporate responsibility to promote a responsible approach in health, safety and fire in the Trust.

Appointing another person, who will undertake the duties of the 'Responsible Person' in his/her absence.

4.3. The Chief Executive

The Chief Executive is ultimately the Responsible Person for adherence to the RRFSO and is accountable for the establishment and achievement of fire policies within the Trust. The Trust Board is also responsible for establishing objectives, policy, priorities and the allocation of funds.

The Chief Executive will be supported in fulfilling this responsibility by other members of the Trust Executive Team.

4.4. Board Level Director (with responsibility for Fire Safety)

The Chief Executive will nominate a Board Level Director with responsibilities for Fire Safety.

The Chief Executive will be responsible for notification of any change of nominated Director.

The Director with Responsibility for Fire Safety is the Chief Operating Officer who is responsible for ensuring that all officers within the Trust, having a responsibility for fire safety matters, meet that responsibility.

The Director with responsibility for Fire Safety must be sufficiently empowered and have access to adequate resources and be able to influence and direct Staff.

4.5. Fire Safety Manager

The **Chief Operating Officer** is the Fire Safety Manager for East Sussex Healthcare and as such is responsible for, but not limited to, the following:

- An awareness of all fire safety features and their purpose;
- Fire safety risks particular to the organisation;
- Requirements for disabled staff and patients (related to fire procedures);
- Ensuring appropriate levels of management are always available to ensure decisions can be made regardless of the time of day;
- Compliance with legislation;
- Development and implementation of the organisation's fire safety policy;
- Development of the organisation's fire safety strategy;
- Development of an effective training programme;
- Cooperation between other employers where two or more share the premises;
- The reporting of fire incidents in accordance with current practice;

- Monitoring and mitigation of unwanted fire incidents;
- Liaison with enforcing authorities;
- Liaison with other managers;
- Monitoring of inspection and maintenance of fire safety systems.

The Fire Safety Advisor must be capable of assisting the Fire Safety Manager in discharging the roles and responsibilities outlined above.

4.6. Estates Fire Safety Management Group

The Estates Fire Safety Management Group will be responsible for the review of all fire safety matters. Standard agenda items will include the current estates strategy, fire safety management plan; construction projects fire incidents, unwanted fire incidents, enforcement action, and staff training.

The Estates Fire Safety Management Group will report to the Health & Safety Steering Group, on standard the agenda items.

4.7. Senior Fire Advisor and Fire Advisor (Authorised Persons: Fire)

East Sussex Healthcare Trust will directly employ Fire Safety Advisors, (Competent Persons) suitably qualified and in sufficient numbers.

The Fire Safety Advisor's role is to provide technical expertise to the Fire Safety Manager to enable them to fulfil their duties effectively.
The Fire Safety Advisors are responsible for the following:

- Ensuring that a fire risk assessment has been carried out
- Ensuring that regular fire safety training and fire drills are provided at suitable times to allow staff to participate. This training is to be appropriate to the needs of all staff and must reflect the diverse needs of all staff, e.g. limited English, visual impairment or hearing impairment.
- Providing expert advice on the application and interpretation of fire legislation and fire safety guidance, including FireCode;
- Advising on the content of the organisation's fire safety policy;
- Assisting with the development of the organisation's fire strategy;
- Helping with the development of a suitable training programme, including delivery of the training;
- Liaising with enforcing authorities on technical issues;
- Liaising with managers and staff on fire safety issues; and
- Liaising with the Authorising Engineer (Fire).

There may be occasions where specialist solutions are necessary to resolve fire safety issues, for example fire engineering. The Fire Safety Advisor would not necessarily be expected to have specialist skills, but would be expected to have sufficient knowledge to realise when they required specialised skills.

Trusts Fire Advisor(s) duties:

- When notified of a Fire, providing advice on formal responses to the Fire and Rescue Service during their enquiries.
- Provide specialist telephone support to enquiries from all relevant persons within the Trust.

- Provide a review of an existing Fire Risk Assessment within a reasonable time for premises that have been subject to material change
- Provide initial Fire Risk Assessments for new properties entering the Trust Portfolio
- Review existing Fire Risk Assessments annually
- Review fire risk assessments taking account building risks, e.g. compartmentation, fire detection etc.
- Provide an annual over view of the Trusts Fire Safety management procedures including :
  - Provide an annual review of the existing Fire Risk Assessments
  - Provide a review and learning outcomes of any fire related incidents as they occur
  - Review Unwanted Fire Alarm activations and indicate trends
  - Continuously improve the content of the Fire Safety training provided by the Trust and ensure bespoke training is provided
  - Provide specialist advice on Fire Safety management i.e. implementation of new policies and new technologies

4.8. Fire Safety Trainer/Fire Risk Assessor

Responsibility for the development, delivery, recording and monitoring of the fire safety training within the Trust and elsewhere, in accordance with any service level agreement that may be in place.

Provide co-ordinated advice and guidance on all aspects of fire training and associated activities across all properties and services within the Trust

To develop, deliver and review fire training for all relevant persons. This may include working outside normal hours.

To plan and implement a training programme for ESHT with the Senior Fire Advisor and to manage the Trust fire training records, course bookings and produce reports as required.

Provide a certificate of attendance, on request, to persons that have attended fire training.

To support the Fire Advisors and local managers in the organisation of fire warden training fire drills, witnessing the effectiveness of those drills and recommending appropriate remedial action where necessary.

To carry out “Suitable and Sufficient” Fire Risk Assessments as required by the AP(Fire) ensuring an action plan is identified and reported to the relevant manager/department to ensure all relevant remedial work is undertaken.

4.9. All Managers

Heads of Department and Line Managers are responsible for the operational management of fire related matters as part of their overall responsibility for health, safety and welfare of their Staff.

Each Head of Department and Senior Manager is responsible for the day to day maintenance of fire related matters within their areas of responsibility. All faults, defects

or omissions are reported and/or actioned. Close liaison with the responsible person is essential to ensure there is synergy within site fire safety management.

Managers are to ensure that all staff under their supervision participates annually in fire safety training and fire drills, and that a record of fire safety training is kept. Heads of Departments, Senior Managers and Managers must also ensure that new staff attends induction training before commencing in their role.

Heads of Department, Senior Managers, and Managers shall ensure that all newly appointed staff (including temporary, agency and bank members of staff) are inducted in the local fire procedures and fire instructions relevant to their premises as required. This induction is to include:-

- The actions in the event of fire
- Who to report to in the event of a fire
- To walk all escape routes
- The location of the fire alarm call points and the presence of automatic fire detectors
- How to operate call points (some units have key operation)
- The position of all fire fighting equipment in the working area
- The type and use of fire fighting equipment
- That security doors unlock when the alarm is activated and if not location of the security door break glass points. Whether there is a time delay on them.
- Familiarisation with the evacuation plan including progressive horizontal evacuation.

This is to be completed on their first day of employment (refer to the Trust Induction Policy checklist).
Managers will provide the employer of any person from an outside organisation, e.g. an agency providing temporary staff, with clear and relevant information on the risks to those employees and the preventive and protective measures taken.

This Includes providing those employees with appropriate instructions and relevant information about the risks to them. This information must be available in formats, which are comprehensible to all relevant persons.

4.10. Ward/Team Manager

Ward/Team Managers are responsible for:

- Ensuring the Action Plan from the current Fire Risk Assessment is actioned in conjunction with the Fire Advisors and Head of Maintenance
- Liaising with the Fire Safety Advisors to write a Fire Evacuation Plan.
- Retaining the Fire Evacuation Plan, the Fire Risk Assessment and Fire Warden Weekly check sheets in their workplace in an agreed format.
- The day to day management of fire safety, including maintaining records, training and supervising the upkeep of precautions
- Acting upon reports from the Fire Safety Advisors, and liaising with the Lead Manager for Fire Safety and the Site Fire Safety Manager with regard to the contents of the reports received
- Co-operating and sharing responsibilities for fire arrangements as required in the Regulatory Reform (Fire Safety) Order 2005
- Ensuring that fire instructions are brought to the attention of, and observed by every member of their staff, and that all staff participates in the fire training.

- Ensure that visitors are aware of the local Fire Safety procedures for their area of control / building
- Ensuring that there is always one or more Fire Wardens designated to ensure that the duties and obligations of the post are always discharged.

4.11. Clinical Site Manager (Acute Hospitals)

Clinical Site Managers are responsible for:

- Ensuring their availability should a fire incident occur
- Attending the scene, taking control and delegating tasks
- Liaising with the Fire and Rescue Service Manager
- Ensuring a successful conclusion to the incident.

4.12. Nominated Site Fire Safety Coordinators (Community)

In order to provide a coordinated approach in the Community settings the Premises Liaison Managers in the Community Settings will:

- Ensure that an adequate number of written fire instructions are displayed in conspicuous positions. This information must be available in formats which are comprehensible to all relevant persons.
- Ensuring those switchboard operators, receptionists and any other members of staff with a responsibility for calling the Fire and Rescue Service have written instructions, detailing the actions required in the event of a fire.
- Prepare and keep up to date general emergency action plans for the safe evacuation of patients, visitors and staff, taking into account the diversity of these persons. Ensuring that the emergency action plan is understood by all individual staff members.
- Coordinate weekly tests of their area of responsibility are carried out using the '**Fire Wardens Inspection Record Sheet'.**
- Consider the presence of any dangerous substances and the risks these present to relevant persons - will there be an outbreak of fire, establishing a suitable means of providing the emergency services with any relevant information about dangerous substances.
- Liaise with the Fire Advisers for the premises in relation to all fire matters and ensure such matters are acted upon as appropriate. i.e. risk assessments, drills, housekeeping, inspections, action plans etc.
- Organise fire drills/exercises for their premises and ensure they are conducted at least once per year to form an important part of staff training.
- Make a record of drills including date, time and outcome which should be kept on site in the Log Book so that they are available for inspection should this be required by officers from enforcing authorities.
- Review the outcome of specified drills and if ineffective will consult the Fire Safety Advisor so that any necessary improvements may be made.
- Audit and ensure that fire log book records are kept up to date.

4.13. Incident and Evacuation Officer (Community Sites)

In the cases of shared sites, the person in charge in the event of a fire could be from the host Trust (who have provided a Ward/Team Manager or equivalent role). However, the Trust must still provide Fire Wardens who will be responsible for day-to-day needs and communication with the host Trust on fire issues. In these cases teams will operate to the buildings fire plan.

Their principle duties are:

- The Incident and Evacuation Officer is responsible for calling for emergency services (999 / 112) when there is a fire, even if the alarm is connected to a dedicated line, call centre etc.
- To act as a focal point on fire safety issues for local staff:
- To organise and assist in the fire safety regime within local areas:
- To raise issues regarding local area fire safety with line management:
- To assist with coordination of the response to an incident within the immediate vicinity:
- To be responsible for roll-call during an incident;
- To support line managers on fire safety issues.

They must also co-ordinate and direct staff actions at a serious fire in accordance with the fire procedure.

Incident Officers (jointly with Team/Ward Managers) must ensure that all fire alarm activations are reported to the Fire Safety Advisors.

4.14. Fire Wardens

Staff will be nominated and trained to act as a local fire warden. They should supervise the day to day maintenance of fire precautions, support line managers to ensure that all staff participates in training and fire drills and co-ordinate and direct the actions of staff in a fire emergency.

Their principle duties include:

- Organising and assisting when evacuation is necessary:
- Raising local fire safety issues (e.g. housekeeping, fire doors being held open etc.) with line management;
- Assisting with coordination of the response to an incident within the immediate vicinity:
- Completing the Fire Wardens weekly checks and maintaining a record in the Trust Fire Wardens Log Book*;
- Reporting fire safety issues to their line manager ;
- Attending a bespoke Fire Warden training course every 3 years.

  *The Fire Wardens Log Book is located on the Fire Safety homepage on the extranet.

4.15. Fire Team (Acute Hospitals)

The Fire Team is comprised* of:

- The Clinical Site Manager
- Nominated Maintenance , Security and Portering Staff

Nominated Staff are provided with handheld radios and bleeps.

Clinical Site Manager - on activation of the Fire Alarm

The Clinical Site Manager will be contacted by the Switchboard in the event of alarm activation by the internal pager system and will attend any relevant Medical Area.

In liaison with the local Manager a plan of action will be formulated.

The Switchboard, on calling the Fire and Rescue Service are to confirm to the Clinical Site Manager that the call has been made. This can be done via the radio network.

The Clinical Site Manager should take control of any evacuation required.

The Clinical Site Manager should liaise with the switchboard and the Fire Team who will inform theatres etc. of the progress of the incident via the portable radios held by porters and maintenance staff.

For a more protracted incident, the involvement of the emergency services will mean a detailed handover of information to the Fire and Rescue Service is required.
An aide memoir is provided and may be used to bring the incident to a conclusion.

When satisfied that the situation is under control, or that a false alarm situation has arisen the Clinical Site Manager can authorise the fire alarm to be silenced. As necessary and only if the Fire and Rescue Service have not been called they may also authorise the resetting of the alarm system.

The Fire Team- on activation of the Fire Alarm

The team will be contacted by the Switchboard in the event of alarm activation by the internal pager system.

*The number of persons comprising the initial attendance of the fire team will vary according to the time of day or night.

When informed of the incident, members of the team are to;

Proceed to the locality of the alarm and in liaison with the Clinical Site Manager and Local Manager identify the cause of the alarm activation.

If a fire has occurred the Fire Team should carry out a dynamic risk assessment and if safe to do so, contain the fire until the arrival of the Fire and Rescue Service.

The Fire Team should assist the Clinical Site Manager and Local Manager to control any evacuation in the vicinity of the fire and prepare for further evacuation as necessary.

The Fire Team should control the perimeter of the area / building to prevent unauthorised entry into risk area

On information from the Clinical Site Manager or the Switchboard, the Fire Team will inform theatres etc. of the progress of the incident via the portable radios held.

One member of Fire Team will go to the main entrance and direct the emergency services to the most appropriate access point to the incident.

One member of Fire Team will ensure that the local access point is available for the emergency services to enter the building.

Once on site the Fire and Rescue Service will take charge of the incident. Any relevant information will be passed to the Senior Fire and Rescue Service Manager.

The Fire Team will attend the debriefing after any incident.

If fire fighting action is to take place it must be done in a manner that will not place any members of staff or others at risk. The action taken to attack the seat of the fire must be carried out only if those doing so can be certain that they can extinguish it, or contain it until the fire brigade arrive.

The identification of any other areas that may become involved should be addressed by setting a fire watch, closing doors, securing access points and clearing others at potential risk.

The On Call Manager (Conquest and Eastbourne DGH): Protracted Incident Procedure.

The On - Call manager will ensure that they attend the Fire and Rescue Service control point to undertake the management role on behalf of the Trust.
They will liaise with all other departments to ensure that they are kept aware of incident operations and trends.
They will inform the duty site manager that they have arrived and indicate whether or not they are taking over the control of the incident or providing an overview, with any necessary additional help or assistance being given.

The On-Call Manager together with the site manager will ensure that suitable staff are assigned to assist in the evacuation of the affected and adjacent areas in liaison with the Senior Fire and Rescue Service Manager.

Together with the senior nursing officer present, the On-Call Manager will ensure that patients are provided with any necessary medical assistance and as necessary liaise with designated hospitals in the transfer of patients for continuance of care.

The On-Call Manager may call upon the assistance of any other member of staff to assist them in the undertaking of their role at the time of the incident.

The On-Call Manager will ensure that the health, safety and welfare of each affected patient or member of staff involved in the incident is maintained at all material times.

4.16. Estates & Facilities Division

The Operational Divisions of the Estates & Facilities Division has the following responsibilities for fire safety:

Ensuring that contractors engaged on work that creates hazards, such as burning, welding, painting or woodworking are trained to a high standard of fire safety and, also, that 'hot work' procedures are followed, where appropriate. This training is to be appropriate to the needs of the relevant member of staff and must reflect his/her needs, e.g. limited English, visual impairment or hearing impairment.

Ensuring that the premises and any equipment provided in connection with fire fighting, fire detection and warning, or emergency routes and exits are covered by a suitable system of maintenance and are maintained by a competent person in an efficient state, in efficient working order and in good repair.

- Ensure that the fire detection systems are tested in accordance with BS 5839, Part 1 (2002) - Testing & Maintenance
- Ensure that fire alarm systems are tested and maintained to the following regime:
- Bells / sounders tested on a weekly basis
- All initiating devices (call points, detectors etc.) tested on an annual basis
- Ensure that fire fighting appliances are maintained to BS 5306-3 2009.
- Ensure that all Fire Exit signs are checked at regular intervals to ensure compliance with the Safety Signs regulations 1996 and accordance with BS 5499, Part 1 "Specification for Fire Safety Signs" (which includes standard colour-coding)
- Ensure the storage of flammable liquids and the recommendations of FPN2 "Storage of Flammable Liquids" and HSG 51 "Storage of Flammable Liquids in Containers" have been followed
- Ensure the storage of flammable compressed gases and oxygen are safe and follow regulatory standards and Approved Codes of Practice.
    - Ensure that all personnel that work on and manage fire alarm systems, have appropriate and relevant training, and the details of their training have been documented
    - Cooperate with the Trust and its agents in monitoring the above responsibilities by evaluating that the above are carried out to the appropriate standards including the British Standards listed and recommendations made in the HTM 05 (FireCode) series of documents

4.17. Authorising Engineer (Fire)

There may be occasions where specialist solutions are necessary to resolve fire safety issues, for example fire engineering. The Fire Safety Advisor would not necessarily be expected to have specialist skills, but would be expected to have sufficient knowledge to realise when they required specialised skills.

NHS organisations are not required to appoint an Authorising Engineer (Fire) in a permanent capacity. Where deemed necessary by the Fire Safety Advisors a fire engineer will be engaged if a specific fire-engineered solution has been identified or is proposed, and the in-house resources have limited expert knowledge.

In seeking to appoint an Authorising Engineer (Fire), NHS organisations should approach the Institution of Fire Engineers (www.ife.org.uk) or the Association of Fire Consultants (www.afc.eu.com) for further guidance and information regarding fire engineers. An Authorising Engineer (Fire) should be able to demonstrate competence.

4.18. Competent Persons (Fire)

This will be a person external to the organisation who provides skilled installation and/ or maintenance of fire-related services (both passive and active fire safety systems). The Competent Person (Fire) must be able to demonstrate a sound knowledge and specific skills in the specialist service being provided.

4.19. Enforcing Authority visits to ESHT sites

In the event that the Fire Authority should request a visit to any ESHT site, a Fire Advisor will meet the Fire and Rescue Service representative.
If any notice or guidance is received the Fire Advisors must inform the most senior operational person on the site of the contents of the notice or guidance.

In the event that the Fire Authority should make an unannounced inspection of the suite, as with any regulatory Authority, the most senior operational person on the site or area will meet with the Fire Authority and subsequently contact the Fire Advisors to liaise regarding notices received or guidance given.

4.20. All staff, contract staff and volunteers

All staff, contractors and volunteers will:

- comply with the trust's fire safety protocols and fire procedures;
- participate in fire safety training and fire evacuation exercises where applicable;
- report deficiencies in fire precautions to line managers and Fire Wardens;
- report fire incidents and false alarm signals in accordance with trust's protocols and procedures;
- ensure the promotion of fire safety at all times to help reduce the occurrence of fire and unwanted fire alarm signals;
- set a high standard of fire safety by personal example so that members of the public, visitors and students when leaving trust premises take with them an attitude of mind that accepts good fire safety practice as normal.

5. PROCEDURES AND ACTIONS TO FOLLOW

Facilitation

The Trust Board will:

- Discharge its responsibilities as a provider of healthcare to ensure that suitable and sufficient governance arrangements are in place to manage fire-related matters;

- Provide appropriate levels of investment in the estate and personnel to facilitate the implementation of suitable fire safety precautions;

- Facilitate the development of partnership initiatives with stakeholders and other appropriate bodies in the provision of fire safety where reasonably practicable.

Implementation

The Trust Board expects those tasked with managing aspects of fire safety to:

- Diligently discharge their fire safety responsibilities as befits their position;

- Have in place a clearly defined management structure for the delivery, control and monitoring of fire safety measures;

- Have in place a programme for the assessment and review of fire risks;

- Develop and implement appropriate protocols, procedures, action plans and control measures to mitigate fire risks, comply with relevant legislation and, where practicable, codes of practice and guidance;

- Develop and disseminate appropriate fire emergency action plans pertinent to each department/building/area to ensure the safety of occupants, protect the delivery of service and, as far as reasonably practicable, defend the property and environment;

- Develop and implement monitoring and reporting mechanisms appropriate to the management of fire safety.

- Develop and implement a programme of appropriate fire safety training for all relevant staff;

6. EQUALITY AND HUMAN RIGHTS STATEMENT

The Equality Act 2010 requires the adjustment of policies, practices and procedures and, where necessary, the building fabric, so as not to discriminate against disabled people. Site Risk Assessments and Operating procedures (including Emergency Action Plans and PEEPS) must take account of the requirements of the act.

The main principle of fire safety is that all people should be evacuated from a building in the event of fire. In terms of healthcare premises, this may not necessarily be the case for all situations. In hospitals, the concept of progressive horizontal evacuation is the norm. Existing fire legislation requires suitable evacuation procedures to be in place for all people using the building. The Fire Safety Manager must ensure that any staff required to assist with evacuation are adequately trained.

7. TRAINING

Fire Safety training is a Mandatory requirement and is outlined in the **Fire Safety Training Plan** developed in accordance with the Trust Training Needs Analysis (TNA). Training sessions will include the need for Personal Emergency Evacuation Plans and general awareness of access needs for Disabled People.

7.1. Fire Drills

Fire drills will be undertaken at least once a year in all premises occupied by East Sussex Healthcare NHS Trust staff. They shall be arranged by the Ward/ team manager or Premises Liaison Manager in community settings, supported by advice from the Fire Safety Advisors, upon request.

Fire drills are training sessions that test the effectiveness of the emergency plans and the fire safety training. They will rehearse procedures and do not necessarily involve the total evacuation of the building/area. Fire drills need not involve moving patients or visitors and at no time will fire drills endanger those taking part. In all cases, the interest of and care of patients and visitors will be a paramount consideration.

All new and temporary staff will be given an induction into the procedures and their responsibilities on their first day. They will attend an induction course within one month of their start date or for non-clinical personnel, complete the on line induction course.

Training arrangements are subject to a full Training Needs Analysis

8. MONITORING COMPLIANCE WITH THE DOCUMENT

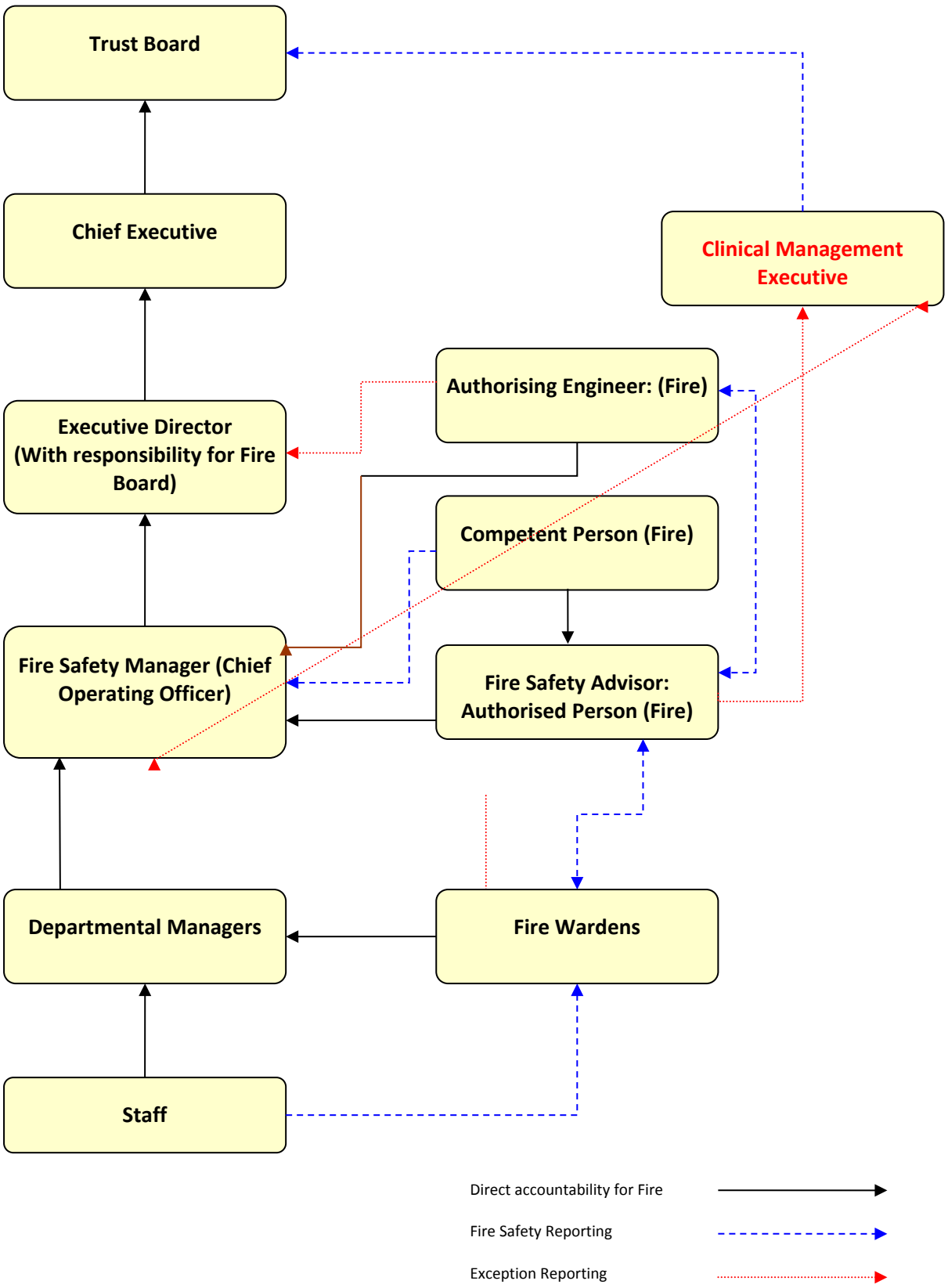
9.1 Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Review of fire and false alarm incident reports;	Senior Fire Advisor	Incident / reports / Data base	Monthly	Fire Safety Team	Fire Safety "Committee". Hosted by The Trust Health and Safety Steering Group (HSSG)	Fire Safety Manager
Review of fire safety training records	Senior Fire Advisor	Data base	Annual	Fire Safety Team	Fire Safety "Committee". Hosted by The Trust Health and Safety Steering Group (HSSG)	Fire Safety Manager
Review of fire service notices and communications;	Senior Fire Advisor	Risk Assessment	Annual	Fire Safety Team	Fire Safety "Committee". Hosted by The Trust Health and Safety Steering Group (HSSG)	Fire Safety Manager
Third-party fire safety audit	Operational Property Manager	Fire Safety Audit report	Annual	Fire Safety Team	Fire Safety "Committee". Hosted by The Trust Health and Safety Steering Group (HSSG)	Fire Safety Manager

9. REFERENCES

- Health & Safety at Work etc., Act 1974
- The Building Act 1984
- The Building Regulations 1985 (as amended 2000)
- Regulatory Reform (Fire Safety) Order 2005
- HTM 05-01: Managing Healthcare Fire Safety
- HTM 05-03: Part A-K: General fire safety
- HTM 05-03: Part B: Fire detection and alarm systems
- HTM 05-03: Part H: Reducing false alarms in healthcare premises
- Healthcare Commission Core Standards

Appendix A – Fire Safety Management Structure



Appendix B – EHRA Form

Due Regard, Equality & Human Rights Analysis

Title of document: Fire Policy
Who will be affected by this work? All Relevant Persons
Please include a brief summary of intended outcome: Compliance with CQC Regulation 15 – 'Premises and Equipment' Compliance with all Firecode HTMS and the Regulatory Reform (Fire Safety) Order 2005

		Yes/No	Comments, Evidence & Link to main content
1.	**Does the work affect one group less or more favourably than another on the basis of:** (Ensure you comment on any affected characteristic and link to main policy with page/paragraph number)		
	• Age	No	
	• Disability (including carers)	No	
	• Race	No	
	• Religion & Belief	No	
	• Gender	No	
	• Sexual Orientation (LGBT)	No	
	• Pregnancy & Maternity	No	
	• Marriage & Civil Partnership	No	
	• Gender Reassignment	No	
	• Other Identified Groups	No	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	No	(Ensure you comment and link to main policy with page/paragraph number)
3.	**What are the impacts and alternatives of implementing / not implementing the work / policy?**	Compliance with CQC Regulation 15 'Premises and Equipment' Non -Compliance with all Firecode HTMS and the Regulatory Reform (Fire Safety) Order 2005 -1.1 Firecode Page4	

4.	**Please evidence how this work / policy seeks to "eliminate unlawful discrimination, harassment and victimisation" as per the Equality Act 2010?**	Introduction Page 4
5.	**Please evidence how this work / policy seeks to "advance equality of opportunity between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	Introduction Page 4.
6.	**Please evidence how this work / policy will "Foster good relations between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	Introduction Page 4.
7.	**Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)**	Purpose .Page 5.
8.	**Please evidence how have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?**	Purpose .Page 5.
9.	**Have you have identified any negative impacts or inequalities on any protected characteristic and others? (Please attach evidence and plan of action ensure this negative impact / inequality is being monitored and addressed).**	No

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2016
Meeting:	Audit Committee
Agenda item:	17
Subject:	Annual Review of Corporate Documents
Reporting Officer:	Lynette Wells, Director of Corporate Affairs Jonathan Reid, Director of Finance

Action: This paper is for **(please tick)**					
Assurance		Approval	√	Decision	

Purpose:

The Trust Board is asked to accept the Audit Committee's recommendation to approve the proposed revisions to the Standing Orders, Standing Financial Instructions, Schedule of Matters Reserved to the Board and Scheme of Delegation.

Introduction:

The Trust Board is required to review its Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation on an annual basis.

Analysis of Key Issues and Discussion Points Raised by the Report:

- Standing Orders cover all aspects of the conduct of the Trust, including governance, committees and their duties and responsibilities.
- The Scheme of Delegation lays down in detail the specifics of committee responsibilities and duties together with that of the executive and the officers to which delegated authority has been designated.
- The Standing Financial Instructions detail the financial conduct and governance of the Trust and requirements therein.

Proposed revisions to these three documents are outlined in the attached appendix.

Benefits:

Annual review supports the strengthening of internal controls, recognise changes in the health care environment and ensure compliance with legislation.

Risks and Implications

None identified.

Assurance Provided:

The annual review provides assurance that the Trust's key corporate governance documents remain fit for purpose.

Consideration by other Committees

Audit Committee 23 November 2016

Proposals and/or Recommendations
To approve the proposed changes to the Standing Orders, Standing Financial Instructions and Schedule of Matters Reserved to the Board and Scheme of Delegation.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
None identified.

For further information or for any enquiries relating to this report please contact:	
Name:	**Contact details:**
Lynette Wells, Director of Corporate Affairs	lynette.wells2@nhs.net

Appendix A

Annual Review of Corporate Documents

Standing Financial Instructions		
Page No	**Section**	**Revision**
12	2.5.1	Trust now appoints the external auditors, not the Audit Commission (see also corresponding change to 4.2)
14	3.1.2 (d)	(..budgets will) be prepared, *as far as reasonably practicable*, within the limits of available funds. Words in italics have been added to recognise that it may be necessary to prepare deficit plans in some circumstances.
15	3.3.1	The following reporting requirement has been added:- *vi) Identification and evaluation of financial risks to the achievement of plan and their potential mitigation*
24	7.5.3 (n)	The following has been added to clarify circumstances in which a waiver of tender can be considered:- *(except in circumstances outlined in 7.5.3 (k) above)*
25	7.6.1, 7.6.2 & 7.6.3	References to hard copy tender returns deleted, as this is no longer the practice.
37	9.3.1 (a)	Authority to appoint staff is changed from authorisation by the Chief Executive to refer to compliance with agreed policies and procedures.
37	9.4.1 & 9.4.2	Responsibility for Payroll changed from Director of Finance and Director of HR to just Director of Finance
39	10.1.1	Changed to enable authority for non-pay expenditure to be delegated from the Chief Executive to the Director of Finance
45	13.1.2 (c)	It is proposed to increase the value of capital projects above which a risk assessment should be carried out by the Head of Financial Services and relevant Project Director from £250k to £500k in order to improve compliance and reflect a more appropriate materiality level.
45	13.1.2 (d)	It is proposed to increase the value of capital projects above which a monthly capital monitoring return should be submitted to Finance from £250k to £500k in order to improve compliance and reflect a more appropriate materiality level.
63		Tendering waiver form redesigned to specify and clarify that the order of sign off should be, as applicable:- Head of Procurement, Director of Finance, Chief Executive

Schedule of Matters Reserved to the Board and Scheme of Delegation		
Page No	**Section**	**Revision**
7	13 – Chief Executive	Reference to Audit Commission removed.
14	1.3.7 (d) – Director of Finance	Amended to 'Providing financial advice to members of the Board and *the wider organisation*'
15	2.3.4	Amended to '*Provide reports as agreed with the Director of Finance and* in accordance….'
15	2.4.1	Amended to 'compliance with the Secretary of State's

		Directions on fraud, *bribery* and corruption…'
17	7.6.3	Deleted delegation to Chief Executive for maintaining a register to show each set of competitive tender invitations dispatched.
18	7.6.8	Amended delegation from Chief Executive to Director of Estates and Capital Development
18	7.7.4	Amended to 'authorisation of the Chief Executive *or Director of Finance'*
18	9.1.4	Deleted as not in line with the Trust's SFIs
19	9.1.4	Deleted as not in line with the Trust's SFIs
19	9.3	Deleted delegation to Chief Executive for Staff, including agency staff, appointments and re-grading.
19	9.4.1 & 9.4.2	Amended to remove delegation for these items to Director of Human Resources
21	11.5	Amend to read 'Be on an authorising panel comprising one other member *for applications for* short term *borrowing'*
22	13.1.2	Updated totals to: c) for all business cases over *£500,000* a risk assessment is completed *(previously £250k)* d) for all projects of £500,000 the project director is required to complete a capital monitoring form *(previously £250k)* f) ensure that capital expenditure over £1000k whole life cost) is approved by the Regulator *(previously £500k)*
23	13.3.7	Amend to read 'Ensure that a review of asset lives is undertaken annually'
23	14.2	Changed delegation from Director of Finance to Head of Procurement
23	14.2	Amended to remove reference to oil
24	14.7	Changed delegation from Director of Finance to Head of Procurement/Pharmaceutical Officer
24	14.7	Changed delegation from Nominated Officers to Head of Procurement/Pharmaceutical Officer
26	15.2.3	Amended CFSMS Regional Team to CFOS
27	16.7	a) Amended to 'systems acquisition, development and maintenance are in line with corporate policies *and IM&T Strategy*' c) Amended to '*Relevant staff* have access to such data'
28	18.3.1	Amended to read 'relevant sections of SFIs are applicable to charitable funds'
28	20	Amended HSC 1999/053 to 'Department of Health guidance'
28	21.1.	Amended to read '*Ensure that the Trust has a* risk management programme.'
28	21.5 & 21.6	Moved reference to risk pooling schemes administered by the NHS Litigation Authority from 21.5 to a separate item at 21.6.
35	m)	Amended to remove reference to 'normal retirement age' and added reference to Trust retirement policy.
40	29	Removed reference to 'NHS purchasers' and replaced with 'NHS commissioners of healthcare'

Standing Orders		
Throughout the document		Reference to Trust Development Authority will be revised to 'the Regulator'
20/21	4.8.1/4.8.2	Remove The Higgs report recommends a minimum of three non-executive directors be appointed, unless the Trust Board decides otherwise, of which one must have significant, recent and relevant financial experience.
20	4.8.3	**Quality and Standards Committee** Amend to 'Quality and Safety Committee" Revise quorum from 3 to 2 non-executive directors
20	4.8.5	Addition of People and Organisational Development Committee The Trust Board will establish a people and organisational development committee to assure itself that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting the Trust objectives and organisational success The Terms of Reference will be approved by the Trust Board and reviewed on at least an annual basis. The Committee and Committee Chairman shall be appointed by the Chairman of the Board and should comprise of at least two non-executive directors.
21	4.8.4	**Finance and Investment Committee** Composition of membership. Remove - but not be the Audit Committee Chairman.
22	4.10	**Remove as duplicated in 5.6** **Overriding Standing Orders** – If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.
22	5.12/.13	Remove as The Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 not relevant.
23	5.6	**Duty to report non-compliance with Standing Orders and Standing Financial Instructions** Remove as duplicated in 4.10
	6.3/6.4	**Remove reference to SFIs and guidance as duplicated in the document**
30	7.7.3 v)	**Non-Competitive Quotations** Addition of: v) Where the goods or services are purchased through

		charitable funds /donations from Leagues of Friends, provided that a value for money evaluation has been undertaken.
32	8.4	**Signature of Documents** Addition: The Company Secretary may act as a counter signatory if required.

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Wednesday 21st September 2016 at 10.00am in Room 5, Education Centre, Conquest

Present: Mr Mike Stevens, Non-Executive Director (Chair)
Mr Barry Nealon, Non-Executive Director

In attendance Dr Tim Arnold, Consultant Anaesthetist (for items 052/16 & 053/16 only)
Mrs Jayne Cannon, Head of Nursing (for items 052/16 & 053/16 only)
Ms Janine Combrinck, Director, BDO
Mrs Michele Elphick, General Manager, (for items 052/16 & 053/16 only)
Mr John Kirk, Facilities Manager (for item 060/16 only)
Mr Tim Leakey, Clinical Governance Manager (for items 052/16 & 053/16 only)
Mr Chris Lovegrove, Counterfraud Manager, tiaa
Mr Adrian Mills, Audit Manager, TIAA
Mrs Emma Moore, Clinical Effectiveness Lead
Mr Jonathan Reid, Director of Finance
Mr Paul Relf, Head of Nursing (for items 052/16 & 053/16 only)
Mr Mike Townsend, Regional Managing Director, tiaa
Dr David Walker, Medical Director
Mrs Lynette Wells, Director of Corporate Affairs
Mrs Alice Webster, Director of Nursing

Mr Pete Palmer, Assistant Company Secretary (minutes)

Action

049/16 Welcome and Apologies for Absence

Mr Stevens opened the meeting and introductions were made.

Apologies for absence were received from:

Mr David Clayton-Smith, Chairman
Mrs Sue Bernhauser, Non-Executive Director
Dr Adrian Bull, Chief Executive
Mr Stephen Hoaen, Head of Financial Services

050/16 Minutes of the meeting held on 20th July 2016

i) The minutes of the meeting held on 20th July 2016 were reviewed and were agreed as an accurate record.

ii) Matters Arising

The following verbal updates were provided:

041/16 – Clinical Audit – Forward Plan 2016/17
Dr Walker explained that he would be meeting with Mrs Moore to discuss management of clinical audits.

051/16 Board Assurance Framework and High Level Risk Register

Mrs Wells presented the Board Assurance Framework (BAF) and High Level Risk Register.

She noted that four areas of the BAF had areas that were rated as red:

- Emergency department reconfiguration/patient flow
- Patient transport
- Finance
- Mortality

Mrs Wells proposed that the gap in control relating to the Trust not having an aligned estates strategy should be removed, as the Trust had now developed a strategy.

Mrs Webster reported that fortnightly meetings were taking place with both Coperforma and the CCG in order to monitor patient transport services. She explained that the Trust was not satisfied with the current provision of patient transport, and noted that the Trust was recharging transport costs to the CCG where appropriate.

Mr Nealon asked about actions being taken to resolve the issues within the Emergency Department. Dr Walker reported that the Urgent Care Board had met, and that the Trust's urgent care model was being revised. He explained that there was a national shortage of A&E doctors and staffing was an issue in both emergency departments. Dr Walker reported that specialist input had been received in order to improve patient flow from A&E, but that recruitment of additional staff would be key to resolving the issues.

The Committee reviewed and noted the revised High Level Risk Register and Board Assurance Framework and were of the view that the main inherent/residual risks had been identified and that actions were appropriate to manage the risks.

The Committee recommended the removal of the gap in control relating to estates strategy from the Board Assurance Framework.

052/16

i) Theatres & Clinical Support Clinical Audit & Risk Register Review

Mr Leakey presented the Theatres and Clinical Support Clinical Unit's (CU) Audit and Risk Register review to the Committee.

Risk Register

Mr Leakey reported that the CU had thirty risks open on their register, with six being rated as adequate, three as uncontrolled and twenty one as inadequate. He noted that due to the recent reorganisation of CUs a number of risks relating to pharmacy would move to the Out of Hospital CU's risk register. Mrs Webster said that she would be happy to meet with Mr Leakey, Mr Relf and Mrs Cannon in order to review the risks relating to pharmacy prior to their transfer to the Out of Hospital risk register. **AW**

Mrs Wells asked about the process for marking risks as being inadequate, and Mr Leakey explained that there had been a recent directive that control of risks should be rated as either adequate, uncontrolled or inadequate. Mrs Wells said that she would speak to the Risk team about changing ratings to either controlled or uncontrolled to allow mitigating actions which were reducing risk to be taken into account. **LW**

Mr Stevens asked for the CU to include timescales for actions on their risk register, as these were missing.

In response to a query from Mr Nealon, Mr Leakey explained that the CU's biggest risk was a lack of experienced staff. Mrs Elphick explained that the CU was experiencing issues with having to rearrange surgical patients as a result of day due to bed pressures. She said that she hoped that the new medical model would help to alleviate the pressure felt within the Trust. Mrs Wells explained that, following review, this issue would be added to the corporate risk register if it was rated above 15 by the CU, and that it would be added to BAF if it became a significant risk to the Trust.

Audit

Mr Leakey reported that the CU was undertaking seven major audits, some of which were interlinked with surgery. He explained that the introduction of VitalPAC Doctor to the Trust would allow access to a greater number of audit tools for the CU. Mr Reid said that he would find out the expected date for implementation of VitalPAC Doctor in order that it could be publicised throughout the Trust. **JR**

In response to a question from Dr Walker, Mr Leakey explained that

two of the audits currently underway were national audits, and seven were instigated locally. Mrs Cannon noted that the CU had a number of audits which had remained incomplete for some years and that it was working to close these. Mr Reid asked whether the CU's audit plans were aligned with those of the Trust, and Mrs Moore replied that she was not aware of any discrepancy between the plans.

Dr Walker asked how often the CU held divisional audit meetings and Mrs Moore replied that these took place every two months. She noted that a register of attendance was taken at each meeting. Dr Walker explained that he expected doctors to attend 60-70% of audit meetings during each year, and that this figure should be fed back to doctors during their appraisals to ensure attendance. He asked whether the information could be automatically generated for consultants every year, and Mrs Webster replied that a business case for a role that would provide this information had been completed, and that she would find out how this was progressing. **AW**

Mrs Moore explained that the Clinical Audit team maintained a register of audits being carried out within the Trust, along with any actions and records of their completion or if they were abandoned. Mr Stevens asked what happened to those that were not recorded as abandoned, but that had been on the register for some time with no progress. Mrs Moore replied that the register was reviewed at clinical audit meetings, governance groups and audit meetings to ensure that it was up to date. She explained that if no comments about audit progress were received then Dr James Wilkinson decided if audits should be removed from the register.

ii) Surgery Clinical Audit & Risk Register Review

Mr Leakey presented the Surgery CU's Audit and Risk Register review to the Committee.

Risks

Mr Leakey reported that the CU had eleven adequate, three uncontrolled, and ten inadequate risks. He noted that the IT department were working to resolve the performance issues being experienced by the diabetic eye screening team, and that Public Health England had given the Trust a three month period in which to resolve the problems.

Mr Leakey highlighted the risk that existed due to the lack of Oxygen cylinders on Cookson Devas Ward, explaining that a full business case had been requested for the work needed. He noted that separate oxygen cylinders were provided for each patient in order to manage the situation. Mr Stevens asked if the business case process could be reviewed, as he didn't feel that vital work should be

held up by administrative processes, and Mr Reid agreed to review the process to see if it could be streamlined. **JR**

Mr Leakey reported that repairs to the patient's kitchen on Michelham Ward to prevent water ingress were due to take place in autumn. Mr Stevens explained that he was concerned that financial processes were slowing down essential work within the Trust, and Mr Reid responded that the Trust was working to make decisions more quickly, and to support the estates team to feel empowered to make improvements.

Mr Nealon asked whether the recent opening of Apex Way had improved the availability of medical records. Mrs Cannon replied that there were no issues with the availability of notes for patients having surgery, but that there had been issues with the availability of clinic notes during the transition to the new facility. She noted that this had recently improved, but that some issues still existed.

Audit

Mr Leakey reported that the CU were awaiting responses from a number of clinicians in order to remove some unfinished audits from their register.

Mrs Cannon reported that the CU's Surgical Surveillance for knee and hip replacement had placed the Trust well below the national average for infection for the fourth year running. Mr Stevens praised the CU for the result, and asked that they ensured that this good news was shared throughout the Trust.

053/16 Clinical Audit Forward Plan

Mrs Moore noted progress on mandated national audits, explaining that four mandatory audits were currently 'red' rated:

- National Adult Diabetes Audit
- Asthma (paediatric and adult) care in emergency departments
- Severe Sepsis and Septic Shock – care in emergency departments
- National Audit of Management of Intra-abdominal sepsis

Mrs Moore explained that the Trust was unable to carry out the National Adult Diabetes Audit as it did not have the software required due to the cost of purchase. She reported that a business case was being written to look at different software which would enable participation, and that the preferred software would enable the diabetic department to collect data additional to that required for the audit. Mrs Moore explained that while the work could technically be undertaken without the software, it was a very time-consuming process. Dr Walker agreed to meet with Dr Dashora, the lead for

Diabetic Audit, in order to discuss resolution of this issue. **DW**

Mrs Moore reported that concerns raised over two Royal College of Medicine audits within her report had now been resolved, and that the Trust was now registered to participate in the National Audit of Management of Intra-abdominal sepsis, with a Trust lead identified.

She reported that she was concerned that the Trust would not be able to fully complete the National Audit of Dementia, as this required 50 cases on each site to be reviewed by the 6th October. Mrs Moore explained that 28 cases had been reviewed at Eastbourne and 19 at the Conquest, and that she was struggling to find staff who could review the notes. She noted that the Trust would be liable for a substantial financial penalty if the audit was not fully completed. Mrs Webster said that she would help Mrs Moore to identify staff who could complete the audit. **AW/EM**

Mr Stevens asked how issues regarding completion of audits were escalated through the organisation, and Mrs Moore, replied that issues were discussed at the Clinical Effectiveness Group and then escalated to the Audit Committee if necessary.

The Audit Committee noted the Clinical Audit Forward Plan.

054/16 Internal Audit

i) Progress Report

Mr Mills explained that that the progress report provided the Committee with an update on work that had been undertaken by TIAA since July.

He reported that the audit of Medical and Dental Locums had been finalised, being given limited assurance, and that the key finding was the annual amount paid to locums in excess of Trust rates. He explained that Trust management had agreed to take robust actions in order to upgrade existing processes to control this spending.

Mr Mills reported that four draft audit reports had been issued; those on procurement and end of life care being given limited assurance, one on serious incidents that had given reasonable assurance and one operational review of CQC compliance of wards which carried no assurance rating. He explained that a lot of progress was being found in all the areas being reviewed, which may not be reflected in the level of assurance given as work continued to be progressed and embedded within the organisation.

The Committee noted the Internal Audit Progress Report.

ii) Audit Recommendations Tracker

Mr Mills explained that he was asking the Committee for approval to close those recommendations on the tracker that were highlighted in green. He noted that a number of recommendations on the tracker were recorded as being outstanding, although subsequent work had reduced this number. Mr Mills reported that the Trust's implementation of recommendations was much improved from 2015/16, explaining that ownership of actions was greater and that they were being demonstrably implemented.

Mr Reid explained that the CQC would be keen to see evidence that the Trust was following up on auditor recommendations, and asked if Mr Mills could provide an update for the Executive Team prior to the meeting of the Audit Committee in November. **AM**

The Committee approved the closure of the recommended audit actions.

iii) Internal Audit Reporting Protocol

Mr Townsend explained that he was presenting an updated internal audit protocol for the Trust. He noted that the contents of the protocol was largely unchanged from the previous iteration but was being presented in a different format for the approval of the Committee. He explained that the protocol set out the TIAA's framework for issuing reports, managing responses, and escalation processes that would be followed.

The Committee approved the revised Internal Audit Reporting Protocol.

055/16 Local Counter Fraud Service Progress Report

Progress Report

Mr Lovegrove presented an update on the Local Counterfraud Service (LCFS) to the Committee, and highlighted that the audit of declarations of interest within the Trust was still ongoing, noting that a further review of undeclared interests was being undertaken.

He reported that LCFS had attended the recent junior doctor's induction in order to provide checks for identity documents, which had proved to be a successful initiative. He noted that the National Fraud Initiative had recently begun a validation service which could be incorporated into recruitment processes for Trust to provide additional checks for new starters.

Mr Lovegrove explained that he would be speak to the Trust's communications teams about the possibility of attending team meetings throughout the Trust in order to raise awareness of

counterfraud services. He noted that he would expect an increase in cases being reported to the service as a result of this initiative.

Mr Lovegrove presented an update on the reactive work that LCFS had undertaken.

The Committee noted the Local Counter Fraud Service Progress Report

056/16 External Audit Progress Report

Ms Combrinck reported that detailed planning for external audits in 2016/17 was due to begin in November when a meeting would be arranged with Mr Reid. She noted that the Trust had the potential to be given a qualified opinion on Value For Money for 2016/17.

She explained that she had tabled the management response to the external auditor's action plan following the quality account review, noting that she had found the management responses to be positive and that she was assured that action was taking place.

The Committee noted the External Audit Progress Report

057/16 Information Governance Update Report

Mrs Wells reported that the Trust had made good progress in meeting the requirements of the Information Governance Toolkit. She explained that a procedure needed to be written about the pseudonymisation of patient data in order for the Trust to reach level 2.

Mrs Wells reported that a near miss in respect of a lost dictaphone had recently been reported, and as a result dictaphones within the Trust were now encrypted to ensure that if they were lost then data could not be accessed.

The Committee noted the Information Governance Update Report. They approved the Information Governance Management Framework 2016/17 and the Information Governance Steering Group's revised Terms of Reference.

058/16 Review of Losses and Special Payments

Mr Reid presented a report on losses and special measures made within the current financial year within the Trust, noting that they were in line with losses and special payments reported in previous years.

The Committee noted the Review of Losses and Special Payments

059/16 Annual Security Report 2015/16

Mr Kirk explained that Mr Reid was the director with responsibility for security management, and noted that the Trust would be designating a Non-Executive Director who would scrutinise security within the organisation.

He explained that during their previous inspection, the CQC had raised concerns about doors being left open on the maternity unit at the Conquest hospital due to high temperatures. He reported that action were now in place to resolve this issue. Mr Kirk explained that a training matrix for security guards had been completed, and that plans for locking down both main sites had been revised. Mr Stevens asked the circumstances that would necessitate a lockdown of the sites, and Mr Kirk replied that the Trust took direction from police, fire services, managers and directors when deciding to implement a lockdown.

Mr Kirk explained that his team would be focusing on lost and stolen patient property by supporting wards in maintaining logs of patient property. He noted that despite the fact that reporting of assaults and verbal abuse of staff had increased, no areas stood out as being a significant problem. He reported that national statistics placed the Trust in the median of reported cases. Mr Kirk reported that a capital project for improving door locking systems within the Trust had been submitted, but that improvements to infrastructure needed to be undertaken before this could be implemented.

Mrs Wells asked about progress in producing an asset register for all items within the Trust valued at under £5k. Mr Kirk explained that this was a mandatory requirement for the Trust, but that it was very difficult to comply with. He noted that the Trust had to explain on a yearly basis about why the register was not available. Mr Reid explained that the Trust maintained an asset register for higher value items and suggested that individual teams could maintain local asset registers, rather than producing a Trustwide register.

Mr Nealon asked whether the Trust had a policy for the management of patient violence, and Mr Kirk explained that the Trust had a violence and aggression policy which included letters that were sent to patients setting out escalating consequences if they were badly behaved.

The Committee noted the Annual Security Report 2015/16

060/16 External Audit Tender Update

Mr Reid presented a paper and explained that the Trust had undertaken a robust formal, open procurement process for an

external auditor. He reported that the Trust had received two bids, both of which were of good quality. He said that an evaluation panel had convened in order to receive presentations, and to question the bidders. He reported that the formally approved scores for the evaluation had been very close, but that Grant Thornton had emerged as the preferred bidders.

The Audit Committee approved the decision to appoint Grant Thornton as preferred bidders.

061/16 Date of Next Meeting

The next meeting of the Audit Committee will be held on:

Wednesday, 23rd November 2016, at 10.00 am in the St Mary's Boardroom, EDGH.

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 26 October 2016 at 9.30am– 11.30am, in St Mary's Board Room, Eastbourne DGH

Present
Mr Barry Nealon, Non-Executive Director (Chair)
Mr Mike Stevens, Non-Executive Director
Mrs Churchward-Cardiff, Non-Executive Director
Dr Adrian Bull, Chief Executive
Mr Jonathan Reid, Director of Finance
Mr Matt Hardwick, Hospital Director (for Pauline Butterworth)

In attendance
Mr Philip Astell, Deputy Director of Finance
Mr Chris Hodgson, Associate Director of Estates & Facilities (for minute item 110/16)
Miss Chris Kyprianou, PA to Director of Finance, (minutes)

097/16	**Welcome and Apologies** Mr Nealon welcomed members to the Finance & Investment Committee. Apologies were received from Pauline Butterworth.	**Action**
098/16	**Minutes of Meeting of 28 September 2016** The minutes of the meeting held on 28 September 2016 were agreed as an accurate record.	
099/16	**Matters Arising** (i) Delivery of Financial Plan Following discussion at a previous meeting on the recruitment process, Mr Reid reported that Dr Sally Herne has been pulling out some metrics around delays in recruitment. It was noted that a detailed report on Temporary Workforce Services would be presented under minute item 105/16 below. (ii) Replacement CT Scanner The Business Case for the second CT scanner had been reviewed in full. The analysis of lease-v-capital had been revisited, and remains valid, as a result of advantageous rates agreed with the supplier in respect of the maintenance component. However on review by the Director of Finance, the case has now been withdrawn. The case was	

	contingent on a donation from the League of Friends which is (a) not available until the fundraising campaign is complete, and (b) was not premised on a leasing agreement, but on the purchase of a capital asset. Mr Reid reported that the Trust was now looking at ways of purchasing the CT scanner, within the capital programme. The impact of this with be discussed at the Executive meeting and a full business case will come back to the December Finance & Investment Committee. (iii) Integrated Performance Report – Finance Update The Committee had asked for a more robust plan for the October meeting. This was discussed as part of the Delivery of Financial Plan below (minute item 101/16). (iv) The Model Hospital The Model Hospital was presented under minute item 107/16 below. (v) Service Line Reporting It was reported that the service line reporting data is being brought to each of the Integrated Performance reviews.	**JR**
100/16	**Integrated Performance Report – Month 6** Mr Reid presented the Integrated Performance Report for month 6. The report highlighted that there were four key performance areas which had agreed trajectories in place for performance over the 2016/17 financial year. These areas were strongly managed by NHSI and the CCGs. These are: A&E (4 hours), RTT (18 week incomplete), Diagnostics (6 weeks), Cancer (62 days). The Trust failed to reach the trajectory for all four areas in September. (August for cancer as this is reported one month in arrears).	

September	A&E	RTT	Diagnostics	Cancer
Trajectory	92.43%	92.50%	0.97%	80.5%
Actual	80.5%	86.64%	2.6%	79.5%

It was noted that the Trust has a financial plan, agreed with NHSI, which delivers a £31.3m deficit – moving from the original plan of £48m through an increase in the efficiency challenge of £6m and additional funding from the Department of Health of £10.4m.

The Trust's financial performance had improved at Month 6, after

	weak performance in Month 4 and 5. However, this was largely as a result of improved income recognition, which has some contractual risk associated with it, and as a result of technical adjustments resulting from a 'hard close' undertaken by the finance team at Month 6. The Trust reported a year to date £4.9m adverse variance from plan, of which £2.6m reflects a reduction in STP funding received. It was noted that the key drivers for the movement off plan were challenges in the delivery of agency cost reductions, increased costs for the treatment of urgent and planned care patients above plan, and a shortfall in the delivery of cost improvement scheme savings. Mr Reid reported that the Trust has a recovery plan in development and was forecasting delivery of the full year planned deficit of £31.3m. Cash flow remains a continued area of focus for the Trust, with additional cash drawn down from the agreed loans with the Department of Health made available from clinical commissioners. Capital expenditure remains within acceptable limits, although the level of capital expenditure in the year to date is lower than planned, and the Trust will continue to carefully monitor capital expenditure over the remainder of the financial year. Mr Stevens raised an issue on complaints (in the Quality & Safety section of the IPR). It was noted that the compliance with providing the final complaint response was improving and the overdue backlog was reducing. However the report highlighted that there were staff shortages and planned sickness episodes which could have an impact on response times during October. It was agreed that Dr Bull would raise this with Mrs Alice Webster and Mr Ashley Parrott and will take this back to the Quality & Safety Committee. Mrs Churchward-Cardiff queried the number of HCA agency shifts to cover escalations beds. Mr Reid explained that the Trust had been exploring the potential for appointing a temporary specialling team. The Committee was pleased to note that there had been significant improvements on mortality. It was agreed that the comments from the Committee would be passed to Dr Walker. **Action** **The Committee noted the Trust's performance report and financial performance for month 6.**	**AB** **JR**
101/16	**Delivery of Financial Plan – Monthly Report** Mr Reid reported that the Trust had agreed an accelerated timetable with NHSI for the development of a refreshed financial recovery plan, aimed at ensuring delivery of the control total. The Trust made an	

	initial introduction to the plan with NHSI on 21October 2016 At month 6, the Trust was reporting a significant variance from plan, and the initial unmitigated forecast for 2016/17 indicates risk to the delivery of the plan. Mr Reid highlighted the key financial challenges for the Trust during 2016-17. It was noted that at Month 6, the Trust was adverse to plan by £4.9m, reducing to £2.3m after the removal of Q2 STP. The identified risks to the delivery of the plan range from £16.2m to £22m, with a most likely unmitigated case of £19.6m. The financial recovery plan requires further clinical and operational engagement, but identifies opportunities for improved financial delivery across four key workstreams. Further opportunities were being sought, but it was noted that the immediate task was to establish the appropriate governance and support arrangements for the workstreams. The temporary workforce workstream has been supported during August and September 2016 to undertake a detailed diagnostic, and an implementation plan had now been agreed. The oversight of the programme, both in 2016-17 and in future years, is through the Financial Improvement and Sustainability Programme Board with support from Programme Management Office and leadership from the Executive Directors. The Board will meet monthly, and the first meeting took place on in October. Mr Reid updated the Committee on the Financial Special Measures meeting with NHSI which required a follow up meeting in 30 days to go through the financial recovery plan which needed to deliver the control total at year end. Mr Reid gave an overview of the presentation provided to NHSI which included information on: - Responding to the challenge - Key numbers - Understanding the shift in cost - Drivers of the deficit - Trends Month 6 - Temporary Workforce - Efficiency Savings - Next Steps It was noted that an intensive period of work was required together with a Board approved financial recovery plan which would be tracked by NHSI on a monthly basis. Mr Reid reported on the immediate actions that were being put in place and explained the further support in place to assist with the	

	recovery plan. The Committee received a proposal from PA Consulting who were already working with the Trust with two priorities: - To improve grip of temporary workforce spend, the primary driver of the deterioration, and - To create a recovery plan. Following a series of discussions it had been agreed that the work that PA Consulting were doing with the trust would expand in scope and accelerate as: - the Trust recognised the need to pick up the pace in terms of financial performance as it enters the second half of the financial year, and special measures gives the trust the opportunity to progress more quickly on the improvement areas it has identified - a number of key quality improvement factors are aligned to financial improvement and need to be prioritised. The aim was to better understand the deficit, realise immediate benefits and prepare a robust recovery plan which would give a realistic view of what can be achieved this financial year, the key risks to the plan and opportunities into the next financial year. PA Consulting would support the Trust in providing assurance to NHSI. Mr Reid circulated an update on forecast which presented the key elements of the divisional forecasts and provided an initial view of the likely recovery trajectory. The key work for the Trust over the next four weeks was to develop the recovery workstreams in partnership with NHSI in advance of the presentation to the Board and Finance & Investment Committee. After adjusting the forecast bias, anticipated income and pay/non pay controls coming in at month 7, there remained a gap of £10.6m. Two key workstreams were in place to address this gap. It was noted that the key financial gap was £10.6m which will need to be bridged by the temporary workforce expenditure reductions and the impact of the flow and capacity work. The temporary workforce group continue to develop the key components of the plan. Mr Reid requested engagement and involvement by the Finance & Investment Committee members in finalising the plan before it goes to the Trust Board. It was agreed that a summarised version would be presented to the Board Seminar on 15 November 2016 and the Committee would review the plan at an extra-ordinary Finance & Investment Committee meeting prior to submission to the Board.	

	Action **The Committee reviewed the report in full and noted the emerging financial recovery plan for 2016-17.**	**JR**
102/16	**Contracts and Income – Monthly Report** Mr Reid provided the Committee with further detail on the income position of the Trust. It was noted that the most significant risk around income related to the local CCGs. It was noted that the Trust had set an ambitious income plan for the year and in the year to date was exceeding plan. However, the levels of activity growth were significant in year, and the Trust was anticipating a significant level of over performance, both against the CCG contract values and against the Trust financial plans. The Committee received an update on the Month 6 position, and the forecast for income to the end of the financial year. The Trust was anticipating full recovery of the income forecast, but was in detailed discussions with CCGs about both affordability and contract challenges. **Action** **The Committee noted the ongoing management of income by the Trust**	
103/16	**Cash flow – Monthly Report** The Committee received an update on the cash flow position for the Trust and noted the key issues and emerging challenges. The detailed cashflow forecast indicated that if the financial position of the Trust did not improve, the Trust will experience a number of cashflow challenges over the remainder of the financial year. . The Committee noted the actions in place to ensure that the cash position of the Trust was managed including work with NHSI to secure access to cash, and management of working capital balances. Arrangements are in place to ensure that the Trust's payment of key suppliers and staff are maintained, although constraints in cashflow can adversely impact supplier relationships. Robust management of cash flow supports the Trust in the delivery of its financial plan and ensures it has access to the cash resources it needs. The current level of scrutiny ensures that risks and potential mitigations are identified and that action is taken on a timely basis. The Committee noted that the Trust finance team regularly review cash and capital balances and have plans in place to mitigate the risks in both areas.	

	Action **The Committee noted the ongoing management of cash and capital within the Trust**	
104/16	**Sussex and East Surrey STP and East Sussex Better Together (ESBT) Progress Report** Mr Reid reported that not a lot had changed since the last update in terms of the Trust components of these two plans. However, it was noted that the Trust and ESBT was divergent from the other places in the STP (Coastal and Corridor). ESBT had submitted a balanced financial plan for 5 years whilst the other places and STP financial plan was unbalanced overall. It was noted that the whole STP financial plan had been submitted on 21 October 2016 and there would be another iteration of the plans within the next few months. Mr Reid discussed the impact that the local plan would have on the Trust planning process. The Trust was working through an accelerated planning process that requires an outline plan signed off by December. The first cut with the financial components of the plan would be presented to the November Finance & Investment committee meeting with the second cut being presented in December. **Action** **The Committee noted the ongoing developments across the STP area.**	**JR**
105/16	**TWS Programme – Progress Report** Mr Reid presented an update on the TWS Programme setting out the position at month 5 and the proposed governance arrangements and workforce projects to reduce expenditure by £2.5m by the end of the financial year. It was noted that £3m had been identified as opportunity, with further work ongoing to extend the opportunity. The Executive Directors had agreed a continuing programme of work to strengthen governance and decision-making around the deployment of temporary resource across the organisation. They had agreed to the recommendations within the report and weekly meetings had commenced. **Action:** **The Committee noted the report and the progress on this key workstream**	

106/16	**Trust Sustainability and Carter Programme (Efficiency Programme) – Progress Report** Mr Reid updated the Committee on the ongoing work within the Carter programme. The key issues were picked up under other agenda items and the committee noted the continued focus in this area. **Action** **The Committee noted the ongoing work within the Carter Programme**	
107/16	**The Model Hospital** Mr Reid reported that the Trust was still deeply engaged in the Carter Programme. Many of the workstreams, nationally, had slowed. However there were 3 workstreams where the Trust was progressing at pace: - Hospital Pharmacy Transformation Programme - Procurement and Purchasing Workstream - The Model Hospital The Committee received an update on the NHS Productivity and Efficiency Programme's Model Hospital (NHS PEP). This outlined the progress to date on the NHS PEP's Model Hospital from both a national and local perspective. It described the Trust's continuing engagement in the project and the steps being taken to ensure that the Trust validates and exploits the true potential efficiency improvement opportunities that are identified. The Committee noted that • The Trust has received reports from the NHS PEP that provide indicative savings opportunities based on the metrics developed as part of the programme; • The Trust has been assigned access to the NHS PEP Model Hospital portal and analysis of the data is on-going as and when each compartment goes live; • The Trust has established a Financial Improvement and Sustainability Committee, whose work will include monitoring the development and implementation of the Trust's formal response to the 2015 Carter Review, including components within and outside the formal Trust efficiency programme; • The Trust is actively engaged with the NHS PEP team regarding the Model Hospital portal by submitting data regularly, querying the outputs, and providing feedback on the development of the portal etc.	

	Action **The Committee noted the contents of the report and the further assurance provided.**	
108/16	**Commercial Strategy and Market Developments** Mr Reid presented the Committee with an update on the Commercial Strategy and Market Developments. It was reported that there was still some work to do to develop the Commercial Strategy. The Committee received an update on the tenders position as at 18 October 2016: • Non-Invasive Ventilation Service AQP- the evaluation has been completed and is with the CCG's for ratification. The outcome announcement was late September 16, the Trust has sent a chaser e-mail to the Commissioner but to date no response has been received. • Direct Access Adult Hearing Services AQP- confirmed as an Accredited Provider subject to gaining IQIP accreditation. • Elective Care Services AQP - confirmed as an Accredited Provider. • Non-Obstetric Ultrasound AQP - confirmed as an Accredited Provider. • Hastings and Rother CCG MSK Service – ITT published 16th of September 2016. The Trust is currently formulating a bid submission as prime contractor, contracting with a number of sub-contractors. The deadline for the bid submission is the 21st of October. • ESCC JC - Tender for the provision of a Community Stroke Support Service - The service is being jointly commissioned by High Weald, Lewes, Havens CCG, Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG and East Sussex County Council Adult Social Care and Health. Mr Reid reported that since the update on 18 October 2016, the Trust had received notification that they had won the AQP tender, and the MSK tender had been submitted. **Action** **The Committee note the update on the Commercial Strategy and Market Development.**	
109/16	**Business Cases Process & Pipeline** The Committee received an update on progress achieved and further plans to strengthen the Trust business case process and pipeline. The report presented explained that processes for producing and managing the flow of business cases were being modified	

	systematically to better meet the needs of the Trust and those of NHS Improvement, who have not approved recent bids for capital support. The briefing included a range of actions involving a re-energised business development and capital planning group, and a series of one hour sessions available to any staff with an interest in business cases. It was noted that over 60 members of staff had attended short one hour sessions, presenting a tried and tested model for producing strong business cases. Focussing on producing successful business cases, which are well aligned with the Trust objectives, the session challenged some historical practices. The Committee noted that the Business Development Group now regularly considers business cases on each agenda under three categories to ensure the greatest benefit is achieved from the expert advice available at the meeting. • Advice and support – for teams wishing to advance a business case already in development. • Approval to next stage – for teams wishing their cases to be approved where appropriate. • Pipeline proposals – for early proposals to be prioritised for development, and for gaps to be identified and addressed where a priority need exists, but no case is on the horizon. The team is currently reviewing the complete list of known cases, with a view to regular and active assessment and management to ensure that cases are being developed in accordance with plans and current priorities. **Action** **The Committee noted the progress achieved and further plans to strengthen the Trust business case process and pipeline.**	
110/16	**Future Development of the Laundry Service** Mr Hodgson presented a report updating the Committee on the Laundry business case and the progress made since the presentation at the July 2016 Finance & Investment Committee meeting. It was agreed that Mr Hodgson would bring a further update to the Committee in December 2016 or January 2017 Committee together with a summary of options. **Action** **The Committee noted the update on the Future Development of the Laundry Service and the progress made since the July 2016 presentation.**	

111/16	**2016/17 Revised Work Programme** The Committee noted the revised work programme. **Action** **The Committee noted the revised Work Programme.**	
112/16	**Date of Next Meeting** The next meeting will take place on Wednesday 30 November 2016 at 9.30am – 11.30am, in the Committee Room, Conquest.	

East Sussex Healthcare NHS
NHS Trust

Quality and Safety Committee

Minutes of the Quality and Safety Committee Meeting

Wednesday 21 September 2016
Committee Room, Conquest

Present:
Mrs Sue Bernhauser, Chair
Dr David Walker, Medical Director
Mrs Alice Webster, Director of Nursing
Dr James Wilkinson, Assistant Medical Director, Quality
Mrs Lynette Wells, Company Secretary
Mr Jonathan Reid, Director of Finance
Mrs Edel Cousins, Assistant Director, Workforce Development (for Monica Green)
Mr Ashley Parrott, Associate Director of Governance
Ms Kim Novis, Equality and Human Rights Lead
Mrs Janet Colvert, Ex-Officio Committee Member

In attendance:
Mr Fritz Bernhauser – for Item 2.0 (Patient Story)
Mrs Lesley Smith – for Item 5.1 (Infection Control)
Mrs Cathy O'Callaghan - Interim Head of Midwifery for Item 6.1 (Maternity)
Mrs Karen Salt, PA to Director of Nursing (minutes)

1.0 Welcome and Apologies for Absence

Sue Bernhauser welcomed participants to the Quality and Safety Committee meeting and confirmed that the Committee was quorate.

Sue Bernhauser noted apologies for absence had been received from:

Mr David Clayton-Smith, Chair, ESHT
Dr Adrian Bull, Chief Executive
Mrs Jackie Churchward-Cardiff, Non- Executive Director
Mrs Pauline Butterworth, Acting Chief Operating Officer
Catherine Ashton, Director of Strategy
Monica Green, Director, HR

2.0 Patient Story

Mr Fritz Bernhauser attended the meeting to talk about his experience of care with the Trust. He reported that every member of staff he had contact with, during a stressful time, had been professional, explaining things carefully, and they took the time to make him feel comfortable. He also noted that the speed with which he went through the patient pathway had helped to keep the period of stress to a minimum. It was noted that positive experiences of care could make a difference to patients undergoing the stress of tests and treatment.

3.0 Minutes of the Previous Meeting

The minutes of the 20 July 2016 meeting were agreed to be an accurate record of the meeting.

3.2 **Matters Arising and Action Log**

Action Log

Updates to the Action Log were noted and it was agreed to close the following:

QSC 1 (12 Jan 16)
QSC 4 (14 Apr 16)
QSC 14 (2 Jun 16)
QSC 15 (2 Jun 16) – Item on the agenda. Action closed.
QSC 18 (2 Jun 16)
QSC 22 (2 Jun 16)
QSC 24 (2 Jun 16)
QSC 28 (2 Jun 16).
QSC 29 (20 Jul 16)
QSC 30 (20 Jul 16)
QSC 31 (20 Jul 16) – Action plan updated with amended dates and approved at Trust Infection Control Group. Action closed.
QSC 32 (20 Jul 16)
QSC 33 (20 Jul 16)

4.1/ 4.2 **Board Assurance Framework and High Level Risk Register**

Lynette Wells presented the **High Level Risk Register** noting that there was some further detail for the risks that were open in June. Key highlights were:

- Some risks (such as asbestos) had been on the register for a long time.
- Capsticks had supported the Clinical Units to do a lot of work on their risk registers.
- There were a lot of Estates risks but it had been agreed not to merge them.
- There was generally an improved picture – risk registers presented to the Audit Committee has been good.

Board Assurance Framework (BAF)

Those showing red were:
2.1.2 – Patient Flow
2.1.4 – Mortality
3.3.1 – Patient Transport
4.1.1 – Financial Position

It was noted that at Audit Committee there had been a discussion about the impact (such as cancellations) the Emergency Department patient flow was having on Surgery. This impact was expected to increase and was on the Surgery risk register and would go onto the BAF. A piece of work around Urgent Care would be reflected in the next iteration of the BAF. It was noted that Emergency Department flow affected the whole of the organisation.

Sue Bernhauser noted that a report on the Emergency Department was due to go to the

Urgent Care Board in October 2016 with a number of recommendations. Executive Directors were sighted on this.

Ashley Parrott explained that he had arranged to have individual discussions with Executive Directors about the big concerns in their areas. The aim was to then check that those concerns/issues were on the risk register. The Corporate Risk Register was weighted towards estates and there was a discussion about this with the following noted:

- this could be due to clinical risks remaining with the Clinical Units and not being escalated.
- There could be an issue around consistency in scoring
- Many had been taken off the register following challenge from Capsticks
- Rae Joel was conducting further work on the risk registers

Janet Colvert expressed concern that 2.1.5 was showing green but that the narrative mentioned 'lack of stability' which would suggest that this should be amber. It was agreed that the wording needed to be tightened as it could refer to the lack of permanent staff or to the quality.

Action – Lynette Wells to clarify and consider rewording the narrative for 2.1.5.

Alice Webster highlighted that at recent CQC focus groups there had been complaints that the pneumatic tube system was not working well leading to samples going to the wrong departments. It was noted that this had not been raised anywhere else and was not showing on the risk register.

Action – Alice Webster to arrange for Director of Nursing office to establish what was happening and refer the matter to the Patient Safety and Quality Group.

Action – Ward staff to be reminded to use the Datix system to raise issues such as this.

Janet Colvert noted that accessibility issues were not on the risk register and that if the Trust were uplifting areas accessibility needed to be considered. It was noted that there were issues with accessible toilets, automatic doors without warning signs, shower grab rails on the wards and lack of signage to warn against irresponsible parking on ramps or areas of access.

Action – Alice Webster to arrange for issues around mobility access to be addressed.

4.3 **Clinical Governance Review**

Ashley Parrott presented the report noting that an action plan had been drawn up following a Governance Review conducted in March and April 2016. Most of the recommendations were reflected in the action plan and there were some actions that had already been underway. It was noted that the recommendation to merge the MOG and the MRG had

been implemented but that with the change of the MOG to Clinical Oversight Group it had been agreed to reintroduce the MRG.

David Walker noted that the two actions marked red (page 2) were due to turn amber and that Clinical Units would be getting mortality scorecards to enable an understanding of how many deaths had been reviewed and when.

Action – update on progress to the Action Plan to be presented to the January 2017 meeting.

4.4 **Risk and Quality Delivery Strategy**

Ashley Parrott presented the Risk and Quality Delivery Strategy which was a merged version of two previous strategies – Risk Strategy and Governance Strategy. This was a first attempt at a Strategy that described governance in the organisation worked and aimed to underpin the Quality Strategy.

The document explained the committees and risk functions and there were policies to underpin them. Clear flow charts(example on page 7) and plans for Clinical Units had been included. The strategy linked with ESHT 2020 and the Trust Vision.

Para 4.11 related to the Improvement Programme Board (on the current governance structure) members of which had become the Improvement Sub Committee. Improvement initiatives identified through other Committees needed to be triaged and risk assessed. Confirmation was needed of how this would work and how to have one group monitor all the initiatives.

It was noted that once an appendix had been done for the Medicine Division the appendices would be circulated to all the areas and the Strategy would need to be presented to Trust Board. The Committee was invited to comment on the Strategy and it was agreed that the document would be circulated to members as a stand-alone document to facilitate this.

Action – Risk and Quality Delivery Strategy to be sent to all members.

Action – Lynette Wells to amend paragraphs 5.3 and 5.5 to reflect changed role titles - Director of Strategic Development and Assurance to Director of Strategy, and Company Secretary to Director of Corporate Affairs.

Action – Ashley Parrott to simplify the appendix for the Women and Children and Sexual Health Division, to be consistent with the other appendices.

Action - Medicine Division governance structure to be finalised and Equality and Diversity input to be obtained.

Action - Members to send comments to Ashley Parrott by 27 Sep for incorporation into the paper before submission to Trust Board.

Action - Risk Management Strategy' to be removed from header of document and replaced with 'Risk and Quality Delivery Strategy'.

The Committee approved the name of the document and commended the work that had gone into the strategy.

4.5 **Quality Strategy**

Alice Webster presented the Quality Strategy noting that it had been presented to the Patient Safety and Quality Group and that this version incorporated comments from the Chief Executive, Adrian Bull.

The Strategy was based on ESHT 2020 objectives, and was designed to be a simple document that could be accessible to all. Page 8 incorporated a glossary of terms and the Safety and Quality governance structure was included as appendix 1. The strategy would be refreshed on an annual basis.

Following invited comments the following actions were agreed:

Action - Page 8 - ESHT 2020 Strategy – Alice Webster to expand description.

Action - Page 6 - bullet point 4 – Ashley Parrott to amend 'Ward to Board' to read 'Floor to Board'.

4.6 **Quality Improvement Plan**

Alice Webster presented the Quality Improvement Plan update noting highlights on page 6.

There was generally an upward trend with an increase in percentages of those completed but the pace needed to be better. Some of the more complex projects, such as stroke mortality, had been targeted with success.

Key points were as follows:

Environment – the Conquest site had a known issue with Estates and Housekeeping but these were being addressed with support from NHS Improvement.

Complaints – there had been discussions with the matrons regarding improvement to responses and the Complaints Team had contributed to a new flow chart to assist.

Workforce – the staff engagement score would remain the same until the next survey was done in October. There had been a decrease in the percentage of staff reporting bullying.

Consultant cover - Accident and Emergency was red and needed to be explored in depth.

Patient flow – 4 hour standard was an issue – some of this related to safe discharge and a group had been put together to look at this. The SAFER bundle was also coming on stream.

Temporary files – The number had increased during the move of Health Records to Apex Way and this needed to be monitored.

Maternity – was to be discussed in the Deep Dive later in the agenda.

Next Actions, Risks and Recent Improvements were noted and it was reported that endoscopy appointment timings had improved.

There had been a discussion around improvement of the management of Root Cause Analyses following post-operative VTEs. The return of a staff member from long term sick leave was expected to address the issue.

Infection Control Annual Report

5.1 Sue Bernhauser noted that the report was a vast improvement on previous years' and commended the work that had gone into it.

The Infection Control Annual Report aimed to set out the key activities and incidents for the year including the IB Team and the NSC team.

The key points noted were:

- An increase on the previous year for MRSA bacteria at EDGH
- Overall C Diff was lower than the previous year
- Overall the Trust had performed well and below the national average with regard to knee and hip.
- There had been one outbreak of Norovirus affecting 4 wards at EDGH – this had been subject to a Serious Incident investigation.
- An unprecedented number of flu cases (150 plus) had presented at Conquest. One case had been subject to a Serious Incident investigation but otherwise there had been no explanation for the large number of cases.
- Legionella had been isolated in water in July 2015 at the Conquest site and despite remedial measures was still there. The team was working with Public Health England and external advisers to put control measures in place.

Some of the plans for the year ahead were already in progress.

Alice Webster noted that the report was well laid out and much easier to read. It was noted that the Infection Control Team had managed and supported some very difficult and complex issues including the management of the Bare Below the Elbows policy. Public Health England had confirmed that all the right actions were being taken and the team was committed to continuing the impetus.

It was noted that a correction would be made on page 12 – 2015 was showing red in error.

Jonathan Reid reported that the Trust had enjoyed £250,000 in contract fine savings due to the accuracy of Infection Control Team figures relating to lapses in care.

It was confirmed that one MRSA case (contributing to a difference in between the table and the graph) was in the process of being investigated to confirm whether or not it sat with the ESHT or UCLH.

Staffing levels were good.

The programme of works was useful for tracking for the Governance subgroups. Asked to look at metrics to measure progress for each one. Separate prog of work, audit to go alongside, then schedule of policies. LS confirmed

Action - Separate programme of work with KPIs available to be added to annual report.

James Wilkinson noted that further signage would be useful relating to hand washing and it was agreed that Lesley Smith would address that.

Action – Lesley Smith to arrange for further signage regarding hand washing.

Quality Report

5.2 **Ashley Parrott presented the Quality Report which pulled together information from 3 domains,**

A more in depth report went to the Patient Safety and Quality Group. The report aimed to give an overview of challenges – the main issues were noted as follows:

- overall complaints backlog
- Risk Register – needing further work.
- Friends and Family Test – low response rates.
- Delays in scan and diagnostic results – a task and finish group was being established to look at this.

Other issues:

- Serious Incidents – key trends such as falls and CTG monitoring were being identified and work was ongoing.

- Never Events – actions were being monitored via an audit with the aim of producing a report to enable an overview of this issue.

- It was noted that with regard to CTG monitoring errors, following a number in 2015/16 there had been only 1 case since April 2016 and no Serious Incidents reported. Cathy O'Callaghan noted that these were monitored at daily risk meetings and all recommendations had been implemented.

5.3 **Integrated Performance Report**

Alice Webster presented the Quality part of the Trust wide Report noting that the full report went to the Trust Board. The report linked with the Quality Report presented at Agenda Item 5.2. Ashley Parrott reported that the Never Events report on page 7 had been sent to all Clinical Unit leads. It was noted that the colour format of the report could be improved to ensure accessibility to all.

Action – Lynette Wells to forward the report to Committee Members.

5.4 **Patient Safety and Quality Group Update**

Alice Webster presented a verbal report noting the following themes:

Diagnostics - A specific piece or work had been agreed to look at this.

Urgent Care – reported a high number of incidents including safeguarding issues. It was agreed to have an update for the next meeting with a Deep Dive in January 2017.

Patient Experience – issues around the main switchboard, lengthy announcement at the beginning of each call, and patients not being able to get through, particularly for Outpatient Department appointments. This was noted as a safety issue. Kim Novis advised that work was ongoing regarding different methods of communication for those with difficulties. Responsibility for the switchboard had moved from Estates to IT and it was agreed that Alice Webster would raise this issue with Andy Bissenden.

Action – Alice Webster to raise the switchboard issue with Andy Bissenden.

6.1 **Deep Dive - Maternity**

The tabled Maternity Deep dive report outlined the ESHT vision and strategy for Maternity over the following 5 years.

The plans were measureable, with KPIs which appeared on a dashboard.

It was noted that there was an outstanding action to update on the National Pregnancy in Diabetes Audit (NPID). This was a mandatory audit that should be completed every year.

In 2015 it had been conducted by a Senior House Officer who had left the Trust before submitting it. Extensive efforts had been made to locate the audit work, without success. A Clinical Support Worker with the diabetes team had been tasked with ensuring that the audit was completed on an annual basis going forward.

Key highlights from the discussions were:

- Sue Bernhauser noted that she had found a high level of satisfaction when speaking to parents at the unit at EDGH. It was noted that the unit was working hard to create an environment that would encourage low risk women to choose the unit.

- Feedback from the mock inspection focus groups had suggested that the unit felt somewhat isolated but it was hoped that the new CSM and Band 7 roles would allow daily visits to improve that.

- Recent infection control issues were being addressed with the support of the Infection Control lead at NHS Improvement. Continuing improvements were anticipated under the leadership of the Interim Head of Midwifery and Gynaecology.

- Healthwatch was meeting with maternity staff following a piece of work they had done with the unit and new mothers.

- Cathy O'Callaghan confirmed that the transfer rate of EDGH maternity patients was low (including nationally) at 36% for first babies and 9% for subsequent deliveries.

- It was further confirmed that staff transfers only happened in circumstances of short term sickness and where the Matron was on a management day. Staff members were given a choice regarding how much notice they received. Ashley Parrott reported that there was SECAmb data regarding transfer that could be shared.

Action – COC to send transfer information and the report to Karen Salt to circulate to all

7.0 **Any Other Business**

8.0 **Deep Dive for next meeting**

Urgent care to be invited to present an update to the November meeting and a Deep Dive presented to the January 2017 meeting.

9.0 **Date of the Next Meeting** - 23 November 2016, John Cook Room, EDGH

East Sussex Healthcare NHS Trust

TRUST BOARD MEETING DATES 2017

24th January	09:30 am – 12.30 pm	Hastings Centre, Hastings
21st March	09:30 am – 12.30 pm	Strand Room, Cooden Beach Hotel
9th May	09:30 am – 12.30 pm	St Mary's Boardroom, EDGH
25th July	09:30 am – 12.30 pm	Uckfield Civic Centre, Uckfield
26th September	09:30 am – 12.30 pm	Hastings Centre, Hastings

To be followed by ESHT's Annual General Meeting

28th November	09:30 am – 12.30 pm	St Mary's Board Room, EDGH

East Sussex Healthcare NHS Trust Annual Board Planner 2017

Each Meeting

- Quality walks feedback
- Monthly staff award
- CEO report
- Board Committee Feedback
- Board Assurance Framework
- 2020 Improvement Programme
- IPR
- Business cases over £500k as recommended by FIC/Contracts awarded in excess of £1m
- Sub-committee minutes
- ESBT & STP Update

24th January 2017

- Intrapreneur (Amy Collis/Debra East) – 15 min presentation
- Business Planning 2017-19 (CA)
- Business and financial planning 2017/18 update
- CQC Update
- Annual plan and budget 2016/18

21st March 2017

- Quality Report quarter 3
- Quality Improvement Priorities 2016/17
- Annual Business Plan 2016/17quarter 3
- Capital programme 2016/17
- Delivering same sex accommodation annual declaration of compliance
- Speak Up Guardian's Report
- Fit & Proper Declarations to be completed at this meeting by Board (not for agenda)

9th May 2017

- Quality Account 2016/7
- Staff Survey Results
- R&D annual report
- Delegation of approval of Annual Report and Accounts 2016/7
- Review of committee structure/work programme
- Nursing Establishment Review (March 2016)
- Quality Report quarter 4

25th July 2017

- Fire annual report
- Equality Annual Report
- Quality Report quarter 1
- Annual Business Plan quarter 1
- Complaints Annual Report

26th September 2017

AGM

- To receive 2015/16 Annual Report and Accounts and Quality Account 2015/16

BOARD

- Revalidation (from Debbie McGreevey – covers both nursing /medical)
- Nursing and midwifery annual report 2016/17
- Clinical Excellence Awards
- Health & Safety Annual Report
- Winter preparedness
- Infection Control annual report
- Safeguarding annual report (adults and paediatrics)

28th November 2017

- Capital programme – mid year review
- Annual Business Plan quarter 2
- Quality Report Quarter 2
- Speak Up Guardian's Report
- Review of standing orders, financial instructions and declaration of interests
- Meeting dates for next year

Board seminars

Monthly standing items – finance flash report, update on performance, current issues

30th January, 17th February & 23rd March – Board Development with NHS Elect

Board seminars

- 8th February – Mental Health Act Training
- 8th February – STP/ESBT
- 19th April - Medical Education
- 19th April – STP/ESBT