EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 21st March 2017, commencing at 09:30 in the Strand Room, Cooden Beach Hotel

	AGENDA		**Lead:**	**Time:**
1.	1 Chair's opening remarks 2 Apologies for absence 3 Monthly award winner(s)		Chair	0930 - 1030
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 24th January 2017	A	Chair	
4.	Matters arising	B		
5.	Speak Up Guardian's Report	C		
6.	Quality Walks	D	Chair	
7.	Board Committees Feedback	E	Comm Chairs	
8.	Board Assurance Framework	F	DCA	
9.	Chief Executive's Report • Including introduction to IPR	G	CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
10.	Integrated Performance Report Month 10 (January) 1. Performance (including plan and recovery trajectories for statutory targets) 2. Finance 3. Workforce	Assurance	H	DN/MD COO HRD DF	1030 - 1130
11.	Financial Update	Assurance	I	DF	

12.	ESHT 2020 Improvement Programme	Assurance	J	CEO/DN	
13.	Quality Account Improvement Priorities 2016/17	Assurance	K	DN	

STRATEGY

					Time:
14.	ESBT	Assurance	L	DS	1130 - 1145

GOVERNANCE AND ASSURANCE

					Time:
15.	Delivering same sex accommodation annual declaration of compliance	Assurance	M	DN	1145 - 1215
16.	Organ Donation Annual Report	Assurance	N	MD	
17.	Board sub-committee minutes: 1 Finance & Investment Committee 2 Quality & Safety	Assurance	O	Comm Chairs	

ITEMS FOR INFORMATION

				Time:
18.	Use of Trust Seal	P	Chair	1215 - 1230
19.	Questions from members of the public (15 minutes maximum)		Chair	
20.	Date of Next Meeting: Tuesday 9th May 2017, St Mary's Boardroom, EDGH		Chair	

David Clayton-Smith

Chairman

9th February 2017

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

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 24th January 2017at 09:30 in the Oak Room, Hastings Centre, Hastings.

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
Miss Catherine Ashton, Director of Strategy
Dr Adrian Bull, Chief Executive
Mrs Joanne Chadwick-Bell, Chief Operating Officer
Ms Monica Green, Director of Human Resources
Mr Jonathan Reid, Director of Finance
Mrs Alice Webster, Director of Nursing
Mrs Lynette Wells, Director of Corporate Affairs

In attendance:
Miss Jan Humber, Joint Staff Committee Chairman
Ms Amy Collis, Head of Nursing - Emergency Departments (for item 002-2017 only)
Ms Debra East, Service Manager – Surgery (for item 002-2017 only)
Ms Kim Miles, Orthopaedic Research Physiotherapist (for item 002-2017 only)
Mr Pete Palmer, Assistant Company Secretary (minutes)

001/2017 **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 a Quality Summit was due to be held with Care Quality Commission (CQC) that afternoon to discuss their recent inspection.

b) Apologies for Absence

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

Dr David Walker, Medical Director

c) Monthly Award Winners

Mr Clayton-Smith reported that the monthly award winner for December was Specialist Nurse Annie Swann, who was responsible for representing the Trust following a child's unexpected death. This was a very challenging role, and Annie ensured that the child's family received the support they needed during this difficult time.

002/2017 **Intrapreneur**

Dr Bull introduced Ms Collis, Ms East and Ms Miles explaining that the Trust was exploring methods of delivering services in innovative ways. He advised that two teams from the Trust had taken part in the Intrapreneur programme in London, with the objective of resolving an identified issue in their department in an innovative fashion. Learning from the programme would be shared throughout the Trust.

Ms Miles explained that the issue identified within Trauma and Orthopaedics concerned the number of patients attending the fracture clinic. Patients were asked about their experiences of attending the clinic and visits to peer organisations were undertaken before it was decided to pursue a virtual fracture clinic model. The aim of the virtual clinic is to give patients the same service they currently receive, but in their own environment rather than within the hospital, resulting in reduced footfall, decreased waiting times and improved accessibility for patients. It was hoped that the service would be launched in April 2017.

Ms Miles reported that the issue identified within Urgent Care was the reduction of ambulance waiting times. An improvement had been realised within six weeks via a social media campaign which had educated patients while enabling staff to feel more engaged and empowered.

Dr Bull explained that the teams had set up, and now led, a network of people across the region who were interested in the positive and swift results of the programme. Staff had provided very positive feedback and their experiences would enable the Trust to look at ways to make improvements throughout the organisation.

The Board noted the report on the Intrapreneur Project.

003/2017 **Feedback from Quality Walks**

Mrs Wells reported that she had spent time with the Conquest's IV team. She had been impressed by the team's kindness and compassion when a patient had allowed her to observe a line being inserted. The team was developing innovative methods of delivering care that could be transferred into the community to reduce the need for patients to come into hospital.

Dr Bull reported that the Quality Walk and the Walking in Your Shoes programmes had had positive effects on the organisation and in

improving the visibility of Board. He explained that he would look at evolving the programme to allow and encourage more informal engagement in the future.

The Board noted the feedback on Quality Walks.

004/2017 **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 Chairman noted that no potential conflicts of interest had been declared.

Mr Clayton-Smith noted that he was Chairman of the East Sussex Better Together (ESBT) Programme Board and that he chaired the Clinical Leaders Forum, explaining that these responsibilities did not conflict with any items on the agenda.

005/2017 **Minutes**

a) Minutes

The minutes of the Trust Board meeting held on 14th December 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.

006/2017 **Matters Arising**

118/2016 – Quality Walks

Discussed as item 003/2017 on the agenda

122/2016 – Trust Digital Strategy

Mr Reid explained that a paper on the Trust's Digital Strategy would be presented at May's Board meeting. Dr Bull noted that the Sustainability Transformation Plan's (STP) local digital roadmap was due to be published before the end of January, and that this would be presented at May's Board meeting. He explained that the Trust was committed to becoming paperlight by 2020.

134/2016 – Questions from Members of the Public – Overseas Patients

Mr Reid reported that the Trust received on average £115k income per annum for treatment of patients who were not eligible for NHS care. He explained that an individual was employed who, amongst other tasks, managed recovery of costs for these patients and that he was confident that only a small percentage of ineligible patients were not identified.

007/2017 **Chief Executive's Report**

Dr Bull reported that the Christmas and New Year periods had seen continued high levels of demand for services and as a result escalation areas had remained open in the Trust. Staff across the Trust had responded extremely well to the pressure, and the safe care of patients

had been maintained, but the demand had led to reduced performance.

He reported that a "Back to Green" week had taken place in January with a focussed system-wide initiative challenging and understanding the issues that existed in moving patients into and out of hospital. This had proved to be a valuable exercise for the Trust, Social Services and the CCGs with a number of lessons learned being taken forward.

Dr Bull reported that workforce strategy initiatives were taking place, looking at the skill mixes for the workforce into the future and maintaining a key focus on recruitment. Mr Clayton-Smith asked whether the improvements shown in medical staffing and recruitment had resulted in a reduction in agency costs and Dr Bull confirmed that the temporary medical workforce remained a small but significant cost. A number of specialities remained below establishment, and recruiting quality staff in these areas had proved to be difficult. Dr Bull explained that the situation was improving, and Ms Green noted that overseas recruitment continued alongside the development of different roles within the Trust, including the development with the University of Brighton of Physician Associate roles.

The Board noted the Chief Executive's Report.

008/2017 **Board Committees Feedback**

Audit Committee

Mr Stevens reported that clinical audit had been discussed at the last Audit Committee meeting. The National Diabetes Audit was not being completed by the Trust due to a lack of software, and a business case was being produced to resolve this issue. He explained that Dr Walker would be reviewing audit proposals in detail in the future to ensure that the Trust undertook less audits to a greater quality and completed them appropriately.

Mr Stevens reported that internal audit and counterfraud teams enabled the Trust to share learning from other Trusts and that this had led to an improvement in identifying potential risks. An audit of the Trust's cybersecurity had been completed and provided a focus on a number of issues. Mr Reid confirmed that the review of cybersecurity had highlighted areas where improvements could be made, but that no areas had been identified where the Trust's systems were vulnerable.

Mr Stevens reported that the counterfraud team would be undertaking a review of Trust mobile phone usage, and would look at whether consolidating to one phone supplier Trustwide could save the Trust money and reduce the potential for misuse.

He reported that Grant Thornton had been appointed as the Trust's external auditors from 1st April 2017.

Finance and Investment Committee

Mr Nealon reported that the Finance and Investment (F&I) Committee had maintained focus on meeting financial targets and monitoring the Trust's cash position. Proposed financial initiatives were carefully evaluated to ensure that they did not affect quality and safety, and support was being given by the Trust's PMO team in transforming these initiatives into savings. Mr Nealon explained that he was confident that the Trust was maintaining good financial controls.

Quality and Safety Committee

Mrs Bernhauser commended the Trust on the improvements it had made in providing feedback and learning from Serious Incidents and complaints.

A deep dive into Urgent Care had been carried out, providing a very useful insight for the Committee, and learning and analysis from the "Back to Green" week would be presented to the Committee in the future.

She reported that the Trust's new End of Life Care (EoLC) policy was almost complete and was awaiting a report and paperwork from a national group prior to being finalised. The policy would be reviewed in detail by the Quality and Safety (Q&S) Committee.

In response to a query from Mr Clayton-Smith, Mrs Bernhauser noted that she felt that communication between the Committees was good and was improving. Dr Bull reported that the Executives had found the improved consistency, support and challenge from Committees to be extremely useful.

People and Organisational Development Committee

Mrs Kavanagh reported that the Organisational Development Strategy was being reviewed by the Executive team prior to presentation to the People and Organisational Development (POD) Committee and the Board. She noted that while response rates to the staff survey had improved, further support would be offered to staff to improve response rates in the future and explained that the Family and Friends Test (FFT) was being reviewed with a view to increasing accessibility.

Dr Bull reported that work was being undertaken with all staff within the organisation in leadership roles to ensure that they had an appreciation of the Trust's expectations were for a core approach to manging teams.

Mr Clayton-Smith asked whether the remit of POD was correct, and Mrs Kavanagh explained that this had been reviewed by the Q&S Committee and was felt to be appropriate. Mrs Bernhauser noted that cross membership of Committees by NEDs was very valuable. Mr Clayton-Smith noted the demands that the committees placed on NEDS and was grateful for their hard work. He agreed to meet with Mrs Wells to see if greater NED capacity was required. **DCS/ LW**

009/2017 **Board Assurance Framework**

Mrs Wells highlighted that the BAF had been reviewed by both the Audit and Q&S Committees. She reported that three areas were rated as red, with no new additions.

She proposed that the risk associated with Outpatient administration should be revised from amber to green as effective controls and assurance were in place. This proposal was approved by 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, and approved the revision of the rating concerning Outpatient administration from amber to green.

QUALITY, SAFETY AND PERFORMANCE

010/2017 **ESHT 2020 Improvement Programme**

Mrs Webster highlighted that the only project that remained rated as red was the Urgent and Emergency Care project, where a significant amount of work had been undertaken but concerns remained about sustainability and management. Mrs Chadwick-Bell explained that the established improvement plan was being reviewed to ensure that actions were fully embedded and implemented, noting that it would take time for improvements to be realised.

Mrs Webster reported that progress was being made on EoLC improvements and that work was being undertaken on improving the experiences of patients and their families during final days of life.

Mr Clayton-Smith asked how lessons learned from exercises such as the "Back to Green" week were being embedded within the organisation. Mrs Chadwick-Bell explained that a review session had been held following "Back to Green" and that learning and actions from the week would be disseminated throughout the Trust. Improvements made as a result of this learning would be closely monitored to ensure that they were effective and sustainable.

Dr Bull reported that work was being undertaken to introduce protocols that would streamline patient pathways throughout the organisation in a consistent fashion. He explained that part of the SAFER bundle project was to give patients an expected discharge date when they were admitted to enable more effective discharge planning. Additional work was being undertaken to ensure a consistent approach to ward boards throughout the Trust, enabling electronic live bed states to be produced in the future.

Mrs Kavanagh asked when the benefits of the changes being made would be reflected in A&E performance. Mrs Chadwick-Bell explained that she anticipated immediate improvements, but did not expect the Trust to be able to meet the 95% A&E target until April 2018.

Mrs Kavanagh asked if the Board could review the mortality report mentioned within the papers. Mrs Bernhauser noted that the Q&S Committee had reviewed what was an internal report on mortality, and Mrs Wells agreed to speak to Dr Walker to see if the report could be circulated to the Board. **LW**

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

011/2017 **Integrated Performance Reports – November 2016 (Month 8)**

Mrs Webster reported that the Trust was now ensuring that Serious Incidents (SIs) were dealt with in an appropriate and timely manner. No SIs were overdue and seventeen had recently been sent to the CCG for closure. She reported that Divisional governance audit groups were ensuring that learning and actions following SIs were circulated and embedded.

Mrs Bernhauser reported that the Q&S Committee had received a report on SIs which had provided high levels of assurance about the changes that had been made. She thanked the governance team for leading on this work. Dr Bull noted that the overall level of incident reporting in the Trust had increased during the year to date, explaining that this demonstrated an improving safety culture within the Trust.

Mrs Webster reported that cards for feedback from FFTs were being used in the A&E department to see if this would increase the number of responses received and an FFT league table for responses on wards had been introduced which had led to improved response rates. A large piece of work, supported by Healthwatch, was underway to look at the quality of the Trust's response to complaints, with a deep dive planned on 22nd February. Dr Bull noted that it would useful to look at compliments received by the Trust alongside the work on complaints.

Access

Mrs Chadwick-Bell reported that the Trust had experienced a 1% drop in performance during the summer which had been stabilised during November and December. The Trust's waiting list had been reduced by 1,000 patients during November, and was due to be sent to an independent company, commissioned by NHSE, who would offer analysis which was hoped would lead to an additional 4% reduction through validation. The Trust saw an increase in inpatients in November of 15.3% from the previous year, and the day case rate increased by 8.4% from the previous year.

Mrs Chadwick-Bell reported that the Trust had seen a 4% improvement against the 4 hour A&E target to 82.4% in November in comparison to October. She reported that a new clinical lead for A&E had recently been appointed and that this had already led to improved engagement with consultant teams. Improvement leads had been appointed in both A&E departments who would support change management and embed changes in working practices across organisation.

The Emergency Care Improvement Programme (ECIP) were supporting the Trust in rolling out the SAFER bundle across medical wards during February and March. A redesign of medical assessment areas within the Trust was being planned in order to increase capacity for assessments and patient flow. An electronic dashboard, enabling current and predicted performance to be viewed in detail was being developed to allow improved planning.

Mrs Chadwick-Bell reported that the Trust had met diagnostic targets for October, and while a dip in performance had been recorded in November it was expected that targets would be met during December.

Sustainable performance was being delivered against cancer targets, with the exception of the 62 day target where further work was being undertaken. All patients breaching the 62 day target underwent a full pathway review and the causes of breaches were investigated.

Daily conversations were carried out with Adult Social Care and the CCGs to discuss the system-wide challenges that existed. Mrs Chadwick-Bell noted that the Trust was receiving excellent support from partner organisations, and that the Trust was taking action to resolve system-wide issues rather than waiting for others to help.

Mr Clayton-Smith asked about how issues with capacity were being resolved, and Mrs Chadwick-Bell replied that a daily call with the CCG and social services took place where issues could be quickly picked up. Dr Bull noted that Community performance against targets was included within the IPR and that an increasing number of patients were being reviewed by Community teams in their own homes in order to improve patient experience and relieve pressure on the Trust.

In response to a question from Mr Nealon, Mrs Chadwick-Bell explained that she felt that the Trust now had the correct team in place to resolve performance issues. She noted that staff in clinical site teams would be increased to improve performance, and time would be given to allow staff to effect improvements. Dr Bull noted that permanent staffing would be fundamental in realising sustained improvement

Mrs Churchward-Cardiff asked whether the system could afford for the Trust to deliver on Referral to Treatment (RTT) targets due to the cost that this would incur as a result of the Trust's Payment By Results (PBR) contract. Mrs Chadwick-Bell explained that the Trust had a duty to meet

constitutional standards and that if it did not treat patients then the CCG would have to pay for them to be treated by an alternative provider. Patients referred in line with agreed protocols would be treated, with affordability playing no part in the decision to offer treatment. Mr Reid confirmed that financial constraints were not impacting on the treatment of patients, and were not reflected within recovery plans, explaining that the CCG had not asked the Trust to limit treatments.

Workforce
Ms Green reported that temporary staff usage had reduced, as had vacancies within the Trust. During November turnover of staff was the lowest it had ever been for organisation, with sickness levels reduced during the month. Staff flu vaccinations had been carried out on 47% of staff, against a target of 50%.

Mr Clayton-Smith noted that the downward trend on turnover was very impressive. Mr Stevens expressed concern about the reduction in staff appraisals and Miss Green explained that focussed work was being undertaken to improve both appraisal and mandatory training compliance.

Finance
Mr Reid reported that Months 8 and 9 had seen improvements in the Trust's financial position, alongside a reduction in agency expenditure in month 8. He reported that an additional drawdown of capital from the Department of Health had been realised in January. As part of the Trust's Financial Recovery Plan, meetings were being held with suppliers to discuss any existing issues and ways to save money.

In response to a query from Mrs Churchward-Cardiff, Mr Reid explained that it had become clear that full delivery of the agreed £14million 2015/16 Cost Improvement Programme (CIP) would not be possible. The Financial Recovery Plan (FRP) had reviewed the CIP, and it was expected that £4-5million of savings from the original CIP programme would be delivered. The Month 9 report showed the much improved trajectory against the refreshed CIP programme developed under the FRP.

The Board noted the Performance, Workforce and Finance Reports for November 2017.

012/2017 **Financial Special Measures Update**
Mr Reid thanked colleagues from throughout the Trust for their support in shaping and implementing the FRP. He reported that the version of the FRP that was being presented to the Board was the second iteration which set a target of delivering £16million in efficiency savings by the end of the financial year.

Mr Reid explained that the Trust had a £4.2 million deficit against the plan in month 8 which had been reduced to a £3.2million deficit in month

9. This was a significant improvement, but further sustained improvement was required in order to meet the efficiency savings target by the end of the financial year.

Mr Nealon noted that the financial improvement programme implemented prior to the Trust being placed into Financial Special Measures (FSM) had been given additional focus and pace by FSM.

Mr Clayton-Smith highlighted the need to ensure that financial efficiencies were sustainable and could be continued into the future. He explained that the Board was being asked to delegate authority to the Finance and Investment Committee to review the revised FRP in detail and agree any changes to the forecast position as necessary.

The Board delegated authority to the Finance and Investment Committee to review and approve the revised financial Recovery Plans.

013/2017 **Annual Plan and Budget 2017-18**

Mr Reid reported the Trust's internal financial planning had been completed with the input of colleagues throughout the Trust who had collectively developed the annual plan and budget for 2017-18. He explained that the Trust's overarching business plan was being completed and would be presented to the Board in April.

Mr Clayton-Smith asked whether system-wide agreement had been reached about the Trust's activity levels and associated income. Mr Reid explained that the annual plan and budget was made using assumptions based on current activity levels and had been developed jointly with the CCGs. The ESBT overarching plan was also in development and work was being undertaken to ensure the overarching affordability of plans, set against a background of an overall affordability gap of £40-60m across services including social services. £30million of plans had been identified so far to bridge this gap in funding.

Mr Clayton-Smith asked whether the assumptions included within the plan about levels of employees, bank staff and agency staff were realistic and Ms Green replied that she felt that they were. Mr Reid explained that the Trust had not achieved its planned agency reduction and that as this would be addressed as part of the annual planning process.

In response to a query from Mrs Churchward-Cardiff, Mrs Chadwick-Bell explained that non-elective bed requirements had been reviewed in order to establish the absolute number of beds required to ensure that patients had access to the right bed at the right time. Bed spaces had to be available to patients when they were needed or pressures would continue to be felt throughout the organisation.

Mr Stevens noted that achieving the planned reduction in agency spend would be challenging, and felt that the planned contingency of 0.5% would not be adequate, suggesting a minimum of 2.5% contingency. Mr Reid agreed that the level of contingency was small, however, regulators may look to reduce contingency levels if they were considered to be too high.

Mr Clayton-Smith noted that concerns had been raised by the Board about income, expenditure, capacity, inefficiencies and contingency.

The Board noted the Annual Plan and Budget 2017-18

STRATEGY

014/2017 **Business Planning 2017-19**

Ms Ashton outlined that the Trust's business planning process was closely linked to the Trust's financial plans. She explained that the paper being presented set out the framework for developing business plans, engaging with Clinical Units and a timetable for progress.

Mr Clayton-Smith asked whether CCG colleagues would recognise the activity assumptions include within the plan and Ms Ashton replied that there was a recognised gap between the Trust's financial assumptions and those of the CCG. The Trust was trying to conform to both regulatory requirements and ESBT's plans, whilst recognising that work emerging from STP plans would have an ever increasing impact on the Trust. Dr Bull noted that strategic planning was now taking place on a cross-system basis, and that Ms Ashton was fully involved in this process.

Mr Clayton-Smith asked whether any actions that arose from the CQC's report would be included within the final plan and Ms Ashton confirmed that actions would be incorporated.

Mrs Churchward-Cardiff asked whether there was any flexibility within the proposed timetable and Ms Ashton replied that major strategic elements had been identified which would inform the direction of planning. She expected that additional items would emerge before plans were finalised in April, and explained that these would be included as necessary.

Mr Nealon noted that a challenge to the Trust's plans would be in balancing investment required within community, to try and reduce patients coming to the hospital, against an actual reduction in patient attendances. Dr Bull reported that a discussion had taken place with the CCGs about this issue and a further review of planned CCG investment in community services would be undertaken to provide assurance.

The Board noted the Business Planning report 2017-19

015/2017 **Board Sub Committee Minutes**

Finance and Investment Committee

The Board noted the Finance and Investment Committee Minutes.

People and Organisational Development Committee

The Board noted the People and Organisational Development Committee Minutes.

Mr Clayton-Smith stated that he was pleased to see evidence of increasing links between Committees, noting the importance of realising improved performance as a result of organisational changes.

ITEMS FOR INFORMATION

016/2017 **Questions from Members of the Public**

Ms Walke noted that the presentation of Board papers was greatly improved from previous meetings, and had made the papers more accessible.

Ms Walke explained that plans to reduce funding to the Trust by £40million by moving care into the community were not being communicated effectively with the public, noting that she planned to raise the issue with the CCG the following day. Dr Bull explained that ESBT was a small part of the overall STP programme, and that there continued to be a focus within the STP on investment in hospitals with significant capital investment being made at Brighton Hospital. A discussion about the reduction in funding continued to take place on a collaborative basis across the system.

Ms Walke noted that the Save the DGH Campaign would like to hold a further meeting with Dr Bull, and asked for this to be arranged.

Ms Walke asked whether mortality data could be reported by age range and Dr Bull replied that Summary Hospital-level Mortality Indicator (SHMI) figures reported by the Trust were already age adjusted. There would be a risk of being able to identify individual patients if more detailed data was released. Dr Bull explained that the Trust was notified of any areas of concern regarding mortality and that all deaths within the Trust underwent clinical review within three months to enable any issues or trends to be identified.

Mr Hardwick asked whether the possibility of providing transport for patients between Eastbourne and Hastings had been comprehensively explored. Dr Bull explained that a review had been carried out looking at

the views of both patients and members of staff and had found insufficient demand for such a service. He reported that the Trust was looking at possibilities for alternate means of transport for members of staff moving between sites for clinical reasons, including the possibility of a fleet of electric powered vehicles. Mr Hardwick asked if it would be possible to see the review and Mrs Wells agreed to see if this could be arranged. **LW**

Mr Hardwick noted that recent response times when trying to phone the Trust had been poor, and asked why staff repeated a message about calls being recorded for training purposes on every occasion. Mrs Webster explained that the issue had been recognised and was being picked up by the Q&S Committee. The Trust was exploring the possibility of installing additional lines to improve the situation, and the explanation that calls were recorded was a mandatory requirement. She explained that improvements were being made to Outpatients' phone systems which would help relieve pressure on the main switchboards.

In response to a question from Ms Walke, Dr Bull explained that the reasons for any delayed transfer of care were assessed. In principle the Trust could charge social services for additional days that patients spent in hospital as a result of delays, but as social services were fully committed to helping the Trust this was not considered to be a useful action to take.

Ms Walke asked whether all staff were aware of the financial challenges faced by the Trust and whether they had been asked if they had solutions to the issues. Ms Green reported that a six week scheme where staff would be asked for suggestions, with a commitment to responding to all suggestions, would be launched. Dr Bull reported that an additional explicit scheme would run in parallel with this which invited staff to come forward to apply for supported programmes looking at improvement projects that would help improve efficiency and quality in different areas.

017/2017 **Date of Next Meeting**

Tuesday, 21st March 2017, in the Cooden Beach Hotel

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 24th January 2017 Trust Board Meeting

Agenda item	Action	Lead	Progress
008/2017 – Board Committee Feedback	Mr Clayton-Smith and Mrs Wells to meet to discuss NED capacity	Lynette Wells	Meeting held. Agreed to review again in 6 months in light of ACO developments.
010/2017 – ESHT 2020 Improvement Programme	Internal mortality report to be sent to Ms Kavanagh	Lynette Wells	Complete. Report sent to Ms Kavanagh.
016/2017 – Questions from members of the public	Mrs Wells to find out if review of possibility of providing cross site transport for patients could be made public.	Lynette Wells	Complete. Report sent to Mr Hardwick

Speak Up Guardian December 2016-January 2017

Meeting information:			
Date of Meeting:	21st March 2017	Agenda Item:	5
Meeting:	Trust Board	Reporting Officer:	Ruth Agg

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

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

Executive Summary:

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

Staff continue to come forward to share concerns, Activity is higher from the number of calls, "drop ins" and emails received. Group activity recorded as one face to face currently but the National Guardian is leading on a data base for all trusts.

- Themes of undermining and poor behaviour which do not fit with the Trust values continue to arise but are being addressed and staff follow up has indicated improvement in areas where this has been raised.

- Patient safety is the priority and the staff survey provides proof that staff are more confident in raising concerns and completing Datix risk forms.

- Wellbeing of staff members remains a priority in supporting high quality care for patients. The Speak up Guardian has an open door policy on site, and since relocating to near the staff restaurant a increased number of staff "knock ". Some are looking for guidance and can receive timely advice; other staff may need to talk through concerns in a confidential space.

- The new role has new pathways with HR and the relationship continues to enable mutual respect and working together to resolve staff concerns in a timely and supportive way. Team working has supported staff on long term sickness in returning to work.

- The National policy for Freedom to Speak up: Raising Concerns (Whistleblowing) has been incorporated into the Trust's local Policy which is due for ratification. This will be rolled out.

- Groups of staff have come forward and this has resulted in investigation into group concerns, to look at Leadership, training needs and wellbeing of staff moving forward.

- Bands 1 up to Consultant level have shared concerns with the Speak up Guardian, clinical, non-clinical and Volunteers have also sought support. Three relatives have contacted the Speak up Guardian in February, and a relative with a patient in another hospital sharing concerns. Speak up Guardian has visited patients, liaised with ward staff and family to provide reassurance and a listening ear.

- A video regarding the role for Mandatory training and inductions due to be filmed to ensure staff are aware of the role and the need to Speak up.

- All trusts have a Guardian in place now, Guardian contacted by a number of trusts to share the work we have undertaken.

- South East Coast Guardian network, elected Vice Chair.

- Concerns raised by staff have linked in with CQC findings

2. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

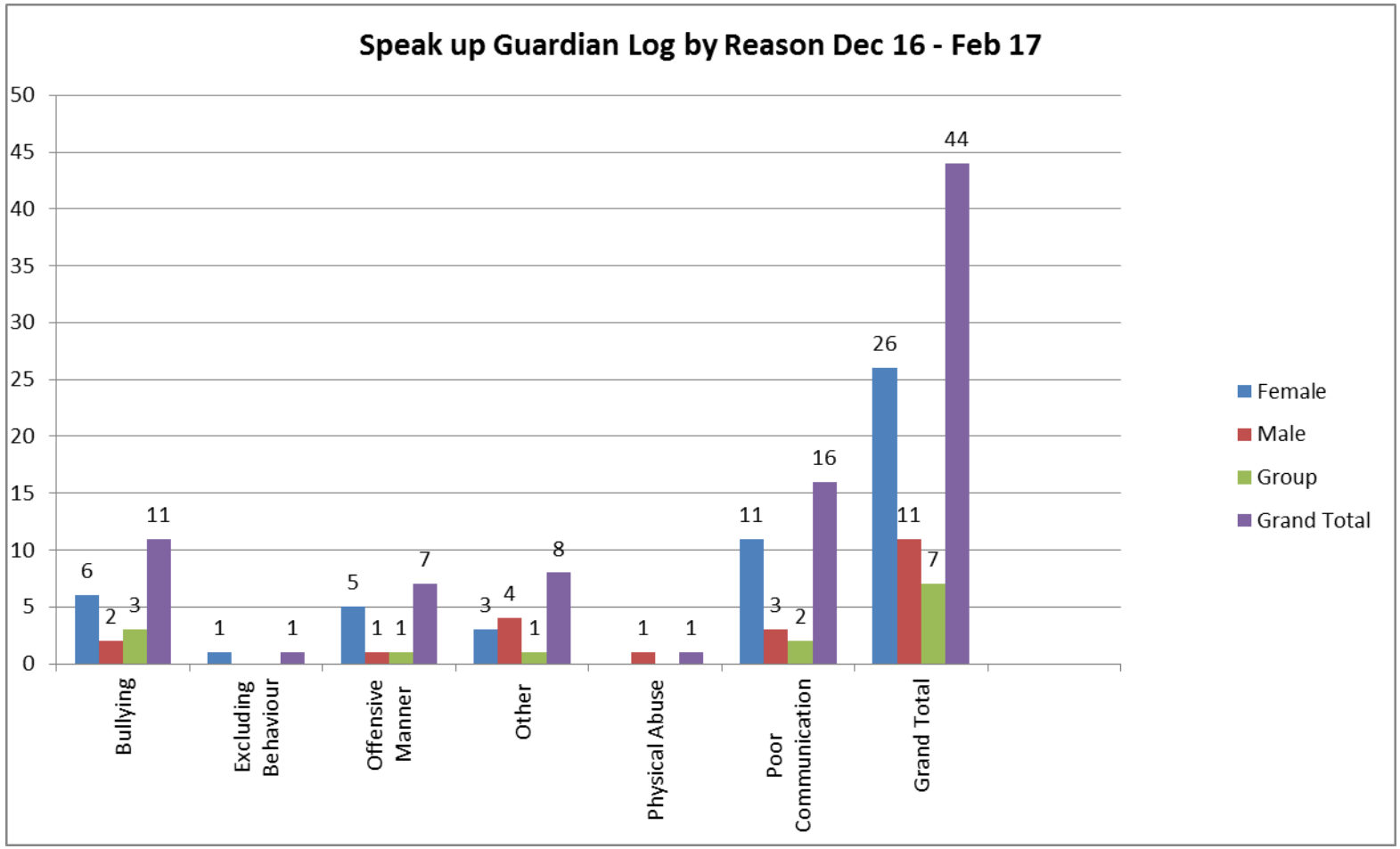
- Regular meeting with Chief Executive, staff wanting to share concerns, fear of reprisal concerns staff, but assurance from Board re zero tolerance of reprisal is facilitating staff coming forward at all levels.
- National Guardian in place to support Guardians with any difficulties raising concerns at Board level is a reassurance to staff and the Public that concerns can be escalated externally.
- Speak up Guardian supported by the Chief Executive with some of the complex concerns.

Freedom to Speak Up **Guardian**

Categories (All)	Female	Male	Group	Grand Total
Bullying	6	2	3	11
Excluding Behaviour	1			1
Offensive Manner	5	1	1	7
Other	3	4	1	8
Physical Abuse		1		1
Poor Communication	11	3	2	16
Grand Total	**26**	**11**	**7**	44

Categories (Open)	Female	Male	Group	Grand Total
Bullying	2	1	1	4
Offensive Manner	3		1	4
Other	2			2
Poor Communication	4	1	1	6
Grand Total	**11**	**2**	**3**	**16**

Categories (Resolved)	Female	Male	Group	Grand Total
Bullying	4	1	2	7
Excluding Behaviour	1			1
Offensive Manner	2	1		3
Other	1	4	1	6
Physical Abuse		1		1
Poor Communication	7	2	1	10
Grand Total	**15**	**9**	**4**	**28**


Speak up Guardian Log by Reason Dec 16 - Feb 17
50
45
40
35
30
25
20
15
10
5
0
6
2
3
11
1
1
5
1
1
7
3
4
1
8
1
1
11
3
2
16
26
11
7
44
Bullying
Excluding Behaviour
Offensive Manner
Other
Physical Abuse
Poor Communication
Grand Total
Female
Male
Group
Grand Total

Quality Walks January – February 2017

Meeting information:			
Date of Meeting:	21st March 2017	Agenda Item:	6
Meeting:	Trust Board	Reporting Officer: :	Alice Webster

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

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☐
Staff	☒	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:	.....		

Have any risks been identified ☐ *(Please highlight these in the narrative below)*	On the risk register?

Executive Summary:

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

22 services or departments have received visits as part of the Quality Walk programme by the Executive Team between 1st January and 28th February. The Chief Executive has also visited a number of departments and staff groups in addition to the formal programme. A summary of the observations and findings noted are detailed in the attached report.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

None

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Board are asked to note the report.

Introduction

Quality Walks are carried out by Board members and can be either planned or 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, observe different roles and functions and afford assurance to the Board of the quality of care across the services and locations throughout the Trust. The process enables areas of excellence to be acknowledged, risks to be identified and allow staff the opportunity to meet and discuss issues with members of the Board.

Analysis of Key Issues and Discussion Points Raised by the Report

22 services or departments were visited as part of the Quality Walk programme by the Executive Team between 1st January and 28th February as detailed below. The Chief Executive also visited several departments and staff groups in addition to the formal programme.

Date	Time	Service	Site	Visit by
11.1.17	9am	Occupational Therapy	EDGH	Monica Green
18.1.17	10am	Community Nursing Team, Park Practice,	Eastbourne	Sue Bernhauser
18.1.17	Evening	OT, Seaford 3, Hailsham 4, CDU, MAU, HIT Team Leader	EDGH	Catherine Ashton
25.1.17	12pm	Cookson Attenborough	Conquest	Jackie Churchward Cardiff
2.2.17	10am	Cuckmere Ward	EDGH	Jackie Churchward Cardiff
2.2.17	10.30am	Radiology	EDGH	Monica Green
6.2.17	3pm	Physiotherapy	EDGH	Catherine Ashton
9.2.17	10.30am	Egerton unit	Conquest	Miranda Kavanagh
9.2.17	11.30am	MacDonald Ward	Conquest	Miranda Kavanagh
14.2.17	3pm	Tressell Ward	Conquest	Lynette Wells
15.2.17	2pm	RADS Team	EDGH	Miranda Kavanagh
15.2.17	3pm	Maternity Unit/Littlington Ward	EDGH	Miranda Kavanagh
20.2.17	2.30pm	SCBU	Conquest	Monica Green
24.2.17	10.30am	Radiology	Conquest	Monica Green
27.2.17	2pm	Glynde Ward (ENT OPD)	EDGH	Jackie Churchward Cardiff
27.2.17	4.30pm	ITU/HDU	EDGH	Jackie Churchward Cardiff

The majority of these visits were pre-arranged and the Ward or Unit Manager notified in advance to expect the visit, other adhoc visits may also have taken place.
Feedback received relating to the visits has been passed on to the relevant managers for information.

Key Themes and Observations

<u>Communication and Engagement</u>

- Some staff commented that they felt disappointed that the Trust had not been able to exit special measures following the CQC inspection last autumn however they had confidence that improvements had been made and as such feel that further improved ratings will follow in the near future.
- The implementation of the ward orderly role is being seen as a positive improvement.

- The Eastbourne Maternity Unit had concerns regarding a lack of awareness and acceptance of the midwifery led unit. A Facebook page for the unit has been developed which is proving to be quite successful.
- The Special Care Baby Unit have published a leaflet about "Our Journey So Far" which details the departments experiences about working together; improvement and development; respect and compassion and engagement and involvement, and gives real examples such as the introduction of a shift co-ordinator role; changes to handover; the introduction of a practice educator and involving services in improvements and staff development. The team recently shared their experiences at a Schwartz Round[1] and this has really made them reflect how far they have now moved on since the reconfiguration of Children's and Maternity Services.

Incidents Risks and Safety Issues

- Medical outliers remain a challenge, for example the short stay surgical unit is not fully equipped for the needs of medical patients but as part of the Trust escalation process often find they are looking after medical patients due to the pressure on bed capacity, and securing medical input can sometimes be a challenge which can lead to treatment and discharge delays.
- Inadequate cover for ward clerks when on leave impacts on ward efficiency and availability of patient documentation.
- The introduction of SAFER bundles[2] which will help coordinate multidisciplinary teams input and allow the wards to develop more efficient patient pathways is being received positively.
- One area providing outpatient services commented that as they receive the patient records on the same day as the clinic this doesn't leave enough time to check that the data is complete.

Other Issues

- Storage space for equipment in some areas remains a challenge.
- Staff have found the recent 'Dump the Junk' initiative to be successful and hope that this will be repeated to decongest wards and departments of obsolete items.
- One ward reported delays for patients scheduled for interventional radiology procedures under anaesthetic.
- The refurbishment and redesign of the radiology department has made a considerable difference especially in relation to patient dignity. There are now separate waiting areas for both outpatients and inpatients and those on trolleys are in separate single sex bays. Patients who are undressed and waiting for a procedure no longer wait in communal waiting areas.
- Some staff feel the procurement process can be frustrating and can delay stock availability. There was an expressed wish for senior staff to be given budget responsibility and a confidence that this would be more efficient and appropriate.

Staffing

- Some staff reported that the requirement to provide escalation beds in some areas presents a mis-match with skills and environment which can destabilise teams.
- An occupational therapist that had recently joined the Trust from another part of the country was very positive about the organisation and felt that there were good opportunities to explore potential career options.
- Staff shortages were still reported in some areas.
- Generally staff were very positive about the organisation and the teams they worked in.

[1] Schwartz Rounds provide an opportunity for staff from all disciplines to reflect on the emotional aspects of their work.
[2] SAFER bundles are a set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients

Patient feedback

- Most of the patients spoken to were very positive about the care they had received.
- One patient reported that they were desperate to go home but were unable to do so because of lack of care provision.
- Some patients reported that communication between departments was sometimes poor so that patients with co-morbidities found it difficult to know 'where they were in the system' when care had to be coordinated between specialties. .

Risks and Implications

Any risks identified are acted upon and escalated to the risk register as appropriate. Any actions identified at a Quality Walk are agreed at the time and noted who will be responsible for taking forward the action.

East Sussex Healthcare NHS Trust

Audit Committee

1. Introduction

An Audit Committee was held on 19th January 2017, but as the final minutes have not yet been approved a summary of the items discussed at the meeting is set out below.

2. Matters Arising

The Trust's non-participation in the National Diabetes Audit, due to a lack of necessary software, was noted. An update on progress was requested for March's meeting.

3. Board Assurance Framework and High Level Risk Register

The Board Assurance Framework and High Level Risk Register were presented. Two new risks had been added to the Risk Register since November 2016, concerning Conquest switchboard failure and the temperature in pathology stores. Three areas on the BAF, relating to emergency department reconfiguration/patient flow, patient transport and finance were rated as red. The Committee supported a recommendation to be made to the Board to reduce the rating associated with Clinical Administration from amber to green.

4. Clinical Audit Update

Plans for reducing the number of abandoned audits were outlined. Discussions were held about including an audit component within the Consultant appraisal process and it was agreed that the POD Committee would pick up this issue.

5. Internal Audit Progress Report and Recommendation Tracker

The Committee received an update on internal audit progress. Four final audit reports had been issued – three gave "Limited" assurance while the fourth was a status report on the IG Toolkit in advance of a Q4 audit. Three draft reports issued , one giving reasonable assurance and two operational reviews. Good progress was being made against the 2016/17 internal audit plan, with first and second quarter work all completed.

ICT Cybersecurity was discussed in some detail. The Trust had set up a digital steering group to oversee implementation of the emerging cybersecurity policy. The Audit Recommendations tracker was reviewed and progress on completed actions noted.

6. Local Counter Fraud Service

The Committee received the Counter Fraud progress report and noted actions that were being taken. A review of Trust mobile phone usage was due to be undertaken and an increase in training sessions to raise staff Counter Fraud awareness had been implemented.

7. Information Governance

IG incidents reported within the Trust had reduced in 2016/17, with no incidents reported to the Information Commissioner's Office during the year.

8. Tenders & Waivers Report

A substantive Head of Procurement had been recruited, and work was underway to build up the Trust's procurement team.

Mike Stevens
Chair of Audit Committee

2nd March 2017

East Sussex Healthcare NHS Trust

Quality and Safety Committee

1. Introduction

Since the Board last met a Quality & Safety Committee meeting was held on 18th January 2017. The minutes of that meeting are due to be approved at the next meeting on 22nd March 2017. A summary of the items discussed at the meeting is set out below.

2. Patient Story

Two Serious Incident reports relating to patient pathways were shared and it was agreed that this should become a regular item (every six months) to monitor evidence, actions and conclusions/learning.

3. Board Assurance Framework

It was noted that 3 areas were showing red:

- Emergency Department Reconfiguration/Patient Flow. Urgent Care Improvement plan was in place and being monitored weekly.
- Patient Transport. Preparatory work for transition was underway.
- Finance

4. High Level Risk Register

Two new risks had been opened since November 2016:

- Conquest switchboard failure.
- Temperature in pathology stores.

Other risks were being followed up with a target date of end January 2017.

3. Quality Improvement Plan

The 4 main programmes within the Improvement Programme were:

- Urgent and Emergency Care Improvement Project
- Mortality and Morbidity Assurance Project
- End of Life Care Project
- Exemplar Ward Project

An additional project had been agreed to focus on patient driven improvements in 2017.

5. **Governance Quality Report**

Key highlights:

- Risk Register – this was continuing to improve.
- Friends and Family Test data was being shared on a monthly basis with the Divisions and individual departments.
- A deep dive on Falls had commenced.
- A deep dive on Pressure Ulcers was planned.
- Complaints backlog was still an issue – further improvements were planned.

6. **Patient Safety and Quality Group**

A clear set of Key Performance Indicators had been developed to measure progress.

7. **End of Life Care Update**

- End of Life Care and Specialist Palliative Care had full time programme management support.
- NHSI had approved funding for an educational programme for consultants and senior registrars.

- Priorities of the project included robust line management and business continuity plans to assure consistent service delivery.
- End of Life Care project to be shared with Non-Executive Directors in April 2017.

8. Deep Dive - Urgent Care Update

Urgent Care Programme was in place with good clinical engagement.
The project was being delivered through 5 work streams:

- A & E improvements
- Revised medical model
- Discharge planning
- Capacity planning
- Governance arrangements

Key Highlights:

- Two improvement leads were in post for Conquest and Eastbourne to advise, mentor, train and help to change the culture within the departments.
- Patient flow work on six wards had reduced lengths of stay.
- A pilot had been started with one GP working one day per week – this was part of the East Sussex Better Together work.
- Discussions were taking place regarding the re-commissioning of GP Out of Hours service.
- Back to Green week had been a success and an update would be presented to the 22nd March 2017 meeting.

Sue Bernhauser
Chair, Quality and Safety Committee

7th March 2017

Board Assurance Framework

Meeting information:			
Date of Meeting:	21 March 2017	Agenda Item:	8F
Meeting:	Trust Board	Reporting Officer:	Lynette Wells, Director of Corporate Affairs

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

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

Executive Summary:

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

Attached is the updated Board Assurance Framework (BAF) which includes 3 areas rated red:

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

Assurance should increase in respect of patient transport once the new service has been fully implemented. There is one addition to the BAF, 2.17 in respect of the Trustwide ability to monitor and formally report on follow up appointments in order to ensure there is no clinical risk to patients suffering a delay.

There is a proposal to remove two items from the BAF
2.1.3 Management of infection control incidents as effective controls in place and shared learning evident
4.4.1 in respect of capacity for tender and AQP as this is now controlled with team in place.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Audit Committee – 23rd March 2017 Quality and Safety Committee – 22nd March 2017

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Trust Board is asked to review and note the revised Board Assurance Framework and consider whether the main inherent/residual risks have been identified and that actions are appropriate to manage the risks. The Board is requested to agree the removal of the two gaps in control in respect of capacity to tender and infection control.

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

	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.	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.
4.	We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.
5.	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 sustainable.
	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 registration and compliance with regulatory bodies.
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, loss of market share and financial penalties.
2.2	There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.
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 operate efficiently and effectively within the local health economy.
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.
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 commissioners
4.1	We are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.
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.
4.3	We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan
4.4	We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.
5.1	We are unable to effectively recruit our workforce and to positively engage with staff at all levels.
5.2	If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.

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 experience for patients	
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 regulatory bodies	
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 PMO function supporting quality improvement programme iFIT introduced to track and monitor health records EDM implementation plan being developed Comprehensive quality improvement plan in place with forward trajectory of progress against actions.
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 independently meets with auditors Deep dives into QIP areas such as staff engagement, mortality and medicines management Trust CQC rating moved from 'Inadequate' to 'Requires Improvement'

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 Improvement plan developed Improvement Director working with the Trust. Mar-16 In depth review of all warning notice actions by exec team . QIP monitored by stakeholders, medicines management and incident deep dive took place Mar-16. May-16 to Sept-16 2020 Quality Improvement Priorities agreed and key metrics developed to support compliance and monitoring. Commenced preparation for Autumn CQC inspection. Mock inspection took place end June, further mock planned end of July. Continued monitoring of QIP and preparation for CQC inspection. Nov-16 CQC inspection took place October - draft report expect Dec 16. Continuing with quality improvement priorities eg end of life care and optimising patient pathways. Jan-17 Draft report expected this month Mar-17 Report published end of Jan 17. Trust rating moved to 'Requires Improvement' Good progress evidenced in a number of areas however 2 must do actions and 34 should do actions to address. Programme of improvements in place.	end Oct-17	◄►	DN	Q&S SLF

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 - Dec15 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. Centralisation of Health Records and records management structure reviewed. Ongoing programme of work to support effective delivery of health records service monitored by SLF. Consultation taking place re health records structure. Mar 16 - Significant reduction in missing notes, positive feedback from clinicians.. Storage remains challenging but is being addressed through the development of an off-site facility. Repairs continue but ultimate solution is the EDM programme. May-16 Marked improvement in the availability of records. Progressing offsite record storage Sept-16 New centralised storage facility open, 4 month transition plan to this facility. Short term rise in incidents regarding temporary notes due to the transition period which is monitored daily/reported weekly. Clear escalation processes in place to avoid impact on patient care. Issues regarding tracking of files outside of Health Records is being challenged and positive engagement encouraged. EDM preparation ongoing. Nov-16 Final stages of reconfiguration underway. Further staff consultation taking place. Some delays due to estates work and other operational pressures (18 week recovery plan). Significant improvement in non-availability of records, currently at 2.6% but not back to target of less than 1%. Now accelerating input into EDM preparation; identifying concern's/risks associated with this based on learning from other Trusts. In all other cases Health Records resources was underestimated and with ESHT we have the additional issue of 'change fatigue' Mitigations will be developed. Jan-17 Non availability currently averaging 2.08% (Dec 16). This includes additional 18 week RTT activity in Ophthalmology and Gynaecology. Storage capacity now resolved however quality of records will remain an issue until the roll out of EDM.. 'Go live' of first specialty delayed until February 17 by Project Board Mar-17 Non availability has averaged 1.90% over January and February 2017 which continues to include the 18 week RTT activity. EDM went live on 27/2/17 for deceased health records. Work is ongoing within EDM for specialty go live. Repairs to health records are currently undertaken prior to the notes leaving the library.	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, loss of market share and financial penalties.	
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 Root Cause Analysis undertaken for all IC outbreaks and SIs and shared learning through governance structure Cancer metric monitoring tool developed and trajectories for delivery identified, part of Trust Board performance report.
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 compliance. Consistent achievement of 2WW and 31 day cancer metrics

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 performance position. Mar-16 - Achieved 2WW breast symptomatic in Jan and both standards in Feb. In addition, TDA support provided 2 days per week to focus on sustainability and 62 day achievement. May-16 Ongoing review and strengthened processes supporting improved performance against cancer metrics. 2WW achieved Feb/Mar, breast symptomatic not achieved Mar, 62 days improving. Jul-16 Achieved 2 week wait and 31 day standard for last quarter. Clinically led Cancer Partnership Board commenced June . Cancer Action Plan providing continued improvements such as the reduction on 2 week wait triage delays. Sept-16 Continued achievement of 2WW and 31 day standards. Number of actions in place to support progress in 62 day achievement. Nov-16 Continued achievement of 2WW and 31 day; 62 days 79.5% against trajectory target of 80.5% Nurse Advisor commenced October to support all cancer pathways and targets. Collaborative piece of work with CCG re 2WW criteria to ensure compliance with guidance and appropriately targeted referrals. Cancer Services and Specialist Medicine are working on a bid to the CCGs for specialist endobronchial ultrasound local provision Jan-17 Compliance with 2WW and 31 day. 62 days off trajectory at 72.^% Continuing to embed actions outlined above. Mar-17 Continued achievement of 2WW and 31 day standards. 62 days 84.1% off trajectory but improving. Number of programmes in place to support improvement including joint PTL tracking with both Brighton and Guys.	end-Jun 17	◄►	COO	SLF

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 Capital bid with TDA for review to support expansion; outcome awaited, planning permission being sought in advance. Dec-15 Capital bid to be considered by ITFF at end of Feb. Mar-16 AHSN developing proposal to support the Trust with patient flow in A&E areas which will have a positive impact on privacy and dignity. Risk remains red as reconfiguration still required. May-16 Finance application being redeveloped for submission to ITFF to support capital plans. Jul-16 Trust prioritising reconfigurations from own capital programme to support effective patient pathways and address privacy and dignity issues. Finance application being redeveloped for ITFF. Sept-16 Urgent Care Programme Board established. Multi-disciplinary summit being planned to further support improved patient flow. Nov-16 Number of improvements being implemented in A&E although some not fully introduced due to staffing and space concerns, particularly at Conquest site. Principles of Medical Model approved by Urgent Care Board and SAFER bundle pilot of 6 wards commenced in October with aim of improving patient flow by discharging patients earlier in the day to enable patients to be “pulled” from A&E, CDU and AMUs earlier in the day. Jan-17 Continued pressure on Urgent Care and Patient Pathway. Urgent Care Improvement Plan ion place and monitored weekly against the 9 improvement areas to ensure the anticipated impact is being realised. Streaming has led to an improvement in the number of breaches. New clinical lead for EDs appointed. Daily Opex call in place to discuss system wide issues. Mar-17 SRO reviewing project and re-aligning to focus on five priority areas. Streaming pathways written up for sign-off with specialties. ESHT Principles of Effective Emergency Care published and communicated to consultant and junior medical staff. SAFER bundle being rolled out across the Trust.	end Jun 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.	Mar-16 External assurance visits via CCG, TDA and External DIPC, Head of Estates and IC Lead. Awaiting report immediate action required in 2 out of 6 areas following one visit. Nothing further identified in remaining CCG assurance visits. Control dashboard being developed and planned to be part of the accountability review meetings. Single comprehensive action plan and annual programme of work being developed for April 2016. Assurance moved from Green to Amber. May-Sep16 Bare below the elbows policy implemented in all clinical and ward areas. Increased compliance with national cleaning specification standards. Further work required to ensure BBE policy is embedded. Increased numbers of C Diff on EDGH site being closely monitored with support from CCG and NHS Imp. Talent work working with the Infection control team to manage the cultural change element of the embedding IC into practice. Increased monitoring of compliance by the IPCT & Hand hygiene peer audits undertaken. Trends from lessons learned from CDI RCAs monitored and discussed at relevant meeting for shared learning. Re-audit of MRSA compliance demonstrated slight improvement. Further work required to improve compliance. Nov-16 Workshops to support IPC strategy through staff engagement commencing Nov 16. Fifteen IPC policies have been update for 16/17 with updates being shared through the Infection Control link facilitators programme for dissemination. Bed space cleaning process re-introduced to provide improved assurance of cleanliness of the patients bed space. IPC team have worked closely with Maternity wards to improve cleanliness issues raised. Shared lessons learned from C diff post infection reviews continue to be shared through various channels. Focus required on improving compliance with the Trust's antimicrobial policy and nursing equipment cleanliness. Jan-17: email from Medical Director and DIPC sent to all Consultants sharing lessons learned from Post Infection Reviews and highlighting the need for improved compliance with the antimicrobial policy. Last lapse in care that caused harm to the patient due to non-compliance with antimicrobial prescribing was in Sept 16. The rates of >72 hours CDI cases have reduced during Qtr 3 as the Trust was within its limit with 8 cases against a limit of 10. Peer hand hygiene audits undertaken in Dec saw an improved score of 81% compared to 72.6% in Sept. We received our first Trust apportioned case of MRSA Bacteraemia in Dec from a patient on MacDonald ward. Post Infection Review in progress. Mar-17 Infection Control Strategy in place 'infection control is everyone's business' Infection control incidents investigated and reviewed by Inection Control Committee and outcomes and learning is shared.	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 reputational impact, loss of market share and financial penalties.

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.	Action plan developed. Identified top 10 drivers for elevated indices and reviewing pathways for cause in these groups. Internal mortality summit May 2016. Mortality Overview Group in place and additional governance review of deaths using data from the Bereavement Office. Peer review and support being accessed. May-16 Weekly review of deaths undertaken by consultant and senior coder. Work underway to understand further co-morbidity profile of our patients. A number of clinical pathway reviews in place to reduce risks eg colitis, deteriorating patient, gastroenterology. Jul-16 Mortality Improvement project expanded to incorporate AKI, Pneumonia, Sepsis. Sept-16 Full time project manager now in post. Plans in development following scope prioritisation. New Medical Director to review programme. SHMI reduced from 114 to 111 now within the normal range. Nov-16 Extensive mortality project developed to address issues. Groups established to review sepsis, VTE, pneumonia and COPD. Sepsis project being rolled out. Lead for AKI being sought as previous one recently stepped down. Consultant mortality review rates improving, with provision of clinical governance support. Mortality review data at individual consultant level to be discussed in appraisals. Independent mortality reviews performed weekly for last 6 months – project completed, report awaited (due shortly). Jan-17 Report or independent review received and being reviewed; no deficiencies in care identified, but note taking poor across the organisation. SHMI remains 111, preliminary data from RAMI suggests risk adjusted mortality is falling towards national mean. Due to delayed reporting of SHMI it will take a while for this to be reflected. Still no AKI lead - advertised for nurse lead to take project forward. Mar-17 SHMI reduced to 110. RAMI monthly data encouraging, suggesting further fall in mortality over the next few months (SHMI reported 6 months in arrears). AKI lead now in place and the project is progressing.	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 and activity being monitored. Dec-15 Business Case (BC) and PTL considered Dec. Further updates to the BC and PTL will be reviewed at Jan meeting. Mar-16 CCG reviewed community paediatric business case, negotiations taking place. Following approval of business case substantive recruitment will take place to reduce the reliance on locums. Date moved to Sept to recognise recruitment timeframe. May-16 – Implementation timeframe of the recruitment plan is currently worked up. This will allow the service to build a recovery trajectory to reduce the waiting time and list size. Jul-16 Wait time to be seen reduced to 6 months for initial community paediatrician assessment. Active recruitment for CDC coordinator and 2 substantive consultant posts. 2 locum consultants start 4th July. Further part time locum consultant starting Aug. Sept-16 Locums in place. Difficulties in division of acute and community patients undertaking validation exercise, moving to Systm one which will support this. Nov-16 Work ongoing as outlined above - no further update. Jan-17 Recruiting to 4 substantive posts interviews mid January, good field of candidates. Validation process in place and waiting list continuously monitored. Community paeds will be fully utilising Systm One by April. Mar-17 Continuing increase in referrals to community paeds, 3 locums supporting. New referrals first appointment reduced to 6 months. Ad hoc clinics for follow up. Systm One data being uploaded for 21 March go live.	end Mar-17	◄►	COO	SLF Q&S

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
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 special the young people Reviewing options for cohorting mental health young people. Liaising with SPT and commissioners re purchasing adequate tier 4 beds. Oct-15-Mar 16 Creating amenity beds and liaising with SPT on a case by case basis for CAMHS patients. Joint working with SPT, CAMHS recruiting assessor to support appropriate pathway for these young people. Continued working with CAMHS and SPT to develop pathway. May-16 A& E Liaison Nurse appointed to Conquest, equivalent being recruited to DGH. HoN requested in-reach pathway from CAMHS for these pts and daily ward visit. HoN attending urgent help/crisis meeting care and attending CAMHS transformation board to raise profile of young people in crisis with commissioners and gain adequate investment for this cohort. Jul-16 Out of hours urgent help service increased weekend capacity from 2 to 4 staff. Business case submitted to CCG to increase workforce to meet the need of CYP in crisis. Awaiting decision. Meeting to be held 8th July to review the A& E Liaison Nurse at Conquest role. Training requested from mental health team at CAMHS for ward nurses. Sept-16 Improving system CAMHs Liaison nurse available every day. Some inappropriate admissions still but these are individually reviewed. Nov-16 Awaiting CAMHs Liaison nurse appointment for west of county. HoN meeting with SPFT and commissioners to discuss inequity of service provision for CYP admitted to children's ward who are resident in west of county, i.e delays in assessments and telephone assessment Jan-17 Situation being reviewed and monitored. GM meeting with CAMHs. Mental health nurse visits wards daily 9-5 Monday to Friday. Additional mental health training for ESHT nursing staff but need therapeutic intervention from CAMHS Mar-17 Strategy meeting planned and also meeting SPFT to discuss further support, need sufficiently skilled staff. Hospital Director CQ linking in with SPFT for mental health matters.	end Jan-17	◄►	COO	SLF Q&S
2.17	C	Effective controls are required to monitor and formally report on follow up appointments in order to ensure there is no clinical risk to patients suffering a delay.	Mar -17 Inability to formally extract data from Oasis PAS to report on patients follow up by time period. Local systems in place but require Trust wide system for monitoring and analysis. Liaising with supplier regarding options for reporting.	end Jun-17	NEW	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 Mandatory training passport and e-assessments to support competency based local training Additional mandatory sessions and bespoke training on request
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 identify unintended consequences Personal Development Plans in place Significant and sustained improvement in appraisal and mandatory training rates

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.	Appraisal process and paperwork redesigned along with a development programme for Appraisers. New L&D manager started Feb and key objectives to review mandatory training, develop competency work and identify further efficiencies. Rating moved from amber to green Mar-16 Review being undertaken to address compliance and quality of appraisal. New appraisal policy in place and additional support offered to staff with this process. Jan-17 Mandatory training compliance trust wide exceptions are safeguarding children level 3 is at 82.59% (urgent care is 55.93%); Safeguarding children level 2 is at 83%; information governance 84.9% (74.5% in urgent care). Appraisals currently at 79.2% lowest for a year. Training is being offered for any staff new to appraising staff, or who want a refresher. Mar-17 – Appraisal rate is 78.42% for January (latest figures), an upward trajectory since December although only a slight increase. Work is being done with A&E to support them in offering additional refresher training for newly appointed managers who undertake appraisals and also to ensure that all staff who need appraisal training can be booked on. Mandatory training figures are improving. The only exceptions are for safeguarding level 2 and 3 where levels are 71.74% (Chief Operating Officer) and 67.19% (urgent care) in two areas.	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 appropriately resourced. Faculty of Medical Leadership Programme in place. CEO leading regular meetings with consultant body. Medical education team continue to work with junior doctors to improve engagement and enhanced support. New Medical Director appointment (subject to central approval) Revision and reappointment of all key medical role job descriptions: CU Lead; Speciality Lead; Chairs of Clinical Boards (urgent care, elective, cancer); Chairs and ToR of key Medical Clinical Governance sub committees. Sept-16 New Medical Director in post, progressing appointments of Chiefs and deputies. Nov-16 Consultant meeting 3rd Nov with CEO, MD, FD. Faculty of Medical Leadership and management training for newly appointed medical leaders 8th and 9th November. Appointments made for Divisions of Medicine and Surgery/Anaesthetics/Diagnostics, but no appointment as yet for W+C. Chairs of Urgent Care and Elective Care Boards have been made. Jan-17 Final FMLM training end of Jan. All Chiefs now appointed, including Women's and Children. Specialist leads advertised. Mar-17 Most speciality leads now appointed. Job planning training to follow. Other training possibilities arranged eg for “case investigation”	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 population in conjunction with other care services.	
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 operate efficiently and effectively within the local health economy.	
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) Clinical Strategy, Workforce Strategy, IT Strategy, Estates Strategy and Organisational Development Strategy Effective business planning process
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 Refreshing clinical strategy to ensure continued sustainable model of care 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 with Eastbourne, Hastings and Rother CCG took place Dec15. Mar-16 SPT footprint agreed. Trust to work with stakeholders to develop strategic plans. Board Seminar planned April 16. May-16 Trust fully engaged with SPT and ESBT programmes. Trust strategy being developed and "stakes in the ground" identified. Priority specialities for clinical strategy development identified and specific work commenced Jul-16 Continuing to work closely with commissioners on aligning ESBT plans with the emerging clinical strategy. Multiple integrated strategic planning workstreams underway and recruiting to better support the planning process. Sept-16 STP for Sussex and East Surrey now incorporates placed based care (ESBT) as one of its key elements. We continue to work proactively with commissioners and other providers to ensure that opportunities to deliver efficiencies at scale and pace are maximised. This includes working across STP boundaries. ESHT CEO is now joint SRO with CCG and ESCC leaders in the emerging Accountable Care Organisation Steering Group which will develop the delivery mechanism by which the challenged health economy issues will be tackled. Nov-16 STP has been submitted which includes 5 year plans reflecting the ESBT position. ESHT has been fully involved in developing these draft plans and they will be considered at November Board Seminar. Jan-17 STP now published and available on Trust website. ESHT continue to be involved in all appropriate work streams with a specific focus our local ESBT plans and the emerging Accountable Care model. Mar-17 Trust are continuing to work with all STP partners to further develop plans. Current work includes participation in the Acute Networks Steering group which is being facilitated by Carnall Farrar. Work is ongoing in developing the governance structures and framework for the ACO which is due to enter shadow form in April 2017	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 population in conjunction with other care services.	
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 commissioners.	
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 Equality strategy and equality impact assessments
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 Audit opinion and reports and external reviews eg Royal College reviews Quality framework in place and priorities agreed, for Quality Account, CQUINs

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 Elite. Issue remains with outpatients. . Oct-15 Tender for service to be awarded end Oct with April implementation date. Will work with CCG and new provider to support improvement. Mar-16 - May16 Following handover to new provider there have been significant service problems impacting on patient care and experience. In addition there has been an increase in DNA rates and loss of procedure time due to failure to collect patients and late arrivals. There is an operational group in place, monitoring of incidents and this has been escalated both internally and externally. All Trust in Sussex are experiencing the same issues and there is a CEO summit w/c 31.5.16 Jul-16 Some improvement on inward bound journeys but still subject to weekly monitoring across Sussex both at operational and strategic level. Independent review of procurement and transition underway by TIAA. Sept-16 Number of incidents regarding transport have reduced but additional dedicated vehicles are still required. Significant adverse publicity continues and is causing ongoing concern to patients. SI has been raised by CCG. Formal investigation into level of harm is being led by CCG. Overall lack of confidence in stability and sustainability of the service Nov-16 Continue to retain dedicated vehicles to maintain patient discharges. Patient Safety report in final stages and will be going to NHS England prior to circulation. Significant changes in contractual arrangements have been agreed and specialist team established by CCG to oversee transition to new provider. Situation at present is reasonably stable and performance metrics indicate performance in line of exceeding national average. Jan-17 Service stable, additional vehicles maintained but now managed through Coperforma. Preparatory work for transition underway. Mar-17 Transition of provider commenced on 1st March 2017 with full implementation at the beginning of April 2017. Training/awareness sessions have been held for staff.	end Jan-17	◄► May-16	COO	SLF

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 liaison between service managers and booking team. Increased working space/ essential equipment. Monitoring of performance via dashboard. Reviewed processes to minimise short notice clinic cancellation and ensure appropriate clinical assessment of affected patients. New call management system introduced to address technical and resource issues in appointments centre/provide enhanced service Review of 700+ letter templates underway to improve patient communication. SOPs and specialty booking rules agreed and implemented. March 16 – 80% referrals registered within 48hrs of receipt, scanned on to e searcher to minimise paper referrals going missing. First specialty about to go live with e referral system, continued roll out through 16/17. Staff capacity/demand remains an issue and is being addressed through business planning. Planning to develop some self- service check in facilities in 16/17 May-16 Business Case for Clinic Manager and Self-Serve check in underway with PMO and IT. New structure with additional resources for OP booking to support retention of staff due for implementation by end of July 16. Informal staff engagement underway. Jul-16 Progressing with new structure but will require formal consultation to extend operational hours, improving access for patients, which is primary cause of complaints. Clinic Manager business case to be submitted to BDG in July. Sept-16 Consultation with staff and additional recruitment completed, training underway and new structure will be in place by Oct/Nov 16.Clinic Manager Case approved but is subject to PAS hardware and software upgrades. Project expected to start Nov-16 for implementation by Spring 17. Nov-16 Consultation complete, final stages of recruitment. Specialty based 'pods' in early stages of development, good feedback to date. Ongoing training in relation to Access Policy and Clinic Manager Case approved but is subject to PAS hardware and software upgrades. Self Check in kiosks ordered and will be introduced alongside reception redesign, retaining face to face contact for those who require it. Significant 'data cleansing' of waiting list in Urology had identified a major area of work across the Trust to support effective utilisation. Jan-17 The team is now able to support services more effectively as demonstrated by the management of referrals, gradual implementation of eRS and new structure. Independent audit (TIAA draft) demonstrates a reasonable level of assurance. Trust is now moving into an improvement programme that supports the overall outpatient pathway. The main area of concern that remains is Cardiology which is under-resourced for the activity. A business case has been prepared for this. Mar-17 The recent CQC report highlights improvements in the administration services since the previous inspection which echoes the TIAA independent audit report. The business case in respect of cardiology will be finalised this month in conjunction with the Clinical Unit.	end Mar-17	◄► Jan-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 sustainable.	
Risk 4.1 We are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.	
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 Modelling of impact of service changes and consequences Monthly monitoring of income and expenditure Accountability reviews in place PBR contract in place Activity and delivery of CIPs regularly managed and monitored.
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. Evidence that actions agreed and monitored. Decrease in medical admissions at CQ continued and new practice being developed at EDGH (medical input is key)

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;	May-16 – Month 1 performance £0.5m adverse to plan. CIP plan for month achieved. Income broadly in line with plan; non-elective over performance offsetting elective shortfall arising from doctors' strike. Jul-16 - Month 2 performance remains adverse to plan, although CIP plan for the month achieved and agency spend reducing. Income is slightly behind plan, elective activity both behind plan and incurring 'send away' costs. Emergency activity ahead of plan, but associated costs also above plan. Recovery plan for elective and emergency activity under development for Improvement Board and discussion with CCG. Fines and Penalties risk reduced due to agreement on S&F funding and refreshed control total. DoF refreshing CIP development and implementation process, and reviewing detail of temporary staffing spend plans. Sept-16 - Month 4 remains adverse to financial plan, after an improvement in Month 3 stemming from a full formal close-down and opportunity review. Key pressures remain agency spend, CIP delivery and cost of operational pressures. FRP developed and shared with F&I, and with Exec Directors. New Financial Improvement and Sustainability Committee being formed to ensure leadership and oversight of both strategic and operational finance. Additional capacity secured within finance team, including short-term ad hoc cost-limited consulting support on temporary resourcing. The level of risk remains significant, but the Trust is developing a measured and coherent response to the key issues. Nov-16 Trust variance to plan improved from Month 5 to 6, but Trust was £2.3m adverse to operational plan and £4.9m adverse to plan after STF funding lost is taken into account. The Trust continues to forecast delivery of the plan, but the level of risk within the financial position remains significant, monitored through the Finance and Investment Committee on behalf of the Trust Board. The Trust was, as a result of its in-year in financial performance, placed in Financial Special Measures by NHS Improvement in October 2016. This is a new control and support regime, which requires the Trust to agree a financial recovery plan within 30 days, present this to NHS Improvement and then review jointly the implementation and delivery of the plan over the remainder of the financial year. The Trust has secured additional external support from professional advisors to work alongside the Trust staff and the Board in the development of the Financial Recovery Plan for 2016/17. The recovery plan will be reviewed at the forthcoming Board Seminar and by a special additional meeting of the F&I Committee in November 2016. Jan-17 Financial Recovery Plan developed and presented to Board, F&I and NHSI in Nov/Dec and is tracking performance on a monthly basis. A strengthened PMO and a series of additional 'grip and control' measures have been put in place. Mar-17 Trust is forecasting £4.8m adverse variance to overall forecast, drive by non-delivery of £3.5m of FRP and £1.3m escalation pressures. The Trust is continuing to strengthen the FRP and the support provided by PMO, with the aim of improving the year end focus. However, the overall level of risk in the financial forecast is such that, at its most recent review, Exec team and F&I Committee maintained the forecast at £46.5m. The Trust is continuing to develop a pipeline of new savings, but these will be impact on the 2017/18 financial year rather than 2016/17 financial plan. Additional scrutiny and support continues to be provided to the Trust through the Financial Special Measures programme.	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 effectively support our mission and strategic plan.

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 allocate resource accordingly. Trust achieved its CRL in 2015/16

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 spend are correct within the limited funds available, including any urgent elements from the Estates Strategy. The Board will also look at medium term priorities to help shape a business case to the Department of Health for a capital loan to support requirements over and above 'core' capital funding. Jul-16 - 5 year capital plan agreed by FIC, reviewed in Board Seminar. Discussions with NHSI re submission of capital bid, with £5m initial amount included in refreshed submitted plan. DoF reviewing internal capacity to develop FBC for submission in Q£ for £35m, and interim bid, in partnership with DoN, in Q2. Finance and Estates teams reviewing alternative sources for finance for discussion in September 2016 FIC. Sep-16 - Additional support secured for development of £35m overarching capital bid and in-year initial bids for £5m to support delivery of financial plan. Capital Review Group taking forward bid development and prioritisation process, the management of in-year expenditure, and the exploration of alternative sources of financing. Initial LTFM includes refreshed capital requirements and being refined to support submission of bid pipelines. Nov-16 There are two risks reflected on the operational risk register. First, the in-year capital plan has a component of overplanning to allow for flexibility in the deployment of the budgets. This is being actively managed within the Capital Review Group, and a prioritised list of schemes has been agreed to ensure that the Trust does not overspend, but continues to develop and maintain the infrastructure. Second, the Trust continues to develop a programme of business cases within the overarching £35m 'minimum ask' baseline case. This is reflected in the STP financial plan, as well as the Trust's own forward programme. As the Trust moves through the financial special measures regime, the forward plan for the capital programme will be clarified in advance of the next iteration of the Trust's long-term financial plan. Jan-17 Capital Review Group continues to closely monitor capital expenditure in year to ensure that over planning does not lead to overspend. The Trust continues to review its capital budget. In developing business cases to address the systematic shortfall in capital the Trust has begun exploring alternative means of financing including lease and hire purchase. Two business cases have been submitted to NHSI for capital loans in respect of ambulatory care and work continues on a series of further cases. Mar-17 – The Trust continues to develop a forward capital plan, but recognises that there is a local and national constraint on capital expenditure which needs to be addressed. The 2016/17 capital plan is forecast to meet budgets, but has been constrained by the availability to access loan funding. The Trust has developed an initial capital plan for 2017/18, which has bids in train of £22m against an available capital fund of £11m, and a detailed clinically-led prioritisation process is in train to ensure an appropriate budget can be agreed for 2017/18. A robust five year capital plan is being developed, supported by and reviewed by F&I on behalf of the Trust Board.	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 mobilisation or demobilisation of resources

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 a specific objective of knowledge transfer. Mar-16 as above Trust successful in Sexual Health Tender. May-16 Business planning team dispersed to support other projects, support required for tendering exercises will form part of portfolio of Director of Strategy. Assurance level moved from Green to Amber. Jul-16 - Trust recruiting for Business Development team, with specific focus on building support for tender planning and submission. DoF reviewing with DoS the forward Commercial Strategy for Trust, including alignment with Clinical Strategy development. Sep-16 - appointments made within Business Development Team, and substantive Director of Strategy, Innovation and Planning appointed with key leadership role. Five year financial plan in first iteration, including commercial strategy, and DoF/DoS working on first iteration of Commercial Strategy, within addition support secured for development work and pending MSK procurement. Nov-16 Additional support secured to complete MSK tender. AD Planning and Business Development joins 5th Dec. Key objective in the first month is to develop an agreed process for how we mobilise to respond to tenders and identify what additional support we might require and have a ready supply of contacts who can be approached to provide specialist support such as bid writers. Jan-17 Draft process developed that ensures appropriate decision making and governance in place for tenders. Will be shared with exec team on 17th Jan for agreement. Collating register of companies/ individuals who have the specialist skills to support the tender process eg: bid writers, Mar-17 Associate Director now in post and team recruited. Propose to remove this from the BAF	end Mar-17	▲ Mar-17	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 need to fulfil their roles.

Risk 5.1 We are unable to effectively recruit our workforce and to positively engage with staff at all levels.

Key controls	Workforce strategy aligned with workforce plans, strategic direction and other delivery plans On going monitoring of Recruitment and Retention Strategy Workforce metrics reviewed regularly by Senior Leadership Team Quarterly CU Reviews to determine workforce planning requirements Monthly IPR meetings to review vacancies. Review of nursing establishment quarterly KPIs to be introduced and monitored using TRAC recruitment tool Training and resources for staff development In house Temporary Workforce Service
Positive assurances	Workforce assurance quarterly meetings with CCGs Success with some hard to recruit areas e.g. Histopathology and Paeds Full participation in HEKSS Education commissioning process Positive links with University of Brighton to assist recruitment of nursing workforce. Reduction in time to hire Reduction in labour turnover.

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	May-16 to Sept 16 Recruitment hotspots identified. Task and finish groups with CUs to develop a recruitment and retention strategy. Use of head hunters to identify suitable candidates. Developing Trust competence and pay grade for junior doctors which will be an extension to the current specialty doctor posts. Reviewing impact of change to funding of nurse training from Sept 17 where pre and post reg training will be funded through student loans. Working with headhunters to attract candidates. Overseas nurses commenced and vacancy fill rate is on target. HCA up to establishment and focus bank recruitment to reduce agency usage. New marketing materials available. Launched use of social media to advertise posts. Participating in NHS Employers Retention programmer. Nov-16 - Urgent care remain key risk area with 50% vacancy fill factor for consultants; 77% for non-consultants. Planned Workshop with CU's postponed to Feb 2017. Meetings with GM's and CU Chiefs to discuss needs are being arranged. Continued focus on overseas recruitment for registered nursing; visits to Philippines and Portugal confirmed for November. Non registered nursing vacancies – continued decline since high point of June this year. Campaign for 100 HCA's (B2 and 3) to start Jan 2017 for integrated service commenced 31st October. Jan-17 Following increases in the establishment and sustained recruitment, substantive workforce numbers have continued to increase, from 5684 ftes to 5949 ftes (April to November). 80 offers made to overseas nurse, due to start Mar-17, able to work as RGN's by July 2017. Currently working on introduction of a number of new roles to address recruitment issues Project to introduce Doctors Assistants to support Junior Doctors, 6 starting Jan-17. Impact of this role will be evaluated and a business case developed to roll out across the Trust. In discussions with Brighton University to establish Physicians Associate role, expect to have work placements for these posts starting Aug-17 and appointable from Aug-18. GP Fellowship role being developed. Part of this will be to undertake some working hours in the acute sector in emergency medicine, rheumatology and dermatology. Skill-mix review being undertaken with nursing to consider the role of Nurse Associate within the Trust. Mar-17 6 Doctors assistants started,3 in SAU at Conquest, 3 in MAU at EDGH. Initial feedback positive in terms of the impact on the workload of Junior Doctors, and consideration will be given to roll-out to other specialties in the Trust. GP Fellowship role being advertised with an anticipated start date of September 2017. Quarterly CU workforce planning and recruitment meetings commenced to review short medium and long term action plans to address recruitment issues. 7 Head hunters engaged to assist with Hard to fill positions. Overseas nurse recruitment continues with additional 76 Philippine nurses offered (start date Oct/Nov 2017. EU nurses c30 offers. Targeted UK nurse campaign commenced Feb 2017. Joined NHS Employers Retention programme and will be undertaking a project internally on the retention of staff. Attending local carers fairs to promote the Trust and roles within the NHS, and Out of Hospital Division have also attended careers fairs for AHP's.	end Mar-17	◄►	HRD	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
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 recruitment taking place. Longer term review of staff model planned. Dec-15 Discussion taking place with commissioners as part of East Sussex Better Together. Mar-16 Recruitment taking place however short falls in staffing remains. Mitigating actions such as use of long term locums Jul-16 Working with ESBT to develop GP triages in A&E. Post currently in recruitment process. Sep-16 Successful recruited consultant and specialist A&E registrars. Number of vacancies in registered nurses in MAU being actively monitored and mitigating actions in place. Nov-16 Skype interview arranged for A&E. CVs requested from Head-Hunters. Discussions with CCG ref GP/Acute rotational posts. First cohort will not be until August 2017. Jan-17 No further update linked to actions in 5.1.1 Mar-17 see above update for 5.1.1	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 need to fulfil their roles.	
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 Staff events and forums - "Unsung Heroes"

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.	Sept-16 Recent Staff FFT had the highest response rate since 2014 and a significant increase in the number of staff who would recommend ESHT as a place for treatment and as a place to work . Most recent pulse survey that focused on communication between managers and staff demonstrated improvement. Focusing specific pieces of work on areas where pulse survey's show low levels of staff engagement despite considerable effort from the leadership teams. Nov-16 - Current National staff survey is live and aiming to increase response rate compared to previous years that has been static at 42%. A communication campaign to raise awareness of the importance of completing the survey is underway . Actions include – letter from CEO, poster campaign encouraging teams to take a break to complete the survey, clinical units/directorates sharing actions taken since the last staff survey, regular updates on the response rates to the survey published on the intranet. All managers asked to follow up with their teams, regular tweets about survey. Ongoing work to increase engagement includes ESHT Vine, new staff forums for Junior doctors, Clinical Orderlies, BME and LGBT staff. Unsung Hero celebration week was a great success with over 400 staff attending during the week. Jan-17 Number of events involving staff in the development of their services are currently underway – Radiology services are currently holding a number of stakeholder events to support development of a robust Radiology Strategy. Clinical administration leaders are half way through their leadership programme Positive Feedback from participants positive. All managers will be required to attend the Management Essentials programme, commencing Jan which will outline expectations of them especially in terms of communicating and involving their staff. Further work is being carried out in bringing values to life through the development of a behavioural framework which outlines the behaviours we expect to see /not see linked to each value Annual national staff survey now closed. Response rate has increased to 46% Staff wellbeing team currently advertising Health Checks for staff aged between 40-70. Department is continuing to run a number of interventions linked to wellbeing including emotional reliance training, Pilates and Healthy weights. The team continue to visit different departments to look how they can support staff in the workplace. Clinical Units continue to try to improve engagement in their area Mar-17 The most recent CQC inspection (October 2016) found that staff were largely positive and well engaged. We have also seen an improvement in our Staff Engagement results and engagement score in the 2016 Staff survey results although we remain below average for many of the key findings . Work will continue to improve staff engagement at all levels of the organisation.	end Apr-17	◄►	HRD	POD SLF

Chief Executive's Report

Meeting information:			
Date of Meeting:	21st March 2017	Agenda Item:	9G
Meeting:	Trust Board	Reporting Officer:	Dr Adrian Bull

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

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

Executive Summary:

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

The purpose of this report is to provide the Board with a summary update from the CEO's perspective.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

None.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

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

1. Introduction

The national results from last autumn's NHS staff survey have now been released. A full report will be available to PoD and the Board. The results show significant improvement in the openness of our culture, in the level of engagement, and in satisfaction with the organisation as a place to work across the Trust. We were starting from a very low base in comparison with peer organisations from the year before, and we remain below the peer average in many areas. An action plan will be developed in response to this survey at corporate level; all divisions and corporate departments will develop their own action plans.

Our 4 hour standard remains a challenge although, in the past few weeks, has shown encouraging signs of beginning to respond to the strategies that we have put in place over several months. There has been improvement in our planned care position.

We are forecasting a year end position of £46.5m. Although better than the original budget approved by the Board (£48m deficit) this fails to meet the control total of £41.5m and indicates failure to achieve the financial recovery plan adopted under special measures in October. We will be appointing a Director of Transformation to strengthen our work to bring the organisation into financial balance in the medium term.

2. Quality and Safety

The Trust's SHMI (yearly, reported 6 months in arrears, and including all community hospitals) has now come down to 1.10 (from 1.11) for the period October 2015 to September 2016, which remains in range. HSMR (CHKS) is down to 106 for the same period, and RAMI is now 101. Monthly data for RAMI (which is less reliable) would indicate that for the last few months we were at the same level as our peers, but it will be six months before this is reflected in the published data.

There have been two serious incidents associated with falls from trolleys in our EDs. The investigations are continuing.

The Quality Account priorities for 17/18 are out for consultation with the organisation and will be brought to the Quality and Safety Committee.

3. People, Leadership and Culture

<u>Recruitment and Retention</u>
Difficulty in recruiting to key posts (especially medical posts but also posts within other clinical areas) causes continued financial risk relating to agency expenditure and quality of service delivery. The details of current vacancies and the action being taken to fill these, and development of new roles are detailed within the workforce section of the IPR.

Opportunities for new clinical support workers including apprenticeship training opportunities are being developed as well as a clearer career framework detailing potential career progression for clinical support workers in bands 1-4.

<u>New junior doctors contract</u>
The new contract for junior doctors has introduced a system whereby there are fines for staff working over their allocated hours and this leads to a financial risk for the Trust. The fines are less than predicted in the first quarter. The system of reporting occasions of over-work is highlighting issues with junior doctor rosters which are being systematically addressed.

Staff engagement
There has been significant improvement in all areas of the Trust's national staff survey, however there is still room for improvement reflecting the journey that the Trust is on and it is therefore necessary to identify both corporate priorities and divisional plans for improvement.

The Trust has introduced a Management Essentials Programme for all people in management or leadership roles in the organisation. The aim is to ensure that everyone in such roles is familiar with the core elements of team leadership that are expected of them and that will ensure full engagement of their team members. A number of people have been booking themselves into additional modules of this programme. We are working to ensure that all of the target participants will complete the Management Essentials Module, although this will not have been achieved by the end of April 2017.

Mandatory training and appraisal
Both mandatory training compliance and appraisal compliance have improved slightly in January, although figures are below what they were at the same time last year. Work is in hand through the divisions to address this.

Apprenticeships
There are low levels of uptake of apprenticeship training despite widespread communications. The levy comes in place in April and all departments are being asked to consider appointing to apprenticeship training and to make it an explicit part of any newly advertised role.

4. Finance and Capital

The Trust is continuing to focus on delivering its financial plans for the year. At Month 6, the Trust identified a risk to forecast outturn of £16m and, working across the organisation with colleagues and key stakeholders, developed a Financial Recovery Plan. This is being tracked on a weekly basis by our Programme Management Office, and Executive Team. Additional support and challenge is also provided to the Trust through the Financial Special Measures regime. As at the end of Month 9, the Trust is forecasting delivery of £12.5m of savings against this £16m, which reflects a significant achievement by staff across the organisation. Coupled with a number of additional pressures from Winter, the Trust is currently forecasting £4.8m non-delivery of the financial plan for the year – although this reflects a improvement on 2015/16's position, the Trust continues to seek alternative opportunities for delivering the best possible outturn for 2016/17.

For 2017/18, the Trust is working to develop a deliverable and robust financial plan which learns the lessons from 2016/17, and takes account of local and national priorities. The Trust draft plan, considered at the Board last month, noted that the financial challenge for 2016/17 – excluding the impact of changes from East Sussex Better Together – would be to deliver £16m of efficiencies. The flow through of £4.8m delayed delivery in 2016/17 would increase this to £20.8, further increased by any non-recurrent elements of delivery in the current year. The Finance and Investment Committee have noted the level of challenge that such a savings target would present and the Trust is in dialogue with NHS Improvement over the appropriate level of financial challenge for the coming year. The Trust remains ambitious to deliver continued reduction in the overall deficit, but needs to set a start plan which is achievable.

Within East Sussex Better Together, the Alliance Executive and Governing body arrangements are taking shape. The key challenge for the system in 2017/18 is the level of efficiency required, and the Trust continues to work in partnership with East Sussex County

Council, and the Clinical Commissioners on both strengthening the arrangements for delivery of the savings within the Strategic Investment Plan, and ensuring that investments reflected within the plan are appropriate and deliver a return for patients and the system. ESBT remains the route for financial and clinical sustainability across East Sussex, and for the Trust.

5. Access and Delivery

The Trust continues to face the challenge of winter pressures, with this being reflected in our 4 hour performance standard (73.4% for Month 10) and bed occupancy at 99%.

Our existing urgent care programme has been refocused on 5 key priorities:

- Medical model - right size acute medical facilities, including ambulatory, assessment and short stay facilities. Role of frailty and specialist medicine in support of the EDs and Acute Medicine.
- Integrated Discharge Team, discharge to Assess and supporting systems and processes
- Roll out of Red to Green and the SAFER bundle across Hospital and Community Wards
- Improve management of minors activity through the emergency department, accurate reporting and increased throughput.
- Staffing to meet demand in the emergency department re profiled to meet demand patterns, nursing, medical and ENPs and GPs

Diagnostics continues to achieve the performance standard of less than 1% of patients waiting over 6 weeks.

Cancer standards also continue to be achieved, with the exception of 62 days. Performance has deteriorated to 78% percent. This is as a direct impact of the reduced working days over the Christmas and New Year period.

The elective performance has improved over January and, despite the limited bed availability, the teams have worked well to ensure timely discharges for surgical patients and use of day-case facilities to treat additional patients. 88% of our waiting list is under 18 weeks and our total waiting list has reduced by 1500 patients. This has been achieved through planned additional capacity in some specialties, e.g. Ophthalmology, but also through the validation of the waiting list

6. Corporate Affairs

This is our first public Board meeting since the CQC published its inspection reports in January 2017. The reports, following the October 2016 inspection, recognised significant improvements since the last inspections in September 2014 and March 2015 and our CQC rating moved from 'inadequate' to 'requires improvement'.

The CQC gave the organisation a total of 114 ratings of which 52 were 'good' and two were 'inadequate', this compares to 11 'good' and 23 'inadequate' in 2015. Within the reports the CQC commended 15 areas for outstanding practice. The reports also identified some areas where we have further improvements to make and included two 'must do' actions, relating to play services in paediatrics and staffing in our A&E departments and 34 'should do' actions. Both hospitals were rated Inadequate for the safe domain of Urgent Care, although Urgent Care was rated 'needs improvement' overall.

We are committed to ensuring we consistently provide high standards of care across all of our services and there is a robust programme of work and governance framework in place to support delivery of continued improvement. The Trust remains in special measures and as a result will benefit from professional and financial support. A CQC re-inspection is expected later in the year. Full copies of the reports are available at:
http://www.cqc.org.uk/provider/RXC

7. Strategy, Innovation and Planning

7.1 iMSK

We were successful in our bid to provide an integrated musculoskeletal service (iMSK) in Hasting and Rother. This is a five year contract worth £76m (Year 1 £17.153m, Year 2 £15.428m, Year 3 £14.816m, Year 4 £14.495m, Year 5 £14.138m) and will start in July 2017, when the staff and patients currently being seen by Virgin MSK will be transferred to iMSK. This will be a community based hub and spoke model with care and diagnostics provided from community settings.

As an integrated MSK service the Trust will be a prime contractor and will be responsible for the entire MSK service. The Trust will directly provide elective orthopaedics, MSK physiotherapy, Podiatry, Orthotics, all of the multidisciplinary Rheumatology service and will subcontract with Kent Community Trust to provide the community chronic pain service. Patients will continue to have choice of secondary care provider such as the Horder, Benenden or Spire.

Patients will enter the service through a single point of access, using Health and Social Care Connect (HSCC), which is a service that is already familiar to GPs. All patients will be e-triaged by Extended Scope Practitioners to ensure they see the right person within the integrated service. A team of Care Navigators working within HSCC will support patients to make decisions about their care and where they want this to be provided. The Care Navigators will also keep GPs informed about their patients' journey at each step, irrespective of provider and up to and including discharge from the service.

We will be setting up a Partnership Board which will have representatives from the three GP federations, ESCC, and Kent Community Trust and of course from ESHT. An Implementation Group has already met and is planning the detailed work needed to get the service up and running by July 1st.

7.2 ACO

The ACO development group has now met twice and is working up the options for our future ESBT Alliance accountable care model. The group will make recommendations for the Trust Board to consider on the most appropriate vehicle to deliver high quality, effective care for the population covered by the ESBT footprint after the 2017/18 test-bed year.

7.3STP

The STP Programme Board has commissioned Carnall Farrar to provide a broad strategic understanding of demand and capacity issues across the system in the STP footprint to provide support to the Acute Services Steering group to consider and develop a plan for service provision that will meet the future needs of our population sustainably

Integrated Performance Report – Month 10

Meeting information:			
Date of Meeting:	21st March 2017	Agenda Item:	10
Meeting:	Trust Board	Reporting Officer:	Trust Executives

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

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

Executive Summary:

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

Key Issues/risks

- 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 trajectory and the national target.
- A&E performance was 73.4% against the 95% standard
- RTT incompletes was 88.88% against the 92% standard. This is the first improvement in the figure since May 2016
- Cancer 62 Days achieved 84.1% against the 85% standard (for December, one month in arrears)
- No urgent operations were cancelled for a second time.
- Financial plan forecasting £46.5m against the planned £41.7m deficit by year end, due to risk on FRP schemes and additional cost of escalation wards.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Finance and Investment Committee, 1st March 2017

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Board is asked to note this report

East Sussex Healthcare NHS
NHS Trust

Month 10 – January 2017

TRUST INTEGRATED PERFORMANCE REPORT

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East Sussex Healthcare NHS Trust

Contents

East Sussex Healthcare NHS
NHS Trust

January 2017

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 trajectory and the national target**

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. Complaints
4. Mortality
5. Safer Staffing

East Sussex Healthcare NHS
NHS Trust

Indicators

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Jan-16	Var	This Yr	Last Yr	Var	
Total patients safety incidents reported	M	916	956	978	1054	1078	1012	1499	1799	1786	1396	1241	1394	1308	916	42.8%	13567	8934	34.1%	
% Patient safety incidents with no harm or near miss	70.0%	67.0%	70.8%	67.8%	64.4%	67.0%	72.5%	84.1%	86.5%	84.5%	82.7%	80.7%	84.4%	82.2%	67.0%	15.2%	80.1%	66.4%	13.7%	
% Patient safety incidents causing severe harm or death	0	0.2%	0.1%	0.7%	0.2%	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.2%	-0.1%	0.1%	0.3%	-0.2%	
Total Non-ESHT patients safety incidents reported	M	122	110	85	319	243	148	168	145	164	136	130	150	178	122	45.9%	1781	1127	36.7%	
No of never events reported	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	4	-3	
No of serious incidents reported	M	7	6	14	7	0	3	8	10	4	3	7	2	6	7	-1	50	104	-54	
No of moderate incidents reported	M	1	2	2	6	5	11	3	6	9	9	8	3	11	1	1000.0%	71	5	93.0%	
Total Falls per 1000 beddays	7	6.7	6.8	6.1	6.0	6.0	6.0	6.3	6.3	6.2	6.4	5.0	6.4	6.5	6.7	-0.2	6.1	6.7	-0.6	
Total falls reported	M	183	178	169	152	149	144	152	156	152	160	124	159	174	183	-4.9%	1522	1634	-7.4%	
No of falls no harm	M	119	122	118	97	101	99	109	116	92	115	80	113	130	119	9.2%	1052	1062	-1.0%	
No of falls minor/moderate	M	64	56	51	55	48	45	43	40	59	45	44	46	44	64	-31.3%	469	568	-21.1%	
No of falls major/catastrophic	M	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	4	-3	
Falls Assessment Compliance	M				92.2%	93.9%	89.6%	91.4%	92.5%	85.2%	90.3%	85.6%	85.3%	90.9%			90.2%			
No of pressure ulcers grade 3 & 4 (trust acquired)	R	9	7	5	6	5	2	2	5	0	5	3	5	7	9	-2	40	61	-21	
No of pressure ulcers grade 2 (trust acquired)	R	53	54	73	62	45	51	32	46	53	54	53	47	57	53	4	500	570	0	
Pressure Ulcer Assessment Compliance	M				93.4%	86.0%	87.5%	92.0%	86.7%	94.0%	91.2%	95.8%	94.4%	96.3%			91.3%			
No of medication administration incidents	M	18	23	17	29	25	16	32	24	31	33	28	37	25	18	0	280	213	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	

Indicators

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Jan-16	Var	This Yr	Last Yr	Var	
Observations completed on time (per protocol)	M	76.3%	76.9%	76.8%	79.7%	80.7%	83.4%	82.5%	84.2%	83.2%	81.2%	82.1%	83.2%	83.1%	76.3%	6.8%	82.4%	71.1%	11.3%	
No of Cardiac Arrest calls		0	0	0	0	0	0	0	0	4	0	0	0	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	4	3	5	2	7	7	2	6	3	4	2	0	0	4	-4	33	40	-7	
No of MSSA cases	M	0	2	1	2	0	2	1	0	4	1	1	0	0	0	0	11	4	7	
Safety thermometer overall score	92.0%	95.3%	93.0%	94.0%	93.0%	93.6%	94.0%	95.4%	93.0%	95.0%	93.3%	93.6%	93.4%	92.7%	95.3%	-2.6%	6.3%	6.1%	0.2%	
% of VTE risk assessments completed	95.0%	96.5%	95.8%	94.8%	95.2%	97.9%	98.1%	97.9%	96.8%	97.0%	95.4%	97.0%	96.2%	96.5%	96.5%	0.0%	96.8%	96.6%	0.2%	
Emergency C-Section rate	9.0%	16.0%	17.9%	12.8%	15.4%	13.4%	14.5%	12.6%	11.9%	17.4%	14.6%	16.0%	25.8%	15.2%	0.16028	-0.9%	15.5%	14.8%	0.7%	
Mixed sex accomodation breaches	0	27	29	0	0	7	0	0	0	0	0	0	0	20	27	-7	27	101	-74	
Inpatient FFT Response rate	45.0%	12.87%	28.99%	13.15%	13.30%	14.01%	13.94%	16.97%	17.31%	14.89%	14.00%	21.37%	27.60%	24.31%	12.9%	11.4%				
Inpatient FFT Score (% positive)	96.0%	97.79%	97.00%	96.48%	95.51%	98.26%	97.29%	96.70%	96.75%	96.13%	96.61%	97.02%	97.07%	97.37%	97.8%	-0.4%				
A&E FFT Response rate	22.0%	7.65%	7.90%	7.94%	6.52%	8.96%	9.91%	8.40%	7.69%	5.98%	6.98%	7.91%	6.40%	8.01%	7.7%	0.4%				
A&E FFT Score (% positive)	88.0%	84.69%	90.20%	87.87%	80.12%	87.97%	83.69%	84.11%	82.00%	81.91%	81.73%	82.80%	84.57%	87.96%	84.7%	3.3%				
Outpatients FFT Score (% positive)	M	94.80%	95.16%	95.65%	95.38%	96.02%	96.08%	95.41%	97.06%	96.02%	94.96%	94.59%	96.54%	93.32%	94.8%	-1.5%			#VALUE!	
Maternity FFT Response rate	45.0%	21.93%	27.84%	20.05%	24.22%	29.19%	11.59%	33.21%	25.25%	29.03%	30.25%	26.70%	46.40%	19.59%	0.2193	-2.3%	29.3%	26.1%	3.3%	
Maternity FFT Score (% positive)	96.0%	95.76%	94.23%	89.76%	92.93%	90.21%	92.45%	93.72%	96.65%	92.86%	94.84%	96.08%	92.57%	98.43%	0.9576	2.7%	94.2%	96.1%	-1.9%	
No of complaints reported	R	41	56	55	75	55	58	46	56	53	53	54	50	61	41	48.8%	561	592	-5.5%	
All ward moves	M	2254	2315	2331	2303	2344	2265	2313	2304	2280	2210	2198	2323	2405	2254	6.7%	22945	22886	0.3%	
Night ward moves	M	462	461	512	470	434	409	416	445	399	375	407	436	395	462	-14.5%	4186	4492	-7.3%	
Crude Mortality Rate	M	2.1%	1.8%	2.3%	2.0%	1.7%	1.5%	1.4%	1.4%	1.4%	1.9%	1.5%	2.1%	2.7%	2.1%	0.6%	1.8%	1.7%	0.0%	
HSMR (CHKS)	100	109	107	104	104	102	102	101	100	99	97									
SHMI (CHKS)	100	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 6 serious incidents reported as occurring in January. 2 were slips/trips/falls, 2 were diagnostic delays, 1 related to ED discharge and treatment and the other to failure to record observations

No new Never Events have been reported.

Infection control reported no incidents of MRSA, MSSA and CDIFF

The emergency caesarean has dropped to 15.2%.

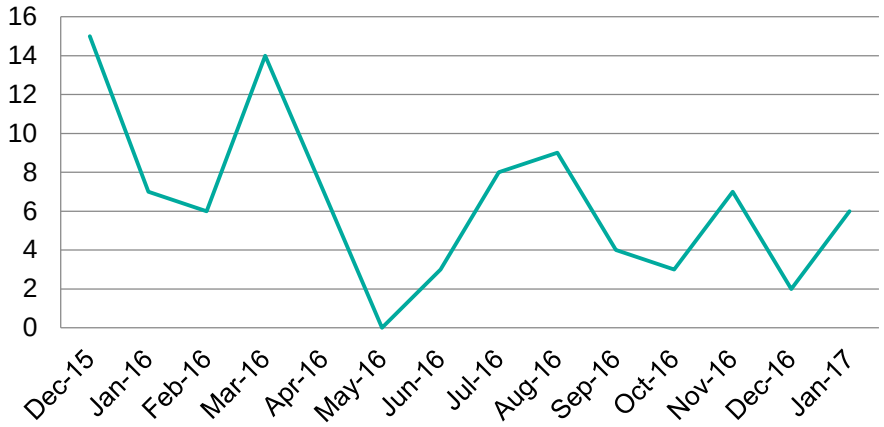
20 overnight mixed sex accommodation breaches were reported. This was due to the exceptionally high occupancy levels experienced throughout the trust.

There were 7 grade 3 and 4 Pressure Ulcers this month, one has subsequently been downgraded and the remaining 6 are outlined below:

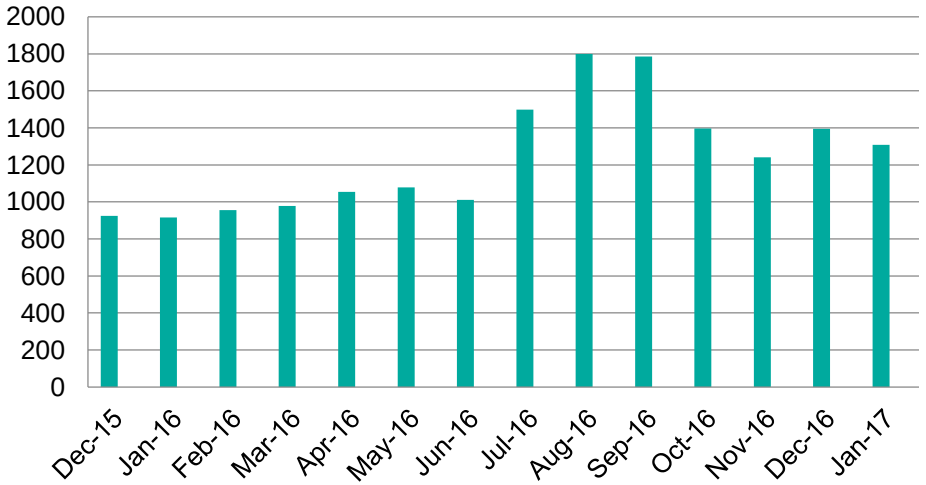
- 2 x 4s and 3x3s all in patients home and being reviewed
- 1 x grade 4 which is reported from MacDonald Ward – this is under review

2. Serious Incidents, Never Events and Patient Safety Incidents

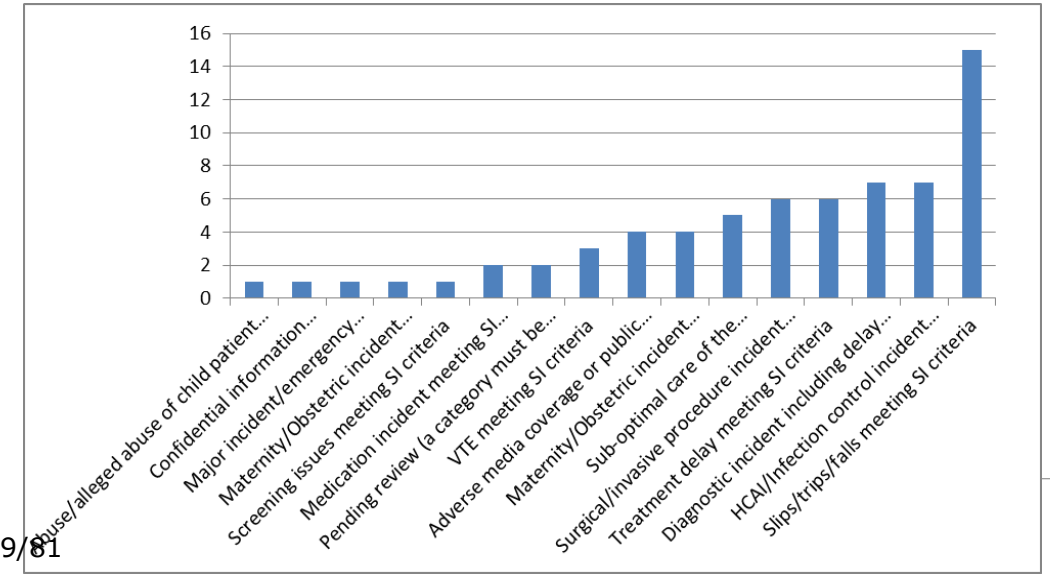
Serious Incidents Reported



Patient Safety Incidents



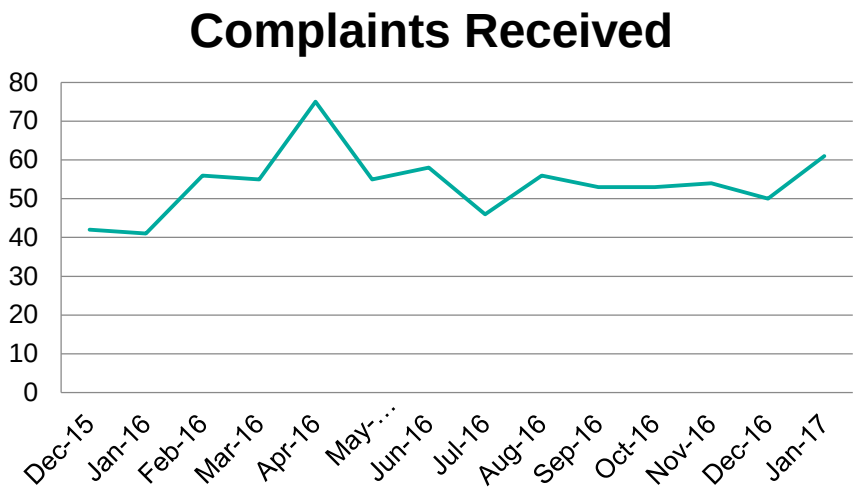
The graph below shows the STEIS categories of the Serious incident reported over the last year.

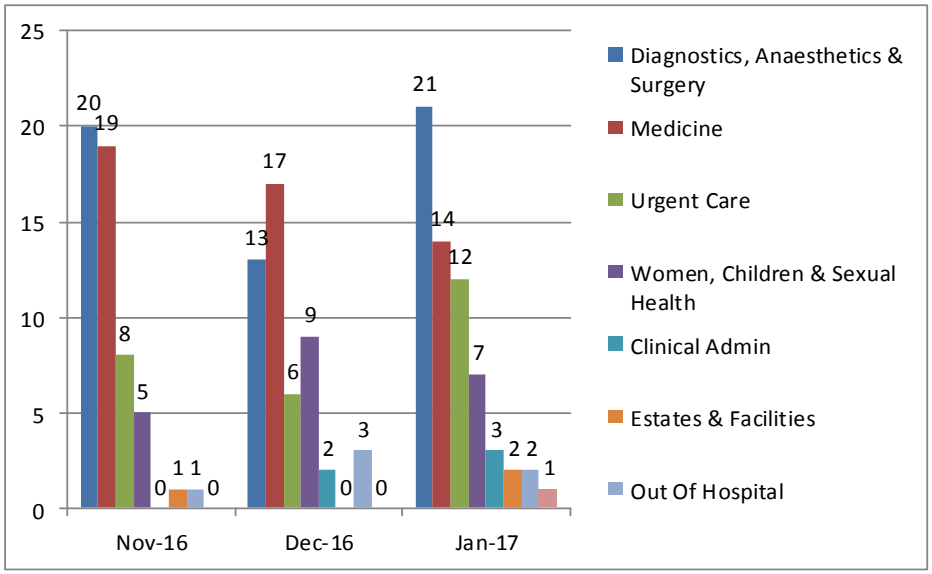


The number of serious incidents reported in January increased to 6.

Patient Safety incidents dropped slightly in January but these were predominantly in the “no or low” harm category with serious harm incidents increasing by 0.1% to 0.2%.

3. Complaints





There has been an increase in the number of complaints received with a noticeable increase for Diagnostic, Anaesthetic and Surgery (DAS) and Urgent Care Divisions compared to December

There has been an increase in the number of complaints closed and slightly less complaints re-opened

The number of complaints open remains the same as December at 147, but the number which are overdue is down

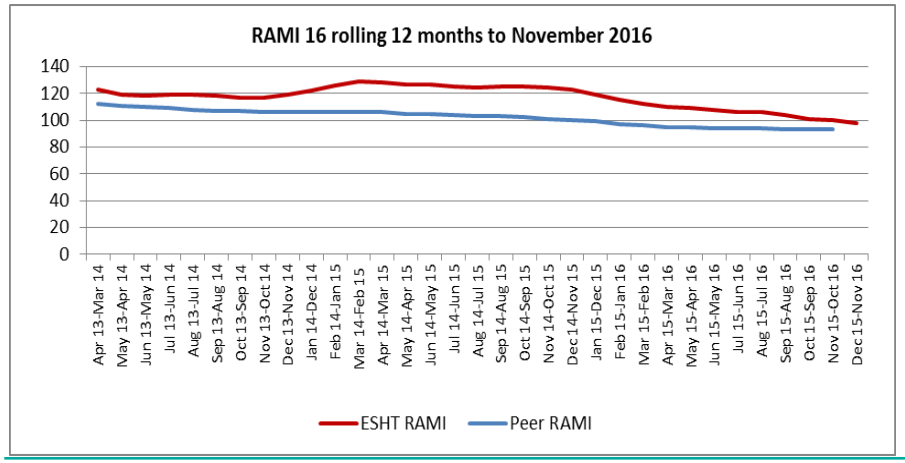
The number of open actions continues to rise and the aim is to address this over the coming months

The top 2 themes for complaints remain Overall care and Unhappy with staff attitude. A deep dive session to understand these themes is more detail is taking place on 22nd Feb 17

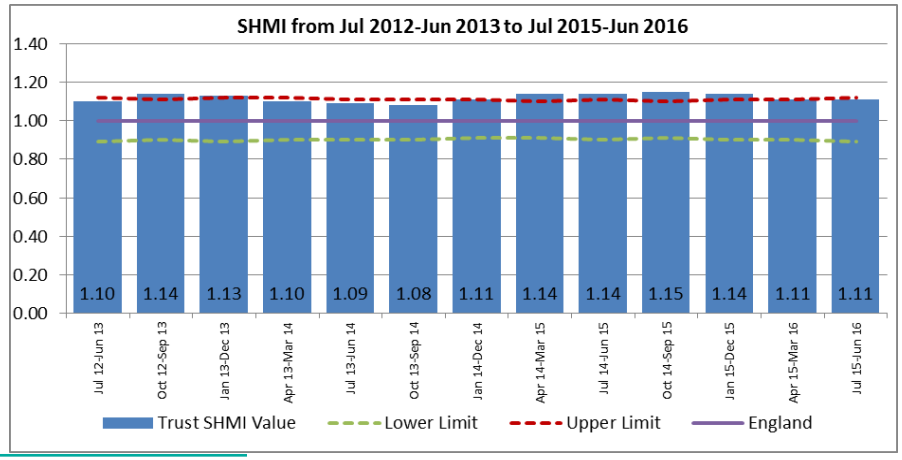
32 post complaint surveys have been received in January which is a 49% response rate since the survey was introduced. 56% demonstrate positive feedback about the service

4. Mortality

RAMI 2016



SHMI (Rolling 12 months)



The latest SHMI was released in December. The Trust remains at 1.11 and is currently within the EXPECTED range.

Depth of coding continues to improve across both sites. There is no longer a difference in the levels between Conquest and EDGH

The percentage of deaths reviewed within 3 months dropped further in October to 61% from September at 67% and 71% in July and August

For the period November 2015 to October 2016 RAMI (rolling 12 months) is 100. This is compared to 124 for the same period last year and down from 101 last month.

RAMI (Monthly) shows an October position of 98 compared to a peer value of 103. The September value was 76 against a peer value of 85.

Crude mortality shows November 2015 to October 2016 at 1.87% compared to November 2014 to October 2015 of 1.89%

Main Cause of Death - January 2017	
Pneumonias	98
Sepsis	27
All types stroke	12
Multi organ failure	7
COPD	7

5. 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	84.6%	113.8%	95.2%	121.8%
CONQUEST HOSPITAL	89.5%	104.0%	91.7%	103.4%
EASTBOURNE DISTRICT GENERAL HOSPITAL	90.9%	102.7%	92.2%	103.7%

From April 2014 all hospitals are required to publish information about the number of nursing and midwifery staff working on each ward, together with the percentage of shifts meeting safe staffing guidelines.

This is part of the NHS response to the Francis report which called for greater openness and transparency in the health service.

Information about staffing levels is published monthly.

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
		Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Jan-16	Var	Yr	Last Yr	Var	
A&E Performance (4 hour wait)	95.0%	84.8%	79.0%	83.9%	85.0%	83.2%	82.6%	79.5%	80.5%	78.1%	82.4%	77.6%	73.4%	84.2%	-10.8%	80.7%	89.4%	-8.7%	
A&E 12 Hour trolley waits	0	0	0	0	0	0	0	1	0	2	0	0	0	0	0	3	1	2	
A&E Unplanned re-attendance	5.0%	3.4%	3.0%	3.3%	3.3%	2.8%	3.0%	2.9%	3.0%	3.1%	3.0%	3.0%	3.2%	3.0%	0.1%	3.1%	3.1%	0.0%	
A&E Time to Initial Assessment (% Ambulance conveyan	M	92.1%	88.5%	94.3%	93.1%	90.7%	91.8%	90.1%	90.6%	89.6%	92.1%	90.1%	89.8%	92.2%	-2.4%	91.2%	95.4%	-4.2%	
A&E Time to Treatment (% within 60 Minutes)	M	48.1%	42.0%	47.0%	40.1%	36.6%	36.8%	36.7%	38.8%	39.5%	43.5%	41.6%	45.4%	52.4%	-7.0%	40.5%	50.5%	10.0%	
A&E Left before seen	M	2.6%	2.7%	2.1%	2.2%	1.3%	1.4%	1.4%	1.2%	1.2%	1.5%	1.8%	1.8%	2.1%	-0.3%	1.6%	1.8%	-0.2%	
Non Elective Conversion Rate	M	26.8%	24.8%	26.5%	24.6%	25.1%	23.5%	23.4%	23.1%	24.8%	26.6%	28.2%	27.5%	27.5%	0.0%	25.3%	25.9%	-0.6%	
A&E Cubicle Waiters (average number per day)	M	51	51	48	51	50	51	52	53	46	47	53	56	55	1	56	57	0	
Number of zero LOS NEL Ambulatory admissions	R	632	556	656	610	595	562	521	404	519	502	555	457	564	-19.0%	5381	6867	-27.6%	
% Zero LOS NEL Ambulatory admissions	M	41.5%	38.0%	43.4%	40.5%	39.6%	38.4%	36.9%	31.5%	37.6%	35.3%	37.6%	35.5%	40.8%	-13.1%	37.8%	43.2%	-5.5%	
Total Non Elective Beddays	M	24183	25729	23674	22694	21657	21958	23015	22688	22917	22592	23335	24854	25732	-3.4%	229384	223568	2.5%	
RTT Incomplete (%patients waiting over 18 weeks)	92.0%	92.2%	90.5%	90.2%	90.7%	89.5%	88.5%	87.5%	86.7%	85.7%	85.6%	85.6%	88.9%	92.1%	-3.2%	87.8%	93.3%	-5.5%	
RTT Backlog (number of patients waiting over 18 weeks)	M	2268	2823	2936	2931	3399	3791	4239	4534	4809	4714	4425	3243	2273	42.7%	281927	249878	11.4%	
RTT 52 Week waiters	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	1	
RTT 35 week waiters	0	74	84	112	140	172	185	180	245	320	275	348	302	44	258	2279	123	2156	
Diagnostic performance (% patients waiting over 6 weeks	1.0%	2.4%	6.7%	2.9%	2.7%	2.6%	2.2%	3.0%	2.5%	0.9%	1.6%	0.8%	0.9%	3.8%	-2.9%	98.0%	98.0%	-0.1%	

East Sussex Healthcare NHS
NHS Trust

Indicators

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Jan-16	Var	Yr	Last Yr	Var	
Cancer 2WW standard	93.0%	92.5%	94.9%	96.9%	96.0%	95.6%	96.5%	97.1%	97.3%	97.1%	97.2%	98.7%	98.0%		92.5%		97.1%	90.8%	6.3%	
Cancer 2WW standard (Breast Symptoms)	93.0%	99.1%	93.0%	90.0%	93.2%	98.5%	96.9%	95.8%	95.8%	96.9%	97.2%	98.2%	97.3%		99.1%		96.7%	89.2%	7.5%	
Cancer 31 Day standard	96.0%	96.9%	98.8%	99.3%	98.5%	99.4%	98.3%	97.7%	99.1%	98.8%	98.7%	99.5%	98.3%		96.9%		98.7%	97.4%	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%	94.1%	100.0%	100.0%	100.0%		100.0%		99.1%	100.0%	-0.9%	
Cancer 62 day urgent referral standard	85.0%	73.0%	70.5%	79.4%	67.6%	68.3%	82.3%	75.3%	79.5%	72.6%	82.5%	78.3%	84.1%		73.0%		76.8%	75.2%	1.7%	
Cancer 62 day screening standard	90.0%	33.3%	100.0%	42.9%	100.0%	66.7%	62.5%	100.0%	88.9%	85.7%	91.7%	100.0%	100.0%		33.3%		89.2%	79.1%	10.1%	
Urgent operations cancelled for a 2nd time	0	1	2	1	0	0	0	0	0	0	0	1	0	0	1	-1	1	3	-2	
Proportion of patients not re-booked within 28 days of las	0.0%	0.0%	5.7%	6.6%	0.0%	0.0%	0.0%	2.4%	0.0%	3.8%	3.8%	0.0%			7.5%		1.4%	2.6%	-1.3%	
Delayed Transfer of Care	3.5%	7.5%	10.8%	9.4%	5.3%	5.7%	7.0%	7.7%	8.0%	9.7%	9.7%	7.6%	7.1%	#DIV/0!	7.5%	#DIV/0!	7.5%	7.0%	0.5%	
Outpatient appointment cancellations < 6 weeks	R	21	21	18	14	29	47	34	37	30	41	44	64	24	21	14.3%	364	332	8.8%	
Outpatient appointment cancellations > 6 weeks	R	1060	1130	1551	1121	1014	1259	1407	1500	1272	1246	1230	1235	1166	1060	10.0%	12450	12096	2.8%	

East Sussex Healthcare NHS Trust

Access and Delivery overview

- The trust remains challenged against the key constitutional targets and trajectories
- A&E performance was 73.4% against the 95% standard
- RTT incompletes was 88.88% against the 92% standard. This represents an improvement of more than 3% on December.
- Diagnostics achieved the standard – 0.87% against the 1% target
- Cancer 62 Days achieved 84.1% against the 85% standard (for December, one month in arrears)
- No urgent operations were cancelled for a second time.
- There was one >52 week wait for admitted care declared. The patient has now been treated.
- A&E attendances increased on November and remain high (0.5% higher than January 2016 and 4.5% higher year to date)

East Sussex Healthcare NHS
NHS Trust

2. ELECTIVE CARE

East Sussex Healthcare NHS Trust

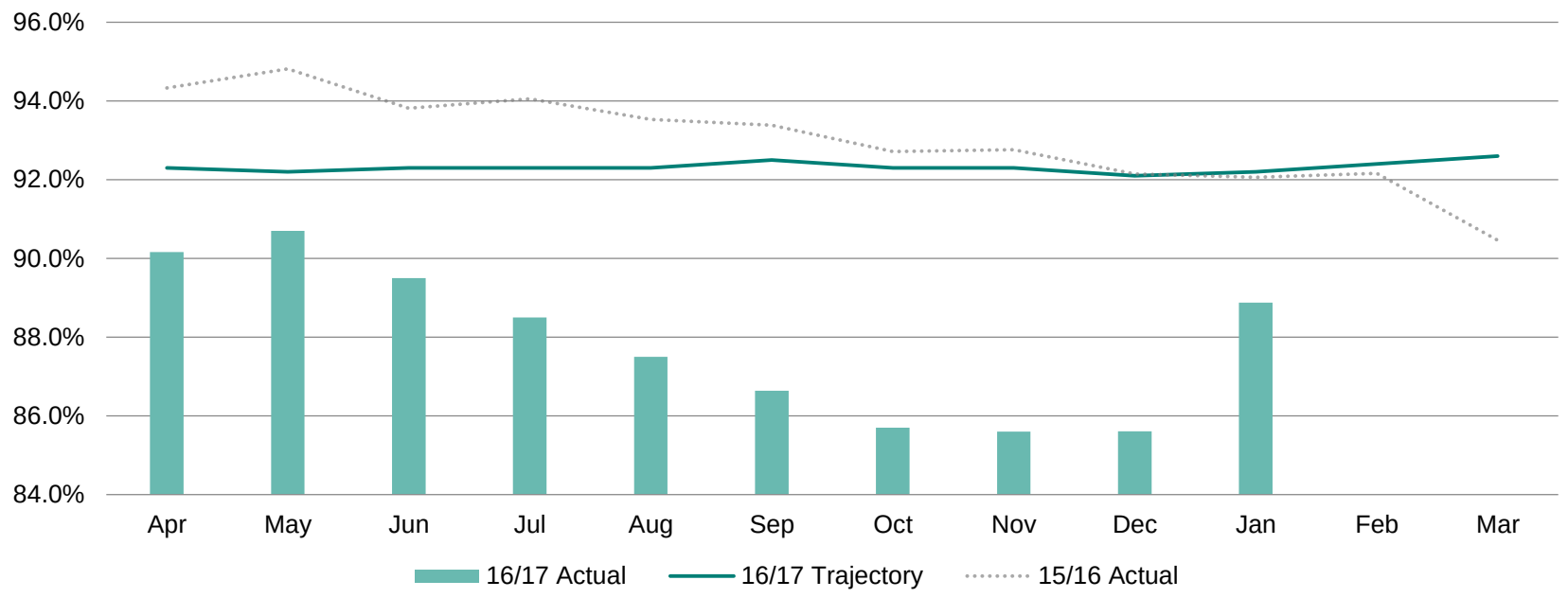
Outpatients

Item	Measure	Target	01.01.17	08.01.17	15.01.17	22.01.17	29.01.17
Registration of referrals (referral received & logged on Oasis)							
0-2 days	Percentage	80%	88%	85%	86%	89%	90%
3-13 days	Percentage	18%	8%	12%	10%	9%	9%
14 days +	Percentage	2%	4%	3%	4%	2%	1%
Total number of referrals received	Total number		**947**	**1452**	**1971**	**2137**	**2114**
Cashing up (incomplete)							
Current Month - February 2017 (Deadlines: RTT Submission 15/3/17 & Trust 20/4/17)	Total number	1750	5	1312	1800	1779	1915
January 2017 (Deadlines: RTT Submission 16/02/17 & Trust 16/3/17)	Total number	175	2152	943	193	88	16
December 2016 (Deadlines: RTT Submission 18/01/17 & Trust 15/02/17)	Total number		37	16	0	0	1
YTD outcome forms not submitted within required deadline			385	379	376	355	354
Clinical letters							
Total number of letters submitted to BigHand	Total number		4031	5646	6708	7603	8170
Total number of letters completed and sent in less than 7 days	Total number		2477	3026	4429	4929	4806
Percentage of letters completed within 7 days	Percentage	80%	61%	54%	66%	65%	59%
DNAs							
New appointments	Total number	-	98	162	217	201	215
Follow up appointments	Total number	-	148	360	479	471	501
New appointments %	Median Target	7.91%	9.07%	9.28%	8.69%	7.88%	8.51%
Follow Up appointments %	Median Target	7.91%	6.72%	8.13%	7.93%	7.70%	8.18%
Health Records							
Number of temporary file notes created			108	133	181	216	214
Total Number of outpatient appointments			4055	7530	10113	9927	10032
Percentage of temporary notes created based on number of outpatient appointments		1.00%	2.66%	1.77%	1.79%	2.18%	2.13%
Cancer - 2ww booking by tumour site							
Brain	Percentage of referrals booked within 7 days		0%	0%	100%	100%	75%
Breast			28%	63%	90%	50%	39%
Colorectal			54%	57%	73%	49%	35%
Gynaecology			39%	38%	25%	48%	42%
Head & Neck			64%	69%	65%	23%	24%
Lung			31%	45%	52%	30%	20%
Max Fax			31%	50%	100%	100%	55%
Other			25%	100%	83%	100%	86%
Paediatrics			100%	100%	N/A	100%	N/A
Skin			20%	48%	50%	67%	94%
Upper GI			42%	13%	45%	46%	38%
Urology			62%	41%	52%	70%	43%
Total Number of 2ww Referrals Received (processed within timescales - see below for details)	Total Number		**374**	**187**	**268**	**392**	**402**
Number of 2ww referrals booked within 7 days			155	91	172	207	183
Number of 2ww referrals booked within 8 - 14 days			251	96	95	185	218
Number of 2ww referrals booked outside 14 days			8	0	1	0	1
Theatre Cancellations due to Notes not being Present							
Number of patients who had their TCI cancelled	Total number	0	0	0	1	1	0

Complaints							
Total number received re clinical administration via PALS contacts	Total number	0	2	7	12	12	8
Total number formal written complaints re clinical administration being the Lead Investigator (data supplied by PALS/Complaints team)	Total number	0	0	0	0	0	1
Datix incidents raised relating to Patient Experience during OPA (reported per week)	Total number		0	1	1	1	0
Number of PALs contacts relating to Patient Experience during OPA	Total number		0	0	0	0	0
Number of formal complaints relating to Patient Experience during OPA	Total number		0	0	0	0	0
Outpatient Clinic Cancellations / Changes							
Total clinic cancellations received	Total number	-	120	116	265	170	147
Clinic cancellations requests received less than 6 weeks notice	Total number		28	43	114	38	66
Percentage of cancellations less than 6 weeks notice	Percentage	25%	23%	37%	43%	22%	45%
Clinic cancellations received less than 4 weeks notice to patients	Total Number		20	32	65	26	38
Percentage of cancellations less than 4 weeks notice to patients	Percentage	10%	14%	22%	20%	13%	21%
Number of Days in advance, clinics are being cancelled	Total number	42	42+	42+	42+	42+	42+
Outpatient Appointments Cancelled by Hospital							
Number of New Appointments Cancelled	Total number		303	416	505	463	513
Number of Follow-Up Appointments Cancelled	Total number		1155	1561	1903	2026	1959
Number of New and Follow Up Appointments Cancelled as overall % of average outpatients bookings	Percentage		36%	26%	24%	25%	25%
Outpatient Appointments Cancelled by Patient							
Number of New Appointments Cancelled	Total number		235	314	476	492	479
Number of Follow-Up Appointments Cancelled	Total number		489	838	1180	1080	1030
Outpatient Clinic Utilisation							
Cardiovascular			N/A	N/A	N/A	N/A	N/A
Medicine			43.5%	58.3%	61.7%	67.2%	65.2%
Surgery			66.9%	73.1%	71.1%	72.3%	73.1%
Women and Children (excludes Paed Epilepsy and Paed Surgery)			69.4%	69.8%	76.2%	72.2%	76.0%
Inpatient Theatre Utilisation							
Theatre Utilisation		85.00%	85.45%	81.12%	87.44%	85.70%	86.86%
Theatre hours available			199	404	564	515.5	563.5
Theatre hours utilised			170	328	493	441.8	489.45
Unused theatre sessions (figure quoted in hours)			221	147.5	124.5	165	171.5
OP Booking (Conquest) - Telephone Call Handling							
Number of calls presented			1018	2581	2785	2646	2688
Number of calls incorrectly presented to OP booking office			44	91	91	113	88
Number of calls answered			908	1927	2048	2078	2157
Number of calls not answered after automated welcome message			110	654	737	568	531
Average waiting time (minutes)			03:08	06:49	06:36	04:58	05:05

RTT

January performance was 88.88% against the trajectory of 92.2%. This represents a significant increase in performance from December. The improvements are predominantly in the non-admitted waiting list and are as a result of focussed validation and waiting list initiatives. There was one patient waiting in excess of 52 weeks identified during this validation period. This was the result of an administration error following the implementation of the new PAS system in September 2015. Further checks for assurance that this is an isolated case have been undertaken.



Report Type Desc		Performance	National Indicator	
Admitted Treatments Unadjusted	[Main Specialty Report]	55.67%	90.00%	✗
Non-Admitted Treatments	[Main Specialty Report]	80.21%	95.00%	✗
Admitted Incomplete	[Main Specialty Report]	64.39%	92.00%	✗
Non-Admitted Incomplete	[Main Specialty Report]	94.24%	92.00%	✓
All Incomplete Pathways	[Main Specialty Report]	88.88%	92.00%	✗
New RTT Clock Periods	[Main Specialty Report]	100.00%		

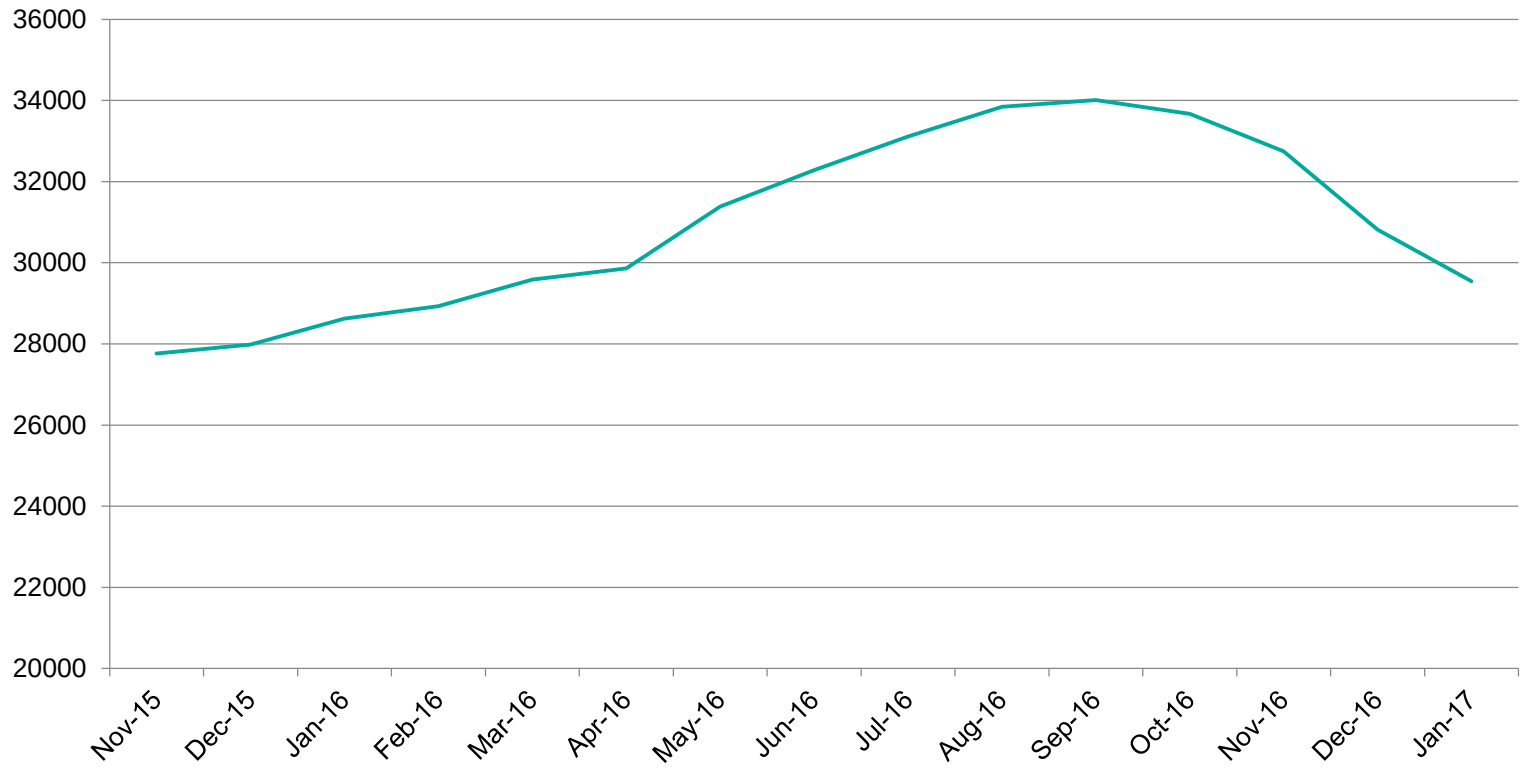
East Sussex Healthcare NHS
NHS Trust

All Incomplete Pathways Main Specialty Report

[Back]

Specialty		Breaches	NonBreaches	Total Cases	Performance	
General Surgery	Report	536	3917	4453	87.96%	✗
Urology	Report	226	1874	2100	89.24%	✗
Trauma & Orthopaedics	Report	391	1983	2374	83.53%	✗
Ear, Nose & Throat (ENT)	Report	546	2810	3356	83.73%	✗
Ophthalmology	Report	501	3091	3592	86.05%	✗
Oral Surgery	Report	101	1610	1711	94.10%	✓
Neurosurgery	Report	1	0	1	0.00%	○
Plastic Surgery	-					○
Cardiothoracic Surgery	-					○
General Medicine	Report	1	59	60	98.33%	✓
Gastroenterology	Report	83	1631	1714	95.16%	✓
Cardiology	Report	16	1696	1712	99.07%	✓
Dermatology	Report	3	641	644	99.53%	✓
Thoracic Medicine	Report	12	532	544	97.79%	✓
Neurology	Report	178	1042	1220	85.41%	✗
Rheumatology	Report	7	336	343	97.96%	✓
Geriatric Medicine	Report	1	317	318	99.69%	✓
Gynaecology	Report	396	1830	2226	82.21%	✗
Other	Report	252	2613	2865	91.20%	✗
	Totals	**3251**	**25982**	**29233**		

The total waiting list size has shown a further reduction over the previous months which reflects the progress being made in the action plans within the specialties and the development of the validation processes.



RTT

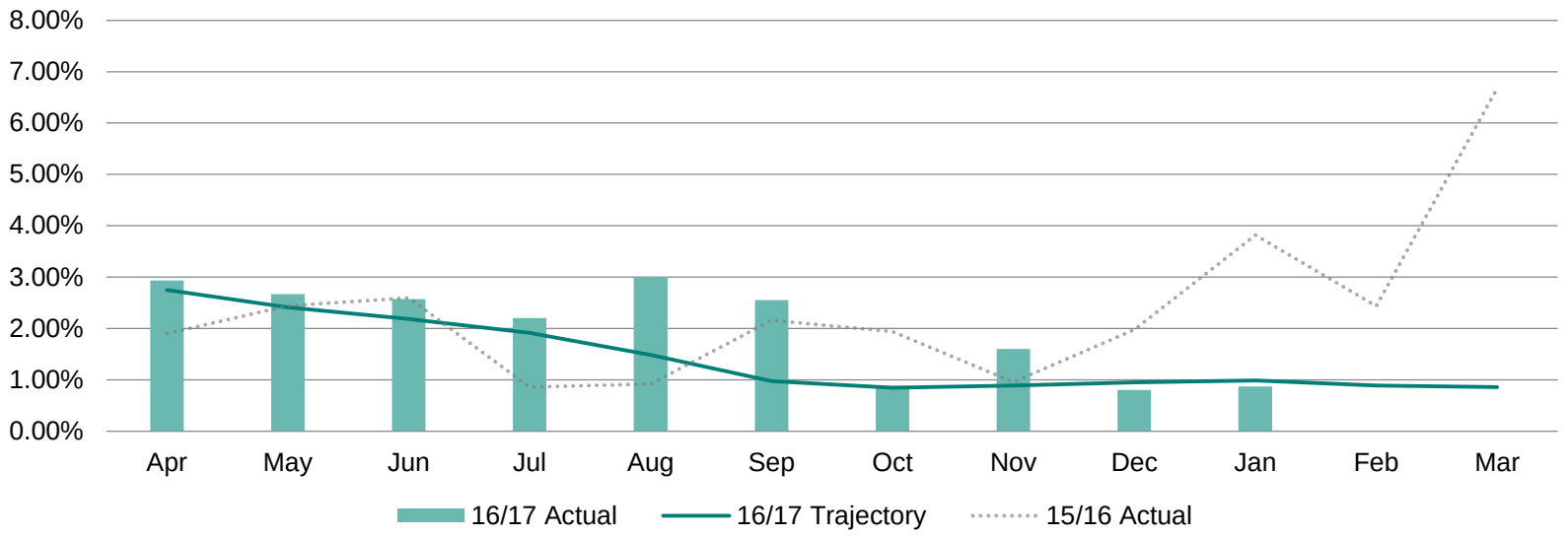
The RTT position remains challenging but showed improvement in January 2017. The non-admitted incompletes showed the largest improvement, reflective of the targetted work that has been undertaken.

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. This is currently on track.

Revised weekly PTLs have begun along with addition trustwide meetings. These take place each week and will give enhanced support to the specialties to help delivery the required RTT performance along as developing and overseeing the required action plan.

Gynaecology – The service are finalising the contract with the 18 Week Support team to run until the end of April. Due to the improved position in outpatients, this is planned to focus on day cases.

Diagnostics



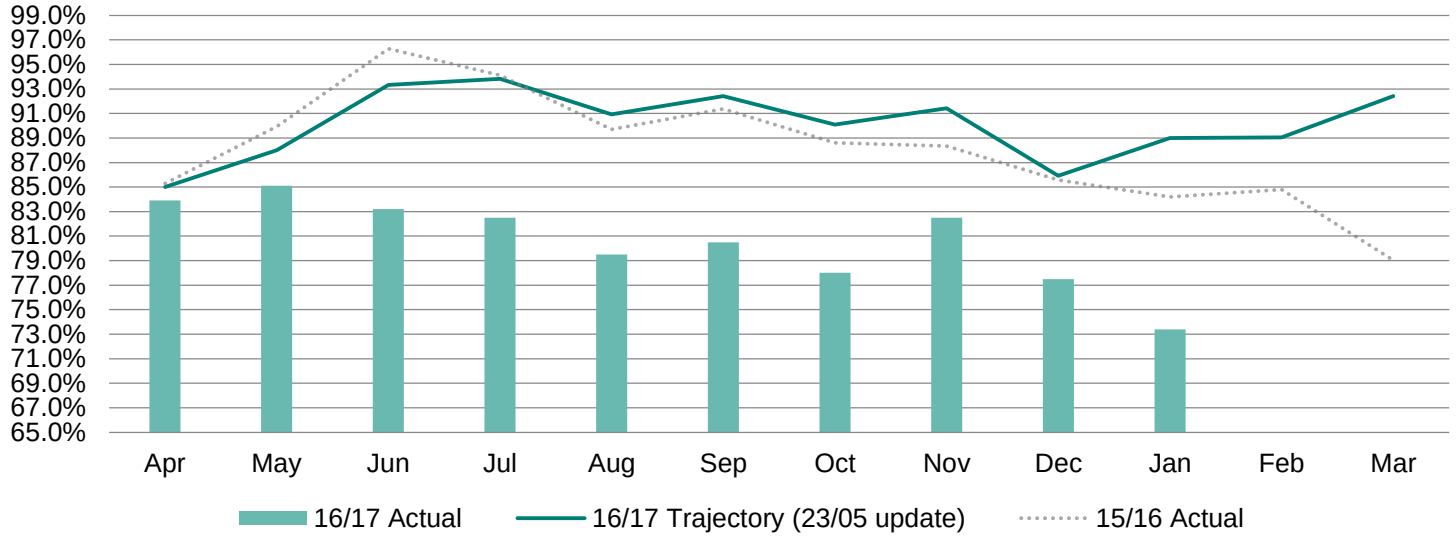
Diagnostics met the 1% standard with a performance of 0.87% in January. This exceeded the 0.99% trajectory.

The breaches were:
24 Radiology
16 Endoscopy
4 Cystoscopy/Urology
2 Audiology

3. EMERGENCY CARE

Sitrep YTD	January	2016/17							
Conquest Hospital, Hastings									
A&E Attend (Type 1)	Emergency	Admissions Emergency Thru A&E	Ordinary	Day Cases	Over 4 Hrs in A&E	% less than 4 Hrs	4-12 Hrs Trolley Waits	>12 Hrs Trolley Waits	Medical Outliers (avg per day)
46,351	23,459	13,617	2,974	15,929	9,572	79.3%	2,099	2	33
Eastbourne District General Hospital									
A&E Attend (type 1)	Emergency	Admissions Emergency Thru A&E	Ordinary	Day Cases	Over 4 Hrs in A&E	% less than 4 Hrs	4-12 Hrs Trolley Waits	>12 Hrs Trolley Waits	Medical Outliers (avg per day)
46,794	14,612	10,300	3,633	22,260	8,439	82.0%	2,563	1	53
East Sussex Healthcare Trust									
A&E Attend (Type 1, 2 and 3)	Emergency	Admissions Emergency Thru A&E	Ordinary	Day Cases	Over 4 Hrs in A&E	% less than 4 Hrs	4-12 Hrs Trolley Waits	>12 Hrs Trolley Waits	Medical Outliers (avg per day)
93,145	38,191	23,923	6,641	39,831	18,011	80.7%	4,662	3	86

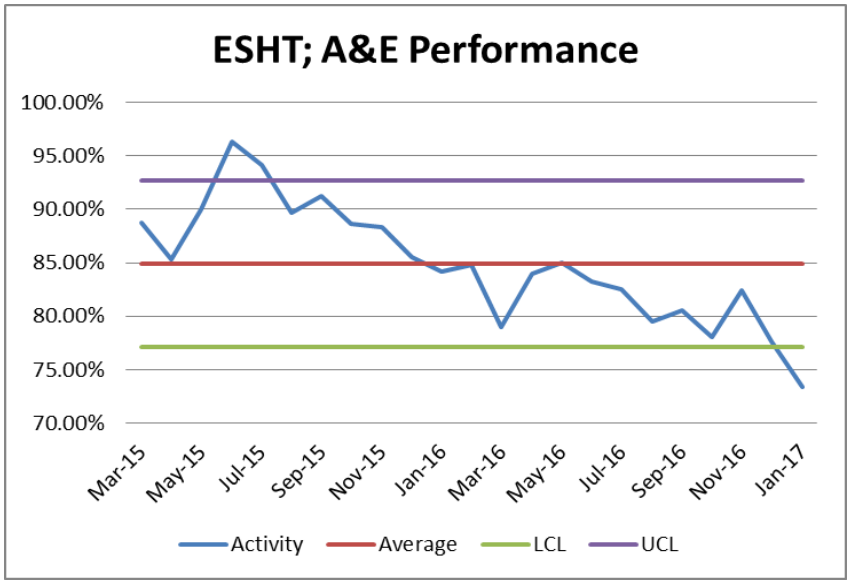
A&E Trajectory

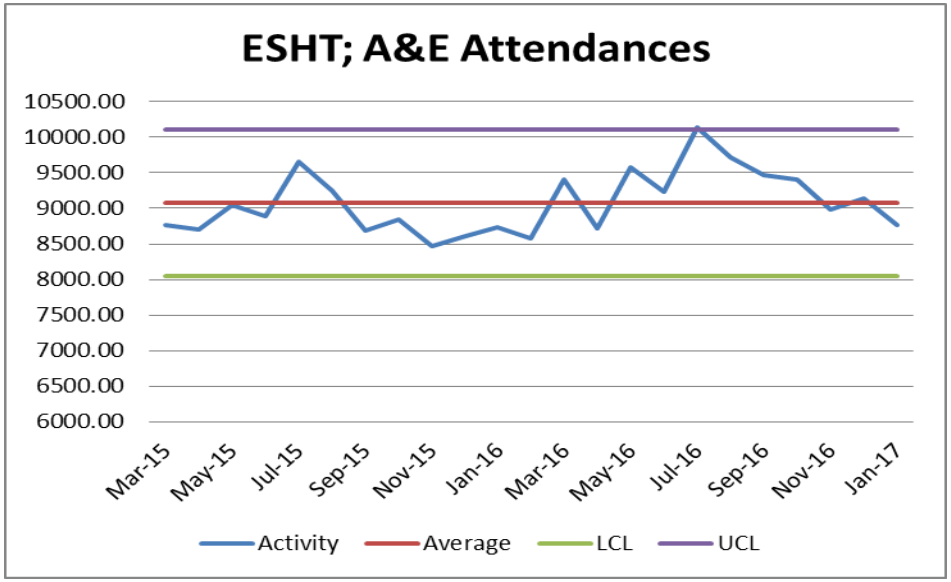


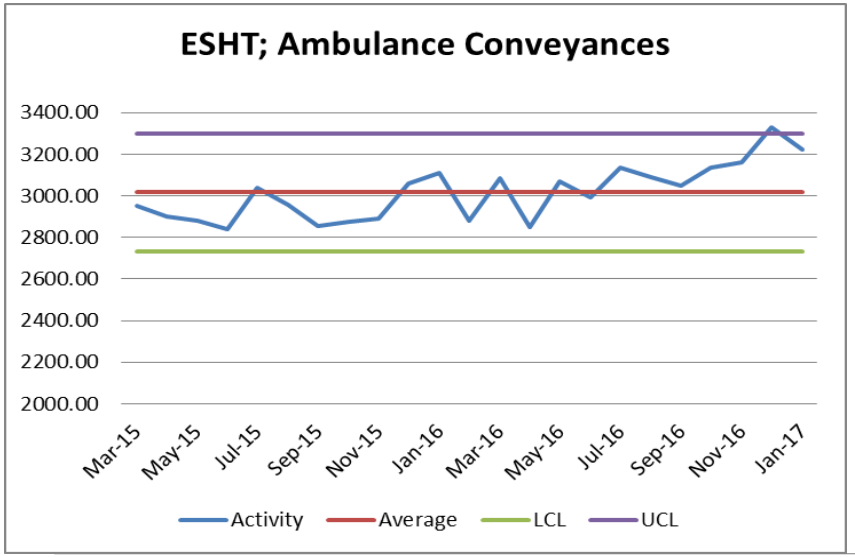
A&E performance deteriorated further in January with a Trust wide figure of 73.4%

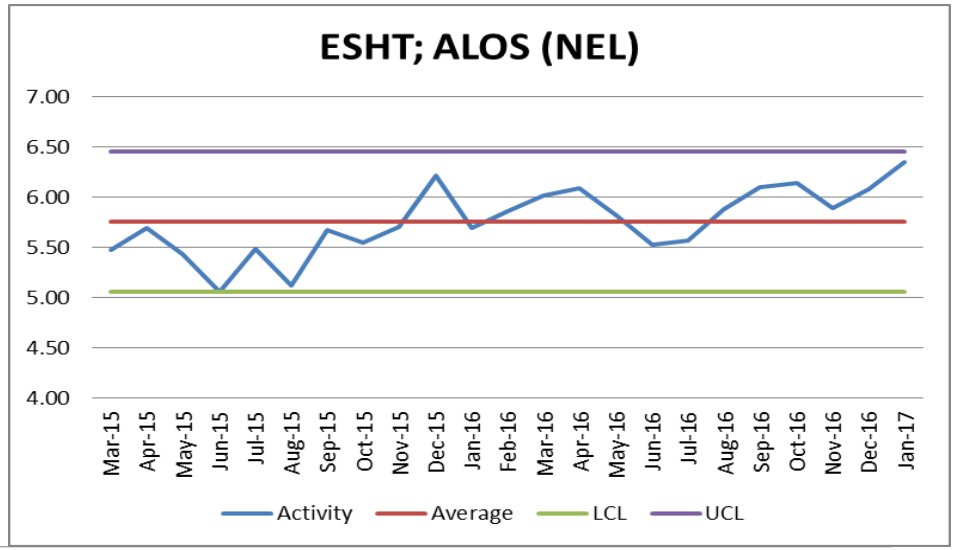
Attendances were remain on the increase across both sites by 4.5% on the year to date

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 minors breaches.


ESHT; A&E Performance
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
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
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Activity
Average
LCL
UCL


ESHT; Ambulance Conveyances
3400.00
3200.00
3000.00
2800.00
2600.00
2400.00
2200.00
2000.00
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Activity
Average
LCL
UCL

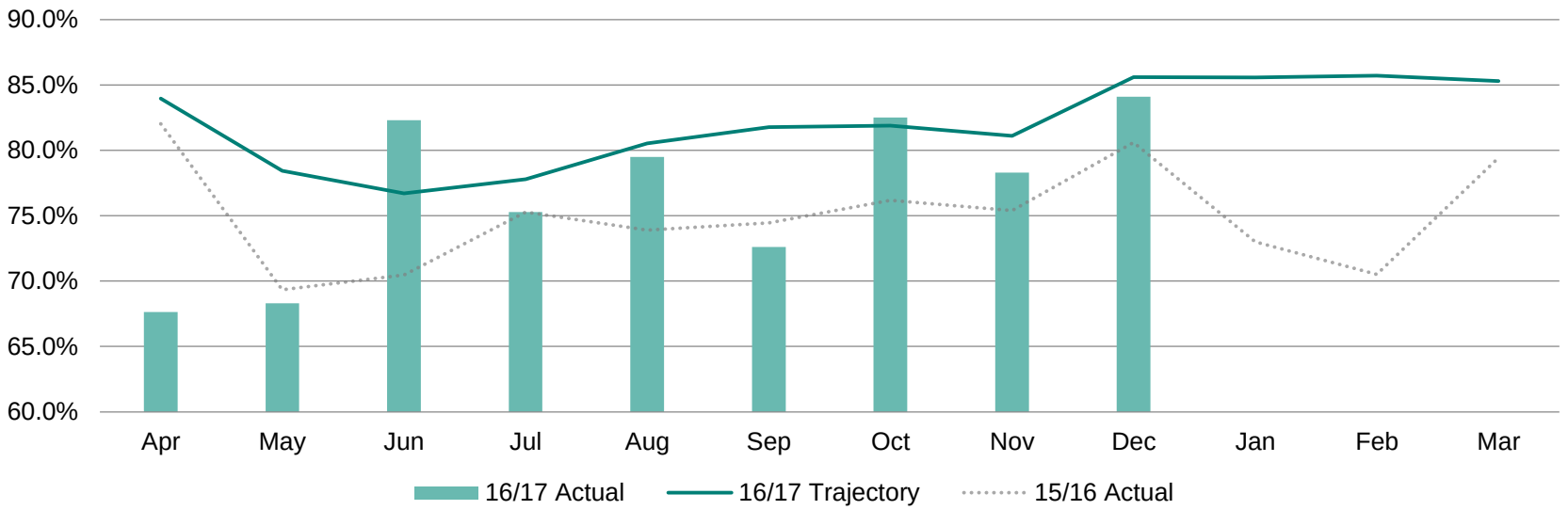

ESHT; ALOS (NEL)
7.00
6.50
6.00
5.50
5.00
4.50
4.00
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Activity
Average
LCL
UCL

A&E improvement progress

- Communications around 4hr waiting time launched
- SRO reviewing project and re-aligning to focus on five priority areas
- Streaming pathways being written up for sign-off with specialties by end Feb17
- ESHT Principles of Effective Emergency Care published and communicated to consultant and junior medical staff
- Pilot phase of SAFER on medical wards EDGH commenced 06.02.17
- Kick off meeting for phased roll-out of SAFER bundle across Trust to be held on 20.02.17

4. CANCER

CANCER



Achieved: 2 week wait

Achieved: 31 Day Standard

Did not achieve trajectory (85.6%) or the Standard (85%) for 62 Days with a performance of 84.1%

62 Days by tumour site

Site	Seen/Treated			On Target			Breaches			Compliance			Target
	Conq.	EDGH	All	Conq.	EDGH	All	Conq.	EDGH	All	Conq.	EDGH	All	
Brain/CNS	0.0	0.5	0.5	0.0	0.5	0.5	0.0	0.0	0.0		100 %	100 %	85 %
Breast Cancer	7.5	7.0	14.5	7.5	5.0	12.5	0.0	2.0	2.0	100 %	71.4 %	86.2 %	85 %
Colorectal	7.0	4.5	11.5	6.0	3.0	9.0	1.0	1.5	2.5	85.7 %	66.7 %	78.3 %	85 %
Gynaecology	1.5	1.5	3.0	0.5	1.0	1.5	1.0	0.5	1.5	33.3 %	66.7 %	50.0 %	85 %
Haematology	1.5	2.0	3.5	1.0	1.0	2.0	0.5	1.0	1.5	66.7 %	50.0 %	57.1 %	85 %
Head & Neck	0.5	1.5	2.0	0.0	1.0	1.0	0.5	0.5	1.0	0.0 %	66.7 %	50.0 %	85 %
Lung	4.0	7.0	11.0	3.0	5.0	8.0	1.0	2.0	3.0	75.0 %	71.4 %	72.7 %	85 %
Other	0.0	1.0	1.0	0.0	1.0	1.0	0.0	0.0	0.0		100 %	100 %	85 %
Skin	10.5	20.5	31.0	9.0	20.5	29.5	1.5	0.0	1.5	85.7 %	100 %	95.2 %	85 %
Upper GI	5.5	4.0	9.5	4.0	4.0	8.0	1.5	0.0	1.5	72.7 %	100 %	84.2 %	85 %
Urology	10.5	15.0	25.5	10.0	12.0	22.0	0.5	3.0	3.5	95.2 %	80.0 %	86.3 %	85 %
Total	48.5	64.5	113.0	41.0	54.0	95.0	7.5	10.5	18.0	84.5 %	83.7 %	84.1 %	85 %

East Sussex Healthcare NHS
NHS Trust

Completed Actions

- 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. Dedicated MP MRI slots for prostate patients are now available with the first list having been completed on 14/01/17. Data collection of the individual points in the pathway is in progress in order to support a further analysis and comparison with the previous pathway
- EBUS Business case to Healthy Hastings was submitted in December, it has been reviewed at the Business case board meeting .Business Case successful, CAPEX form completed. Training commencing for operators.
- Shared 62 Day PTL meeting with Brighton planned to commenced on 10th February 17, this will support the transfer of Day 38 patients and the 62 Day target.
- In addition to the PTL meeting, additional intensive 62 Day PTL reviews are taking place (separate from the PTL meeting) within Cancer Services to try and reduce the number of patients experiencing longer waits.
- Increased focus on 104 day breaches as part of Cancer PTL to reduce numbers of patients experiencing longer waits. Patients approaching 104 days and 104 day breaches are now reviewed at the Cancer PTL meeting.
- Rotating dates of Cancer Partnership Board to facilitate GP Cancer Lead attendance to provide additional support to the Cancer Waiting Times agenda.

Planned Actions

- Head & Neck Deep Dive is arranged for Monday 6th March 2017
- Joint PTL with Guys & St Thomas's is being set up to run weekly in order to replicate the scrutiny on 38 day transfers currently in place with MTW. .
- Collaborative working on NG12 continues with CCG partners. Additional scoping work underway for the straight to diagnostics element of the NG12. The forms are to go live by April 2017.
- Review of Oncology SLAs to ensure adequate capacity for ongoing increased demand. Review is underway and second meeting is arranged for 13th March 17
- Fusion biopsy software for prostate patients is being trialled following funding agreement from NHSE.
- Prostate pathway re-review meeting to be arranged in April 17 to review the outcomes of actions from the previous deep dives and a review of pathway data (3 months' worth) for comparison.

Finance

FINANCE

Financial Summary – January 2017

Key Issue	Summary	YTD
Overall RAG Rating	The NHS Improvement (NHSI) finance risk assessment criteria are shown in full on page 7. The Trust's overall RAG rating under the revised NHSI criteria is red in month 10.	R
Financial Recovery Plan	The Trust submitted a Financial Recovery Plan to NHSI in November 2016. This was based on delivery of the previously agreed control total of £31.3m. This plan requires the delivery of £16m additional financial improvements.	R
Financial Summary	The Trust performance in month 10 was a run-rate deficit of £3.3m with an adverse variance against the original plan of £1.6m. Year to date the deficit now stands at £39.3m, which is £10.5m worse than plan. Performance in the month represents a £1.3m adverse variance against the Financial Recovery Plan.	R
Income	Total income received during January was £0.8m above planned levels in spite of a £0.9m adverse variance for non-achievement of STF funding in the month. The year to date variance is now £9.0m above plan. The main cause of favourable variances in the month and year to date is activity in excess of planned values.	G
Expenditure	Operating Pay costs are above plan by £2.0m in month and are cumulatively £11.2m above plan. Operating Non Pay costs are £0.6m above plan in month and are £9.0m above plan cumulatively. Total costs are now £19.8m overspent year to date.	R
Forecast Outturn	The forecast outturn position has been amended to reflect the risks in the Financial Recovery Plan, including continuing operational pressures. This amended forecast shows a £46.5m deficit against the operational planned deficit of £41.7m and a £43.9m deficit compared to the £31.3m control total.	R
Balance Sheet	DH loans have increased by £41.8m in year as a result of the draw down of the revolving working capital facility and exceptional working capital.	A
Cash Flow	The cash position of the Trust remains challenging as a result of the current year deficit and historic cash shortages. This continues to result in increasing creditor values and poor performance against the Better Payment Practice Code. The Trust has secured cash to back the worsened income and expenditure forecast for the year.	R
Capital Programme	The charge against the Capital Resource Limit (CRL) is £9.0m year to date. The current forecast over planning margin stands at £0.6m and this is under close review to ensure the Trust does not exceed its capital resource limit at 31st March 2017.	A

Income & Expenditure – January 2017

Headlines

• Total income in the month was £31.6m against a plan of £30.8m, a favourable variance of £0.8m. The YTD position is £9.0m above plan.

• Total costs in the month were £35.0m, this was £2.5m above plan. The YTD position is now £19.8m above plan.

• The £39.3m year to date deficit against plan was an adverse variance of £10.5m

• The FRP has delivered £2.9m against the £3.4m target, this is £0.5m behind plan in the month.

• Operating pay costs in the month, including ad hoc costs, were £2.0m above plan and are now £11.2m above plan YTD.

• Operating Non Pay costs were £0.6m above plan in the month and are now £9.0m above plan YTD.

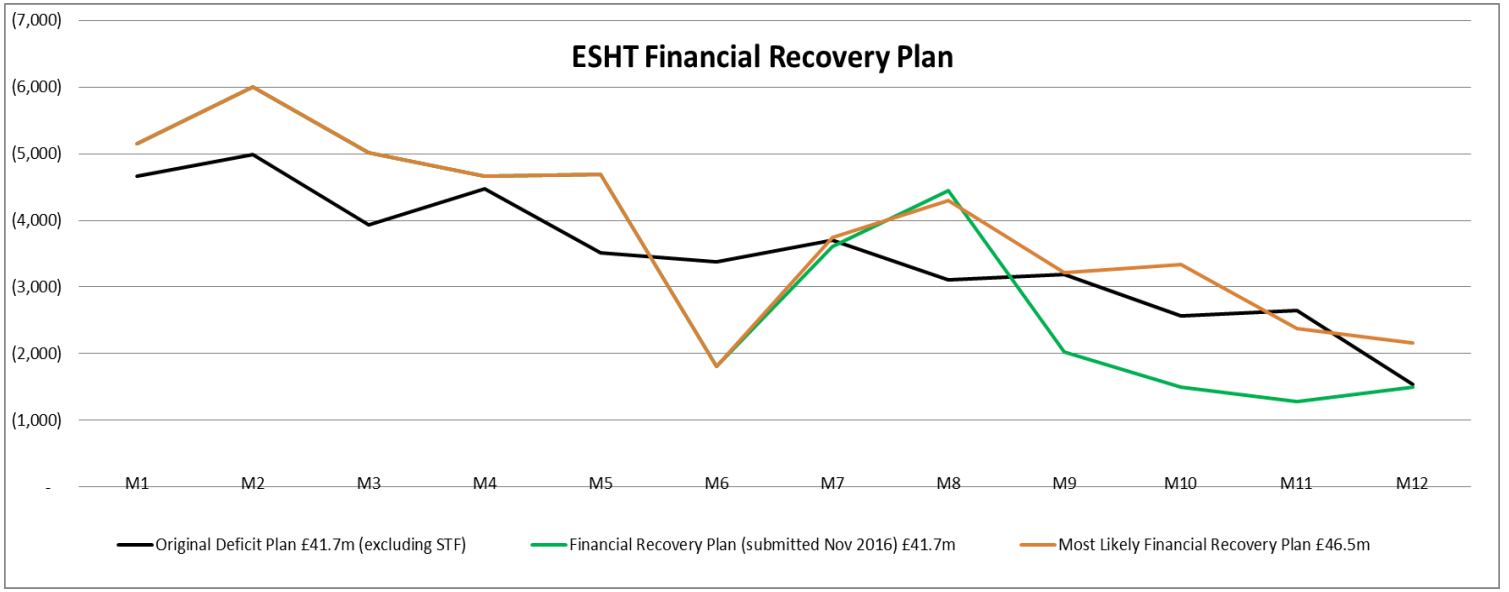
• A number of mid-year review adjustments have been made in the year to date position, including a £0.4m favourable stock adjustment and a release of accrual on community property rental costs.

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	24,418	25,960	1,542	238,048	249,413	11,365	286,487
Sustainability & Transformation Fund	867	0	-867	8,667	2,600	-6,067	10,400
Tariff-Excluded Drugs & Devices	2,608	2,717	109	26,083	26,657	574	31,300
Private Patient/ ICR	243	289	46	2,433	2,151	-282	2,919
Trading Income	376	316	-60	4,730	4,063	-667	3,631
Other Non Clinical Income	2,325	2,351	26	22,739	26,844	4,105	29,148
Total Income	**30,837**	**31,633**	**796**	**302,700**	**311,728**	**9,028**	**363,885**
Pay Costs	-20,750	-22,701	-1,951	-213,072	-224,258	-11,186	-254,517
Non Pay Costs	-7,575	-8,057	-482	-76,312	-84,769	-8,457	-90,076
Tariff-Excluded Drugs & Devices	-2,608	-2,717	-109	-26,083	-26,657	-574	-31,300
Total Operating Costs	**-30,933**	**-33,475**	**-2,542**	**-315,467**	**-335,684**	**-20,217**	**-375,893**
Surplus/- Deficit from Operations	**-96**	**-1,842**	**-1,746**	**-12,767**	**-23,956**	**-11,189**	**-12,008**
P/L on Asset Disposal	0	0	0	0	0	0	0
Depreciation	-1,043	-1,036	7	-10,433	-10,329	104	-12,519
Impairment	0	0	0	0	0	0	0
PDC Dividend	-430	-309	121	-4,302	-4,157	145	-5,162
Interest	-135	-183	-48	-1,343	-1,191	152	-1,611
Total Non Operating Costs	**-1,608**	**-1,528**	**80**	**-16,078**	**-15,677**	**401**	**-19,292**
Total Costs	**-32,541**	**-35,003**	**-2,462**	**-331,545**	**-351,361**	**-19,816**	**-395,185**
Net Surplus/-Deficit	**-1,704**	**-3,370**	**-1,666**	**-28,845**	**-39,633**	**-10,788**	**-31,300**
Donated Asset/Impairment Adjustment	0	32	32	0	305	305	0
Adjusted Net Surplus/-Deficit	**-1,704**	**-3,338**	**-1,634**	**-28,845**	**-39,328**	**-10,483**	**-31,300**

Financial Recovery Plan – January 2017

Headlines

- Month 10 had an operational deficit at £3.3m in the month, in line with last month's run rate. This is partly due to a reduction on agency and overall pay costs compared with previous months.
- The financial recovery plan submitted to NHSI in November delivered £2.9m towards the £3.4m target.
- The £2.9m achieved FRP in the month, included an adjustment for clinical Work in progress at £0.3m ahead of plan. However there are some schemes that are behind plan, leading to the latest forecast of £3.5m risk against the FRP.



This position is based on the Operational Deficit and excludes STF

The revised Financial Recovery Plan target for January was £3.4m, actual performance was £0.5m adrift from this plan, (see page 11 for detail by FRP scheme), there were also additional escalation areas opened as a result of increasing Winter operational pressures. Since submitting the November financial recovery plan of £41.7m, the Trust have submitted a revised forecast of £46.5m deficit (excluding STF) to take into account risks against FRP schemes and continued operational pressures.

Balance Sheet – January 2017

Headlines

• The forecast increase in non-current borrowings is in respect of the interim revolving working capital support facility (RWCF) and exceptional working capital.

• The original facility is fully utilised and the Trust received additional exceptional working capital funding which was drawn in January 2017.

• The increased forecast deficit is assumed to be matched by additional borrowing to be drawn in February and March

• The reduction in the forecast retained earnings reserve is as a result of the planned deficit.

BALANCE SHEET £000s	Actual 31/03/16	Actual 31/01/17	Forecast 31/03/17
Non Current Assets			
Property plant and equipment	231,172	230,100	235,207
Intangilble Assets	1,650	1,853	2,130
Trade and other Receivables	1,193	1,030	1,193
	234,015	**232,983**	**238,530**
Current Assets			
Inventories	6,472	6,020	6,341
Trade receivables	8,397	9,526	7,026
Other receivables	8,787	21,480	20,663
Cash and cash equivalents	2,100	2,833	2,100
	25,756	**39,859**	**36,130**
Current Liabilities			
Trade payables	-13,571	-31,797	-21,797
Other payables	-26,259	-19,265	-16,954
DH Capital Investment Loan	-427	-427	-427
Provisions	-253	-427	-459
	-40,510	**-51,916**	**-39,637**
Non Current Liabilities			
DH Capital Investment Loan	-3,553	-3,339	-3,126
Borrow ings - Revenue Support Facility	-35,218	-77,063	-89,662
Provisions	-2,709	-2,377	-2,319
	-41,480	**-82,778**	**-95,107**
Total Assets Employed	**177,781**	**138,148**	**139,916**
Financed by:			
Public Dividend Capital (PDC)	153,562	153,562	153,562
Revaluation Reserve	98,247	98,247	104,746
Retained Earnings Reserve	-74,028	-113,661	-118,392
Total Taxpayers' Equity	**177,781**	**138,148**	**139,916**

Cash Flow – January 2017

Headlines

• The cash position of the Trust remains extremely challenging. It is planned to meet the £2.1m balance at 31st March 2017 as required by the Department of Health. Based on current projections, this will involve extending supplier and BPPC payment terms.

• The Trust has utilised its revolving working capital facility (RWCF) of £31.3m and received exceptional working capital of £8.9m in the current month.

• The increase in forecast deficit is assumed to be matched by borrowing in February and March.

• The level of trade & other payables is resulting in the non-delivery of goods and services across a range of suppliers. The current financial performance will not enable the Trust to fully clear outstanding creditors.

Cash Flow Statement April 2016 to March 2017

£000s	Jan Actual	YTD Actual	Feb Forecast	Mar Forecast
Cash Flow from Operations				
Operating Surplus/(Deficit)	-2,878	-34,287	-1,800	-1,600
Depreciation and Amortisation	1,036	10,330	1,048	1,130
Operating Surplus/(Deficit)	-1,842	-23,957	-752	-470
Interest Paid	-184	-1,205	-180	-258
Dividend (Paid)/Refunded	0	-2,209	0	-2,922
Trade and Other Receivables	5,033	-9,845	500	394
Cash Advance from CCGs	-4,000	8,000	-4,000	-4,000
Trade and Other Payables	-7,164	-2,631	-606	2,846
Provisions Utilised	-9	-160	-40	-243
Net Cash Inflow/(Outflow) from Operating Activities	**-8,166**	**-32,007**	**-5,078**	**-4,653**
Cash Flows from Investing Activities:				
Interest Received	1	15	3	10
Property, Plant and Equipment	-794	-8,905	-2,560	-717
Net Cash Inflow/(Outflow) from Investing Activities	**-793**	**-8,890**	**-2,557**	**-707**
Net Cash Inflow/(Outflow) before Financing	**-8,959**	**-40,897**	**-7,635**	**-5,360**
Revolving Working Capital Facility	0	31,300	0	0
Revenue Support Loans (6%)	8,925	10,544	8,000	4,600
Loan Repayments	0	-214	0	-338
Net Cash Inflow/(Outflow) from Financing Activities	**8,925**	**41,630**	**8,000**	**4,262**
Net Increase/(Decrease) in Cash	**-34**	**733**	**365**	**-1,098**
Opening balance	2,867	2,100	2,833	3,198
Closing balance	2,833	2,833	3,198	2,100

Receivables, Payables & Better Payment Practice Code Performance – January 2017

Headlines

- The Better Payment Practice Code (BPPC) requires all NHS organisations to achieve a public sector payment standard for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services.
- The target achievement of BPPC is 95%.
- The Aged Debt (over 90 days) KPI is measured as a percentage of the total level of debt. The target is for this to be no more than 5%.
- The current Aged Debt KPI is 22% at the end of January and key accounts are being reviewed.
- A large credit note (£828K) for MSK Partnership is forcing the Non-NHS over 31 day balance in to a credit.

Trade Receivables Aged Debt Analysis - Sales Ledger System Only	NHS Debt Outstanding		Non-NHS Debt Outstanding	
	Current Month £000s	Previous Month £000s	Current Month £000s	Previous Month £000s
0 - 30 Days	3,077	3,692	1,849	1,597
31 - 60 Days	2,540	1,095	75	(512)
61 -90 Days	465	325	(600)	238
91 - 120 Days	205	97	211	329
> 120 Days	813	793	891	594
Total	7,100	6,002	2,426	2,246

Trade Payables Aged Analysis - Purchase Ledger System Only	No of Invoices		Value Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0 - 30 Days	6,779	5,465	7,094	6,777
31 - 60 Days	7,999	9,565	9,828	11,865
61 -90 Days	7,045	5,595	8,620	7,014
91 - 120 Days	1,723	1,766	2,972	2,365
> 120 Days	1,761	1,407	3,283	2,737
Total	25,307	23,798	31,797	30,758

Better Payment Practice Code	Month Number of Invoices	Month By Value	YTD Number of Invoices	YTD By Value
Trade invoices paid within contract or 30 days of receipt	12.15%	23.13%	28.75%	39.72%
NHS invoices paid within contract or 30 days of receipt	15.06%	97.81%	29.50%	80.97%

Key Performance Indicators – January 2017

NHSI Finance Risk Assessment Criteria

• NHS Improvement (NHSI) has set out its reporting requirements in the Single Oversight Framework (SOF).

• The finance and use of resources metrics have been revised by NHSI and span three main areas:
- Financial sustainability
- Financial efficiency
- Financial controls

• A rating of 4 on any metric will mean that the best overall rating that can be achieved is a 3.

Finance and Use of Resources Metrics (UoR)

• The Trust has a liquidity ratio rating of 4, a capital servicing capacity ratio of 4, an I&E margin of 4, a distance from financial plan rating of 4 and an agency spend rating of 3. This results in an overall rating of 4.

Better Payment Practice Code (BPPC)

• YTD performance is below the BPPC target for both Trade invoices and NHS invoices paid by value due to the difficult cash position which is being managed by the Trust.

Finance and Use of Resources Metrics	YTD Actual	YTD Plan
Liquidity Ratio Rating	4	4
Capital Servicing Capacity Rating	4	4
I&E margin rating	4	4
Distance from Financial Plan Rating	4	
Agency Spend Rating	3	1
Overall Use of Resources Rating	4	4

Local Measures	YTD Actual	YTD Plan
BPPC – Trade invoices by value (%)	40	95
BPPC – NHS Invoices by value (%)	81	95

Activity & Contract Income – January 2017

Headlines

NHS Patient Income in the month was £0.9m above the TDA plan, increasing the cumulative favourable variance to £5.9m.

The following are the main variances in performance :-

- Electives (including Day cases) £2.4m over-performance across multiple areas including Cardiology £380k, T&O £906k, Urology £401k, General Medicine £330k, General Surgery £174k, Ophthalmology £232k and Gastroenterology £420k with under performance in Dermatology £181k and Gynaecology £165k.
- Non-Electives over-performing with £2.6m mainly linked to General Medicine £1.4m, T&O £539k, Geriatric Medicine £1.3m and Respiratory Medicine £580k partially offset by £882k Diabetes & Endocrinology (activity believed to be sitting within General Medicine)
- STF funding shortfall of £6.1m
- Outpatient activity is over performing across multiple specialties, Rheumatology, Ophthalmology and Urology being the most significant over plan.

Under the terms of the Sustainability and Transformation Funding (STF) no provision has been made for fines and penalties, other than £30k relating to MSSA breaches.

Activity	Current Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,589	2,966	-623	36,233	33,388	-2,845
Elective Inpatients	655	638	-17	6,612	6,615	3
Emergency Inpatients	3,666	3,432	-234	36,179	34,597	-1,582
Total Inpatients	**7,910**	**7,036**	**-874**	**79,024**	**74,600**	**-4,424**
Excess Bed Days	2,228	4,446	2,218	22,033	27,191	5,158
Total Excess Bed Days	**2,228**	**4,446**	**2,218**	**22,033**	**27,191**	**5,158**
Consultant First Attendances	7,901	8,561	660	79,762	82,898	3,136
Consultant Follow Ups	12,347	13,396	1,049	124,638	125,604	966
OP Procedures	4,504	5,986	1,482	45,473	49,329	3,856
Other Outpatients inc WA & Nurse Led	12,124	14,370	2,246	122,394	131,809	9,415
Community Specialist	172	354	182	1,737	2,295	558
Total Outpatients	**37,048**	**42,667**	**5,619**	**374,004**	**391,935**	**17,931**
Chemotherapy Unbundled HRGs	617	1,737	1,120	6,223	12,521	6,298
Antenatal Pathways	310	317	7	3,131	2,882	-249
Post-natal Pathways	285	236	-49	2,879	2,835	-44
A&E Attendances (excluding type 2's)	9,476	8,884	-592	93,538	94,621	1,083
ITU Bed Days	517	581	64	5,108	5,094	-14
SCBU Bed Days	309	279	-30	3,048	2,842	-206
Cardiology - Direct Access	67	51	-16	684	699	15
Radiology - Direct Access	5,103	5,414	311	51,513	54,591	3,078
Pathology - Direct Access	276,561	287,840	11,279	2,791,955	2,794,716	2,761
Therapies - Direct Access	2,540	5,180	2,640	25,648	31,410	5,762
Audiology	1,014	785	-229	10,235	6,671	-3,564
Midwifery	13	11	-2	130	91	-39

Income £000's	Current Month			YTD		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,093	4,030	-63	41,323	43,767	2,444
Inpatients - Emergency	6,310	6,591	281	62,285	64,905	2,620
Excess Bed Days	493	760	267	4,866	5,687	821
Outpatients	3,994	4,586	592	40,323	42,933	2,610
Other Acute based Activity	2,803	2,653	-150	27,838	27,293	-545
Direct Access	771	803	32	7,791	8,221	430
Block Contract	5,381	6,308	927	53,807	52,640	-1,167
Fines & Penalties	0	-10	-10	0	-30	-30
Other	960	-178	-1,138	3,681	1,508	-2,173
CQUIN	480	517	37	4,801	5,089	288
Subtotal	25,285	26,060	775	246,715	252,013	5,298
Exclusions	2,608	2,717	109	26,083	26,657	574
GRAND TOTAL	**27,893**	**28,777**	**884**	**272,798**	**278,670**	**5,872**

Clinical Unit, Estates & Corporate Performance (budgets) – January 2017

Headlines

Pay

Total Pay reported an overspend of £2m against original plan in the month and £11.2m year to date. Total agency spend in January was £1.8m, which is consistent with last month.

A detailed action plan to reduce reliance on temporary workforce costs is underway as part of the financial recovery plan, however challenging operational pressures over Winter have led to additional escalation areas being opened and agency still required.

Non pay

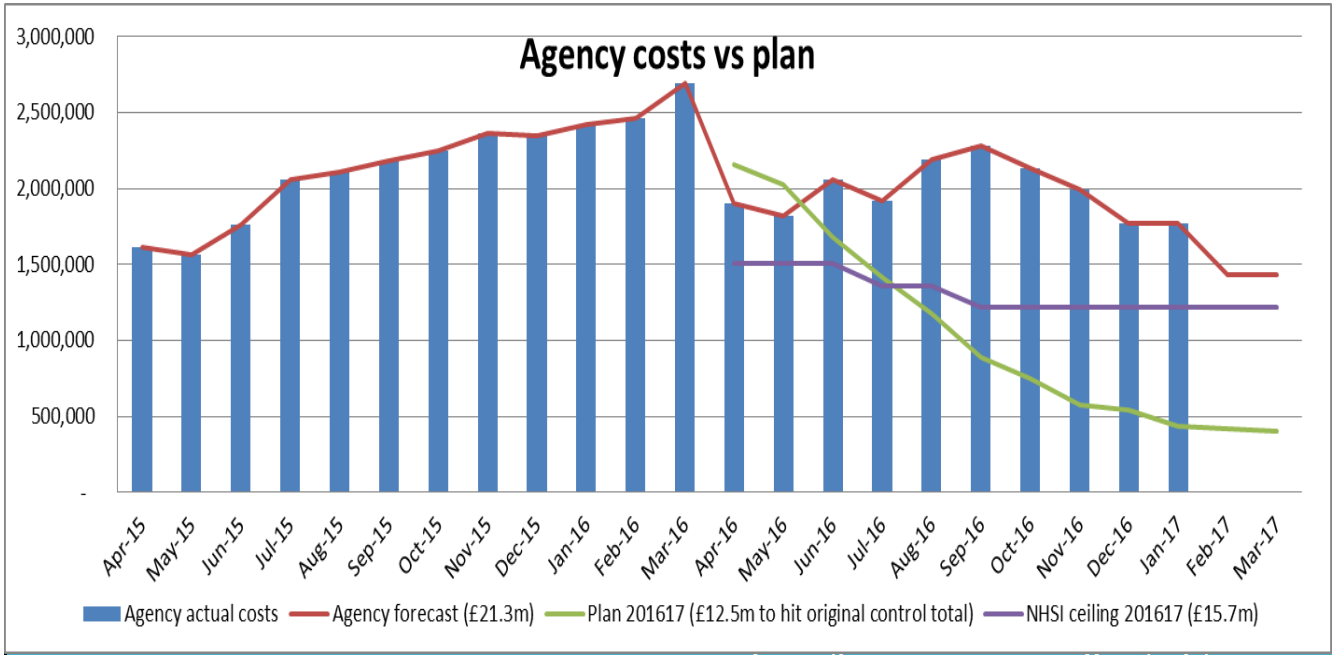
Total non pay recorded a £0.5m overspend in January and cumulatively £13.9m. Activity pressures including escalation beds and outsourcing activity to help with capacity pressures, have reported an overspend of £3.4m cumulatively, offset by over-performance on contract income.

Tariff Exclusions were £0.6m overspent to date, offset by over delivery on income.

Income & Expenditure Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
Urgent Care	-903	-1,002	-99	-9,860	-9,948	-88
Medicine	-3,898	-5,277	-1,379	-46,534	-53,541	-7,007
Surgery, Anaesthetics & Diagnostics	-8,627	-9,555	-928	-97,523	-99,829	-2,306
Women's, Children's & Sexual Health	-2,384	-2,564	-180	-25,567	-25,554	13
Out of Hospital Care	-3,434	-3,350	84	-33,787	-33,464	323
Tariff-Excluded Drugs & Devices	-2,608	-2,717	-109	-26,083	-26,657	-574
Total Clinical Units	**-21,854**	**-24,465**	**-2,611**	**-239,354**	**-248,993**	**-9,639**
Estates & Facilities	-2,013	-2,131	-118	-19,700	-20,920	-1,220
Corporate Services	-3,532	-3,612	-80	-35,659	-39,367	-3,708
Central Items	-632	-1,549	-917	-1,383	-11,987	-10,604
Total Central Areas	**-6,177**	**-7,292**	**-1,115**	**-56,742**	**-72,274**	**-15,532**
Contract Income	27,893	28,077	184	272,798	278,670	5,872
Non-contract Income	-1,566	310	1,876	-5,547	2,964	8,511
Donated Asset/Impairment Adjustment	0	32	32	0	305	305
Adjusted Net Surplus/- Deficit	**-1,704**	**-3,338**	**-1,634**	**-28,845**	**-39,328**	**-10,483**

Workforce Plan FTE	Workforce Actual FTE	Pay Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
226	234	Urgent Care	-951	-934	17	-9,373	-9,290	83
1,179	1,286	Medicine	-4,416	-4,880	-464	-45,434	-46,591	-1,157
1,809	1,822	Surgery, Anaes & Diagnostics	-7,399	-7,346	53	-74,510	-74,165	345
641	606	Women's, Children's & Sexual Health	-2,363	-2,407	-44	-23,327	-23,419	-92
918	907	Out of Hospital Care	-2,701	-2,653	48	-26,256	-26,246	10
4,773	**4,856**	**Total Clinical Units**	**-17,830**	**-18,220**	**-390**	**-178,900**	**-179,711**	**-811**
648	644	Estates & Facilities	-1,283	-1,348	-65	-14,246	-14,631	-385
1,049	1,038	Corporate Services	-2,966	-3,011	-45	-29,619	-29,841	-222
1,697	**1,683**	**Total Non-Clinical Divisions**	**-4,249**	**-4,359**	**-110**	**-43,865**	**-44,472**	**-607**
0	**0**	Central Items	1,329	-122	-1,451	9,693	-75	-9,768
6,470	**6,539**	**Total Pay Analysis**	**-20,750**	**-22,701**	**-1,951**	**-213,072**	**-224,258**	**-11,186**

Agency Expenditure – January 2017

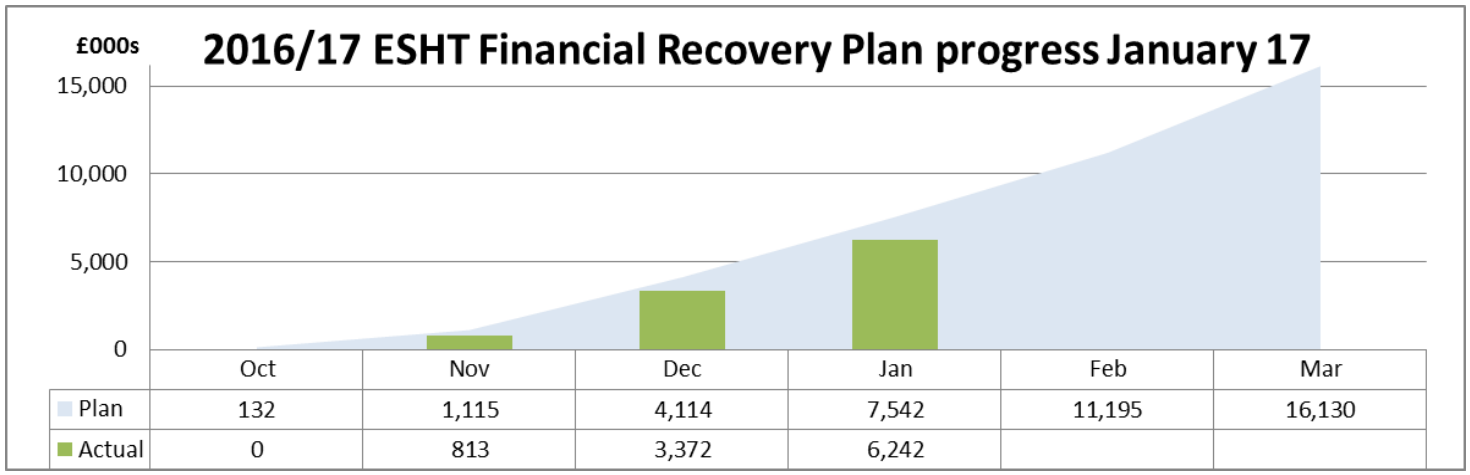


AGENCY STAFF SPEND BY STAFF GROUP (INCLUDING, AGENCY, LOCUM)	In month Actual £'000	In month Plan £'000	In month Variance £'000	Year to date Actual £'000	Year to date Plan £'000	Year to date Variance £'000
Total Pay Bill Agency and Locum Staff	**1,771**	**432**	1,339	**19,847**	**11,642**	8,205
Non Medical -Clinical Staff Agency	**638**	**279**	359	**9,518**	**7,337**	2,181
Registered Nurses	257	152	105	4,272	3,319	953
Qualified Scientific, Therapeutic and Technical Staff	231	23	208	3,120	1,257	1,863
HCA nursing	150	104	46	2,126	2,761	- 635
Non Medical- Non-Clinical Staff Agency	152	40	112	2,313	984	1,329
Medical and Dental Agency	**981**	**113**	**868**	**8,017**	**3,321**	**4,696**
Trainee Grades	335	73	262	3,730	2,021	1,709
Consultants	646	40	606	4,287	1,300	2,987

Headlines

- Actual agency costs are in line with last month as a result of the actions taken in the Trust's Financial Recovery Plan.
- Medical agency spend has totalled £8m month 1-10, £4.7m above original plan, although locum and permanent medical spend reported £0.7m below plan. Recruitment to consultant vacancies and middle grades remains challenging and the majority of medical agency shifts are above the capped rates. The Trust has now implemented Direct Engagement and spend on medical agency is lower than last month.
- HCA agency shifts continue on average 200 shifts per week to cover escalation beds, vacancies and special observation needs.

Financial Recovery Plan(2) – January 2017



Headlines

- January reported £2.9m savings towards the £3.4m target and cumulatively £6.2m achievement.
- However there are some schemes that are behind plan, leading to the latest forecast of £3.5m risk against the FRP.
- Ongoing work with divisions to identify alternative schemes to close this gap and work towards 17/18 savings ideas.

	Month			YTD			Full Year		
Division	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000
Corporate	272	136	136	610	281	330	1,156	1,356	-200
Specialist Medicine	764	379	384	1,622	687	935	3,200	1,442	1,757
Surgery, Anaethetics & Theatres, Diagnostics	1,256	385	871	2,623	540	2,083	5,577	1,839	3,739
Urgent	178	56	123	430	298	132	791	561	230
Women's & Children's	274	40	234	604	319	285	1,170	562	608
Out of Hospital	135	10	125	253	110	143	536	378	158
Trustwide	550	1,865	-1,315	1,400	4,008	-2,608	3,700	6,451	-2,751
Total	3,429	2,870	558	7,542	6,242	1,300	16,130	12,589	3,541

	Month			YTD			Full Year		
Workstream	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000
Data Quality & Clinical Networks	241	222	18	658	626	31	1,389	1,358	31
Elective Pathways	760	523	237	1,527	963	564	3,246	1,984	1,262
Non-pay	245	273	-28	591	413	178	1,081	1,444	-362
Patient Flow	311	0	311	585	0	585	1,207	215	992
Workforce - Medical	221	59	162	372	273	99	814	587	227
Workforce – Non-clinical and other clinical	70	0	70	113	11	102	252	153	99
Workforce - Nursing	115	73	42	166	249	-84	478	560	-83
Clinical Services Contribution	541	134	407	1,081	134	947	2,163	272	1,891
Income Cost Recovery	600	300	300	1,800	900	900	3,000	1,500	1,500
Technical	325	1,286	-961	650	2,673	-2,023	2,500	4,516	-2,016
Total	3,429	2,870	558	7,542	6,242	1,300	16,130	12,589	3,541

Year on Year Comparisons – January 2017

Headlines

- Total Inpatient activity to date is 5.2% lower than last year's level.
- Total outpatients are 6.0% higher than last year.
- Total A&E attendances are 5.3% higher than last year.
- Total income is £16.5m (5.6%) up on the same period last year.
- Total expenditure is £15.2m (4.5%) up on the same period last year.

Activity	2016/17 YTD Actual	2015/16 YTD Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Day Cases	33,388	37,085	-3,697	-10.0%
Elective Inpatients	6,615	6511	104	1.6%
Emergency Inpatients	34,597	35,067	-470	-1.3%
Total Inpatients	**74,600**	**78,663**	**-4,063**	**-5.2%**
Elective Excess Bed Days	2,144	1,579	565	35.8%
Non elective Excess Bed Days	25,047	20,316	4,731	23.3%
Total Excess Bed Days	**27,191**	**21,895**	**5,296**	**24.2%**
Consultant First Attendances	82,898	78,348	4,550	5.8%
Consultant Follow Ups	125,604	124,127	1,477	1.2%
OP Procedures	49,329	43,832	5,497	12.5%
Other Outpatients (WA & Nurse Led)	131,809	121,672	10,137	8.3%
Community Specialist	2,295	1,723	572	33.2%
Total Outpatients	**391,935**	**369,702**	**22,233**	**6.0%**
Chemotherapy Unbundled HRGs	12,521	6,239	6,282	100.7%
Antenatal Pathways	2,882	3,077	-195	-6.3%
Post-natal Pathways	2,835	2,890	-55	-1.9%
A&E Attendances (excluding type 2's)	94,621	89,824	4,797	5.3%
ITU Bed Days	5,094	4,964	130	2.6%
SCBU Bed Days	2,842	2,973	-131	-4.4%
Cardiology - Direct Access	699	672	27	4.0%
Radiology - Direct Access	54,591	50,431	4,160	8.2%
Pathology - Direct Access	2,794,716	2,741,243	53,473	2.0%
Therapies - Direct Access	31,410	27,404	4,006	14.6%
Audiology	6,671	10,077	-3,406	-33.8%
Midwifery	91	125	-34	-27.2%

Income £000s	2016/17 YTD Actual	2015/16 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	278,670	265,088	13,582	5.1%
Private Patient/ RTA	2,151	2,245	-94	-4.2%
Trading Income	4,063	4,834	-771	-15.9%
Other Non Clinical Income	26,844	23,044	3,800	16.5%
Total Income	**311,728**	**295,211**	**16,517**	**5.6%**
Pay Costs	-224,258	-214,357	-9,901	-4.6%
Non Pay Costs	-113,481	-105,596	-7,885	-7.5%
Other	2,055	1,450	605	
Total Direct Costs	-335,684	-318,503	-17,181	-5.4%
Surplus/-Deficit from Operations	**-23,956**	**-23,292**	**-664**	**-2.9%**
Profit/Loss on Asset Disposal	0	15	-15	
Depreciation	-10,329	-10,683	354	3.3%
Impairment	0	0	0	
PDC Dividend	-4,157	-6,054	1,897	31.3%
Interest	-1,191	-955	-236	-24.7%
Total Indirect Costs	-15,677	-17,677	2,000	11.3%
Total Costs	**-351,361**	**-336,180**	**-15,181**	**-4.5%**
Net Surplus/-Deficit	**-39,633**	**-40,969**	**1,336**	**3.3%**
Donated Asset / Other Adjustment	305	341	-36	10.6%
Normalised Net Surplus/-Deficit	**-39,328**	**-40,628**	**1,300**	**3.2%**

Capital Programme – January 2017

Headlines

Work is ongoing on a pipeline of business cases to be submitted to NHS Improvement (NHSI) in the current financial year, the intention being that these are then externally funded. However, the current £11.0m capital programme excludes the bid for additional capital resources while the ongoing business case work continues.

Year to Date performance:-
After 10 months of the financial year, capital expenditure has increased to £9.0m across a range of headings. Commitments currently entered into amount to £11.0m.

The forecast over-planning margin has also moved to £0.6m following a robust review during the month.

A review of forecast capital expenditure is continuing and this includes a review of the over-planning margin to ensure that the Trust does not exceed its capital resource limit at financial year end.

Capital Investment Programme £000s	2016/17 Capital Programme	Expenditure at Month 10
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	759
IT Systems	2,187	1,108
Electronic Document Management	948	582
Estates Strategy	1,600	1,140
Backlog Maintenance	2,285	950
Minor Capital Schemes	1,000	2,055
Pathology CLD	797	821
Vital Pac	338	165
Project Management	106	138
Brought Forward Commitments - Various	1,183	1,261
Sub Total	**11,325**	**8,979**
Donated Asset Purchases	1,000	480
Donated Asset Funding	-1,000	-480
Net Donated Assets	**0**	0
Sub Total Capital Schemes	**11,325**	**8,979**
Overplanning Margin (-) Underplanning (+)	-358	1,988
Net Capital Charge against the CRL	**10,967**	**10,967**

Financial Sustainability Risk Ratings – January 2017

Headlines

Use of Resource Metrics (UoR):-

- Liquidity Ratio (days)
  - Days of operating costs held in cash or cash equivalent forms.
- Capital Service Capacity Ratio (times)
  - The degree to which the organisation's generated income covers its financial obligations.
- Income and expenditure (I&E) Margin (%)
  - The degree to which the organisation is operating at a surplus/deficit.
- Distance from financial plan (%)
  - The YTD I&E surplus/deficit compared to plan.
- Agency spend (%)
  - The distance from the providers cap..
- The NHSI assigns ratings between 1 and 4 to each component of the UoR with 4 being the worst rating and 1 the best. The overall rating is the average of the five.
  - The liquidity ratio of -16 days is a rating of 4.
  - The capital servicing capacity ratio of -4.38 results in a rating of 4.
  - The I&E margin of -12.7% results in a rating of 4.
  - The distance from financial plan of 3.2% results in a rating of 4
  - Agency spend of £19.8m YTD is 41.7% above cap, a rating of 3.
  - As a result, the overall Trust rating is 4.

Liquidity Ratio (days) £000s	2015/16 Outturn	2016/17 YTD
Opening Current Assets	25,115	39,859
Opening Current Liabilities	-39,869	-51,916
Net Current Assets/Liabilities	-14,754	-12,057
Inventories	-6,472	-6,020
Adj Net Current Assets/Liabilities	**-21,226**	**-18,077**
Divided by:		
Total costs in year	383,768	335,684
Multiply by (days)	360	300
Liquidity Ratio	**-20**	**-16**

Capital Servicing Capacity (times) £000s	2015/16 Outturn Actual	2016/17 YTD Plan	2016/17 YTD Actual
Net Surplus / Deficit (-) After Tax	-47,759	-28,845	-39,633
Less:			
Donated Asset Income Adjustment	-947	-833	-480
Interest Expense	846	1,366	1,205
Profit/Loss on Sale of Assets	-29	0	0
Depreciation & Amortisation	12,664	10,433	10,329
Impairments	-411	0	0
PDC Dividend	6,940	4,302	4,157
Revenue Available for Debt Service	**-28,696**	**-13,577**	**-24,422**
Interest Expense	846	1,366	1,205
PDC Dividend	6,940	4,302	4,157
Temporary PDC repayment			
Working capital loan repayment	31,842	214	214
Capital loan repayment	335		
	39,963	5,882	5,576
Capital Serving Capacity	**-0.72**	**-2.31**	**-4.38**

Financial Efficiency £000s	2015/16 Outturn Actual	2016/17 YTD Plan	2016/17 YTD Actual	2016/17 YTD Variance
Normalised Net surplus/ deficit	-47,759	-28,845	-39,633	
Less fixed asset impairments/disposals	-440	0	0	
	-48,199	-28,845	-39,633	
Divided by:				
Total Income (excl donated assets)	-355,205	-301,867	-311,248	
I&E Margin	**-13.6%**	**-9.6%**	**-12.7%**	**-3.2%**

Financial Risks & Mitigating Actions – January 2017

A Financial Recovery plan was submitted to NHSI in November to address the 2016/17 deficit, the trust has amended it's operational forecast deficit plan from £41.7m to £46.5m (excluding STF) this reflects £3.5m risk on FRP and continuing operational challenges as below.

RISKS:-	**MITIGATING ACTIONS:-**
The following areas of risk have been identified in the amended £46.5m forecast (£43.9m net of Q1 Sustainability Transformation Funding)	**The following mitigations have been identified to offset the risks.**
£3.5m The latest assessment of the forecast is that FRP will under deliver, this is made up of Income (Generic Growth) and Data Quality & Clinical Networks (U Codes)	Weekly progress check via PMO meetings to escalate key areas of risk and agree actions required. Additional pipeline schemes are being reviewed to mitigate this risk.
Challenging operational pressures, e.g. RTT capacity shortfall leading to outsourcing of activity and additional escalation areas	Capacity review of beds as part of the Urgent Care Board and Patient Flow project to ensure bed requirements are met at specialty level. Specialty reviews undertaken to look at different ways of working with ASC and primary care as part of ESBT to reduce length of stay and free up capacity in acute setting.
Continued reliance of agency staff at premium rates.	FRP actions to address Temporary Workforce spend, Exec approval process for authorisation of agency expenditure, success in international recruitment and negotiation of agency rates within prescribed caps.
ADDITIONAL RISKS:-	**MITIGATING ACTIONS:-**
Contract negotiations (QIPP, CQUIN, Winter funding)	Ongoing dialogue with CCG to negotiate / agree income position
Technical adjustments have been made to improve the YTD position which carry a level of risk (provision for stock, review of accruals treatment)	Continued work with divisions and the finance team to identify and develop additional schemes, including a review of P2P SLAs, procurement review and a full balance sheet review.

Sustainability and Strategy

SUSTAINABILITY

STP

Integrated Community MSK Services

The Trust were successful in the Tender to provide Integrated Community MSK services for NHS Hastings and Rother CCG. The contract will commence from the 1 July 2017 and a mobilisation plan is in place to ensure a smooth transfer of the staff and services from Virgin, the current provider.

STP Diabetes Bid

The outcome of the bid submitted by the CCGs to NHS England seeking £1.3million investment, from a national pot of £44 million, across the Sussex and East Surrey STP for improvements in the treatment and care of people with diabetes is awaited. In the meantime work is being done regarding a diabetic foot CQUIN across the East Sussex CCGs.

Acute Services Clinical Strategy

Carnall Farrar have been appointed to support the STP in developing an acute services clinical strategy, including reviewing acute hospital activity and capacity, networking services and evaluating the potential to deliver care out of hospital. This will complement the work that is already happening locally in our place based care plans (ESBT).

Developments

Accountable Care Model Development

We are working closely with ESBT colleagues to develop the Governance Structure for the ACO during its shadow year. ESHT Chairman David Clayton Smith Chairs the Alliance Governing Board, and Dr Adrian Bull chairs the Alliance Executive.

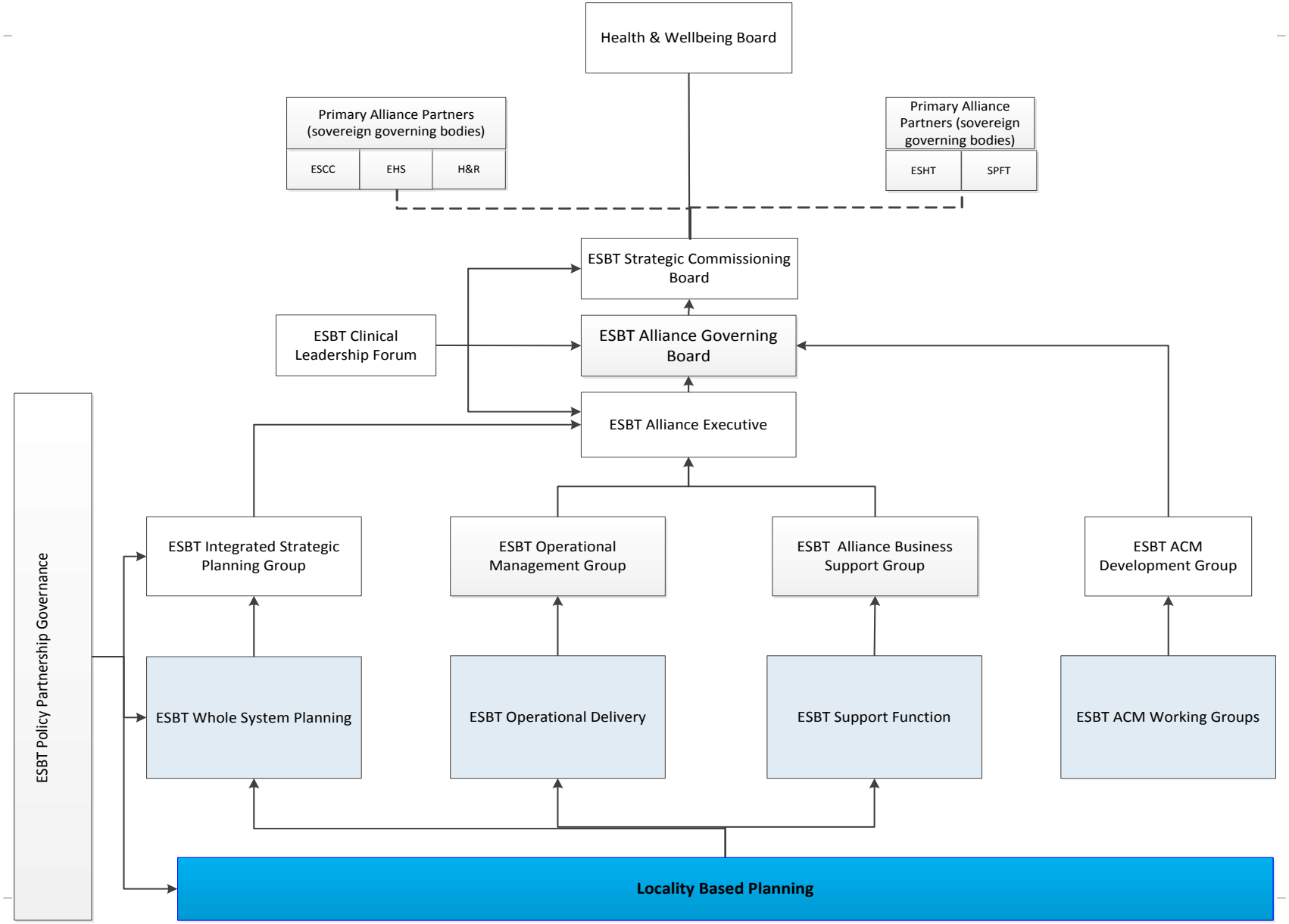
A memorandum of agreement is being developed between the key partners and a draft will be available in the next few weeks.

Pathway Redesign

NHS Elect are running three masterclasses in pathway redesign for clinical leaders and service managers across the system. These will be delivered in February with follow up workshops in March and April to progress each individual pathway redesign programme.

ESBT Shadow Governance Arrangements

East Sussex Healthcare NHS Trust



Leadership & Culture

LEADERSHIP & CULTURE

East Sussex Healthcare NHS Trust

1. WORKFORCE EXECUTIVE SUMMARY – KEY POINTS

Actual workforce usage of staff in January was 6539.29 full time equivalents (ftes), 69.27 ftes above budgeted establishment.

Temporary staff expenditure was £3,169K in January (13.96% of total pay expenditure). This comprised £1,366K bank expenditure, £1,771K agency expenditure and £32K overtime. This is a reduction of £218K overall compared to December.

There were 476.68 fte vacancies (a vacancy factor of 7.56%). This was an increase of 4.43 fte vacancies compared to last month, partly due to an increase of 11.79 ftes in budgeted establishment.

Annual turnover was 9.77% which represents 533.29 fte leavers in the last year. This is an increase of 0.05% compared to last month.

Monthly sickness was 4.78%, an increase of 0.19% from December. The annual sickness rate was 4.41%, an increase of 0.03%.

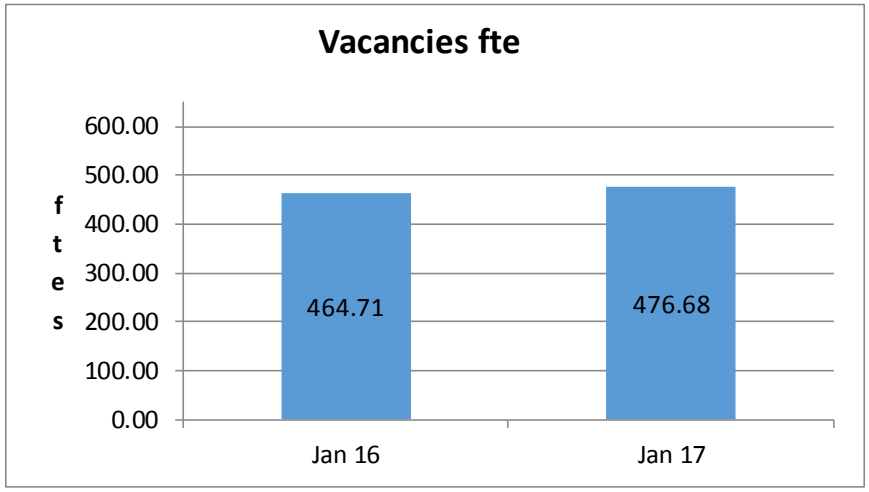
The overall mandatory training rate increased by 0.77% to 88.13%. Compliance rates increased for all mandatory training courses, except for Trust Induction and Infection Control which were marginally down.

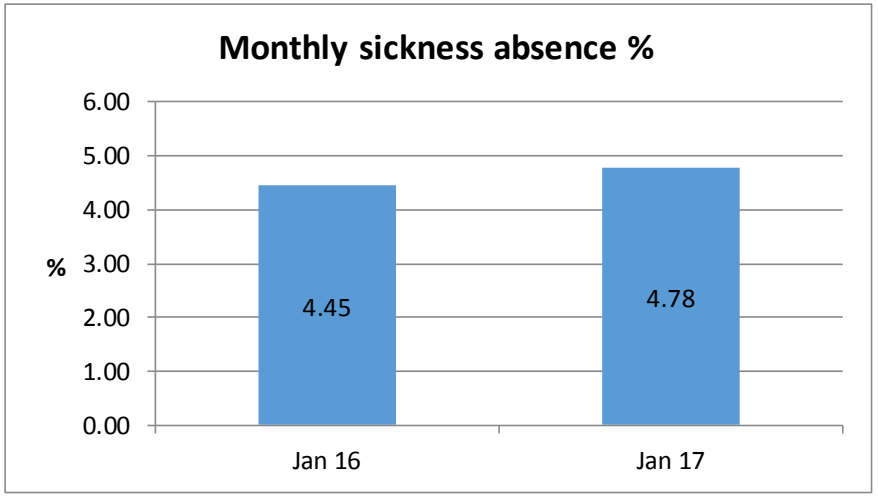
Appraisal compliance increased slightly by 0.07% to 78.42%

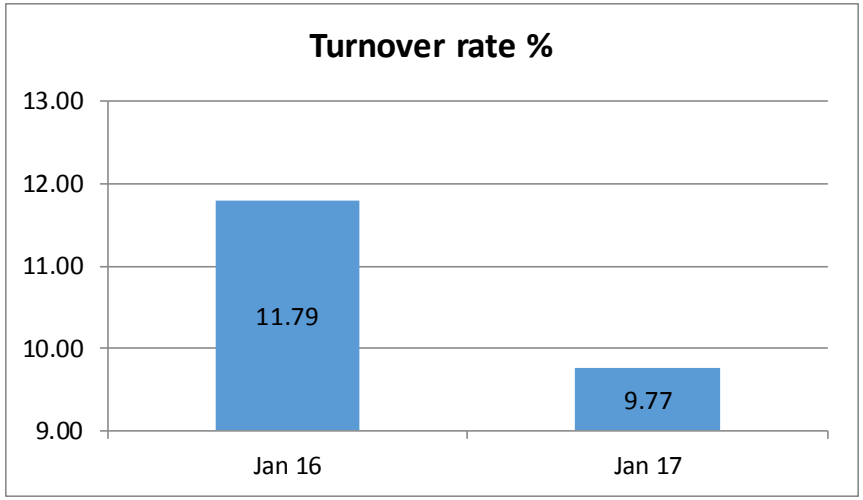
2. Overview

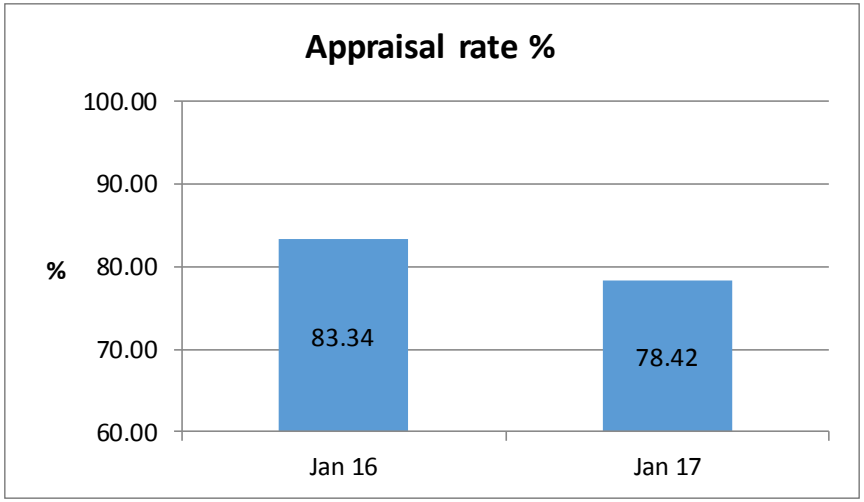
TRUST	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Trend line
WORKFORCE CAPACITY													
Budgeted fte	6057.36	6057.39	6368.93	6381.23	6437.07	6328.78	6394.73	6416.78	6477.44	6521.75	6458.23	6470.02	
Total fte usage	6334.88	6492.33	6320.64	6340.02	6370.72	6380.32	6465.06	6516.26	6542.43	6596.92	6526.36	6539.29	
Variance	-277.52	-434.94	48.29	41.21	66.35	-51.54	-70.33	-99.48	-64.99	-75.17	-68.13	-69.27	
Permanent vacancies	422.43	342.18	606.76	579.45	611.23	564.18	496.62	517.21	504.71	507.66	472.25	476.68	
Fill rate	92.84%	94.20%	90.17%	90.66%	90.23%	90.94%	92.01%	91.71%	91.99%	92.00%	92.49%	92.44%	
Bank fte usage (as % total fte usage)	6.65%	6.58%	6.97%	6.23%	6.26%	6.40%	6.31%	7.42%	6.98%	7.23%	7.22%	7.29%	
Agency fte usage (as % total fte usage)	7.06%	8.09%	5.29%	5.37%	5.49%	5.32%	5.71%	5.33%	5.14%	4.98%	4.37%	4.09%	
WORKFORCE EFFICIENCY													
Annual sickness rate	4.53%	4.53%	4.50%	4.46%	4.42%	4.40%	4.39%	4.37%	4.38%	4.37%	4.38%	4.41%	
Monthly sickness rate (%)	5.10%	4.79%	4.18%	3.94%	3.77%	4.08%	4.10%	4.01%	4.68%	4.47%	4.59%	4.78%	
Turnover rate	11.28%	10.62%	10.25%	10.00%	10.03%	10.02%	9.76%	9.66%	9.87%	9.53%	9.72%	9.77%	
TRAINING & APPRAISALS													
Appraisal rate	85.29%	87.26%	88.47%	89.68%	88.07%	85.77%	87.01%	83.14%	81.61%	79.21%	78.35%	78.42%	
Fire	85.07%	85.31%	86.25%	87.01%	87.62%	86.91%	85.51%	86.28%	86.16%	86.27%	84.46%	85.31%	
Moving & Handling	88.09%	88.25%	89.43%	89.57%	89.91%	90.58%	90.09%	90.99%	90.12%	89.75%	87.98%	89.06%	
Induction	92.79%	93.83%	93.67%	94.69%	94.38%	94.50%	93.73%	94.09%	92.54%	92.05%	93.70%	93.15%	
Infec Control	87.86%	87.37%	87.92%	88.40%	89.24%	88.97%	87.95%	89.01%	88.92%	88.63%	86.98%	86.84%	
Info Gov	86.23%	85.49%	84.78%	84.48%	84.51%	83.86%	83.64%	84.79%	84.32%	84.96%	84.21%	85.70%	
Health & Safety	85.35%	85.94%	86.74%	87.42%	87.95%	88.05%	87.75%	88.42%	88.83%	88.96%	88.59%	89.09%	
MCA	93.40%	93.10%	93.92%	93.37%	94.13%	94.09%	93.83%	94.45%	94.68%	95.27%	95.02%	95.43%	
DoLs	93.29%	93.81%	94.06%	95.35%	95.04%	95.68%	95.64%	95.64%	95.97%	96.61%	96.89%	97.42%	
Safeguarding Vulnerable Adults	79.06%	79.71%	81.54%	81.37%	83.10%	83.82%	83.06%	83.90%	84.71%	85.86%	85.87%	86.76%	
Safeguarding Children Level 2	82.46%	82.12%	83.25%	83.35%	82.93%	82.35%	82.43%	83.32%	83.40%	83.43%	83.16%	84.44%	

3. Recruitment









The medical vacancy rate has increased by 1.05% to 9.72% (56.13 fte vacancies, up by 6.02 ftes), for registered nursing & midwives the rate has increased slightly by 0.08% to 8.28% (167.03 fte vacancies, up by 1.49 ftes), whilst for unqualified nurses, the vacancy rate has also increased by 1.08% to 4.43% (37.21ftes, up by 9.11 ftes),

An additional recruitment headhunter has been engaged to address the key medical recruitment areas of A&E. CVs continue to be forwarded to stakeholders as soon as they are received by Recruitment.

The qualified nurse recruitment programme continues with existing suppliers Drake (for Philippines recruitment). c.20 Nurses are still due to start by March 2017. In addition, 3 Radiographers are due to start in March. Those Philippine nurses who were interviewed in October – November 2016 (76 offers, of which 6 withdrawn) have now started to be booked in for their language assessments and their predicted start date is November 2017 – March 2018.

A recruitment campaign in Italy and Spain is planned for the end of February. The target is for c.20 nurses to join the Trust in April or May. A business plan is also being prepared for another visit to the Philippines over Easter 2017.

A recruitment campaign for surgical nurses is to be designed and delivered to assist current and future recruitment needs, taking into account upcoming retirees. As this is an area of particular recruitment difficulty, a UK nurse recruitment headhunter will be engaged to assist the campaign.

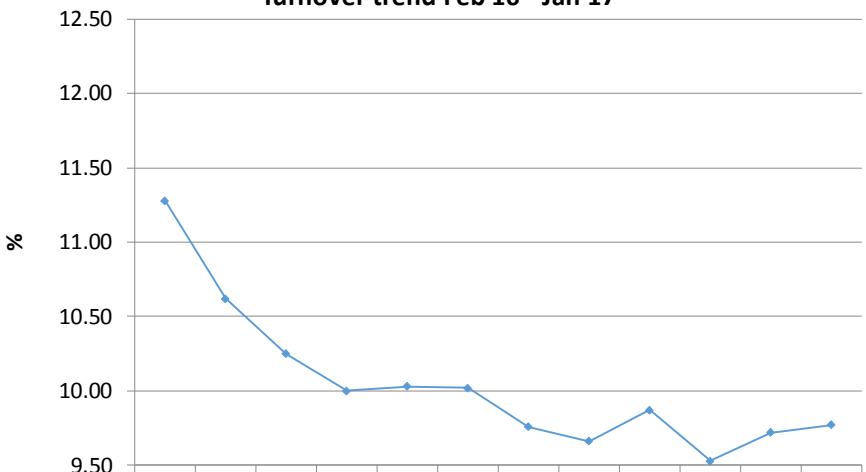
A recruitment campaign has commenced for 80 integrated support workers using social media and local media. Following a slow start, an additional Facebook campaign has been undertaken. Currently, 34 offers have been made with a further 27 candidates booked for a selection event on 17th February, Recruitment roadshows at the Arndale and Langley shopping centres are planned and a bus poster campaign.

The Recruitment team continue to meet with Divisions to review vacancies and discuss recruitment plans. The Trust's Business Planning process will also serve to determine and agree future recruitment activities and Trust requirements for 2017/18. Key Performance Indicators (KPIs) and targets will be established and communicated to all stakeholders and recruitment teams.

The weekly Vacancy Control Panel continues. 253 posts have been reviewed, with 195 approved and 58 challenged for additional information.

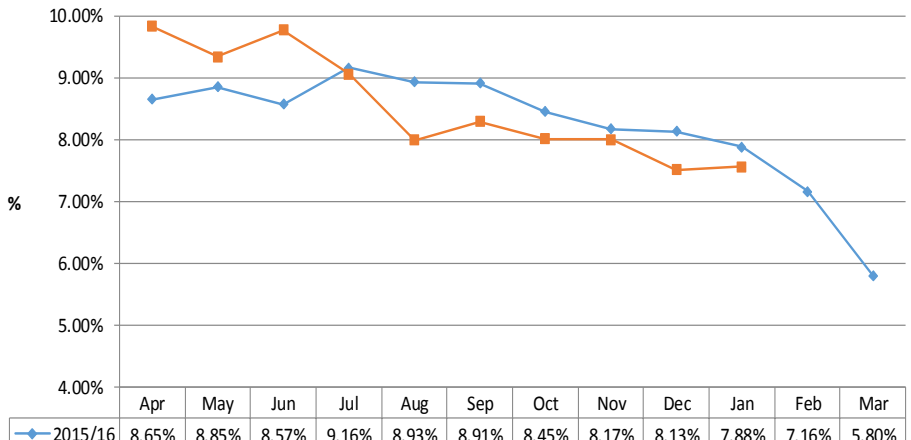
A "refer a friend" scheme proposal has been put forward as a supplement to existing recruitment activity.

Turnover trend Feb 16 - Jan 17



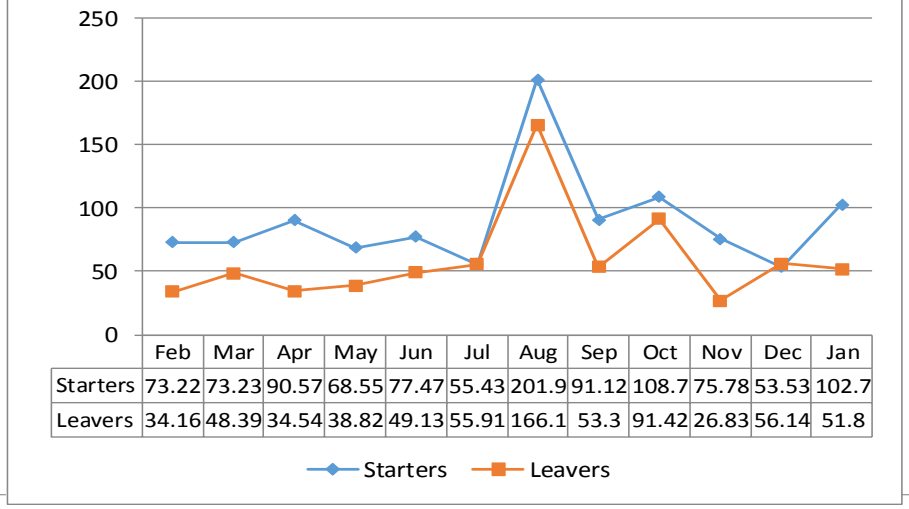
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Turnover	11.28	10.62	10.25	10.00	10.03	10.02	9.76	9.66	9.87	9.53	9.72	9.77

Trust Vacancy rate



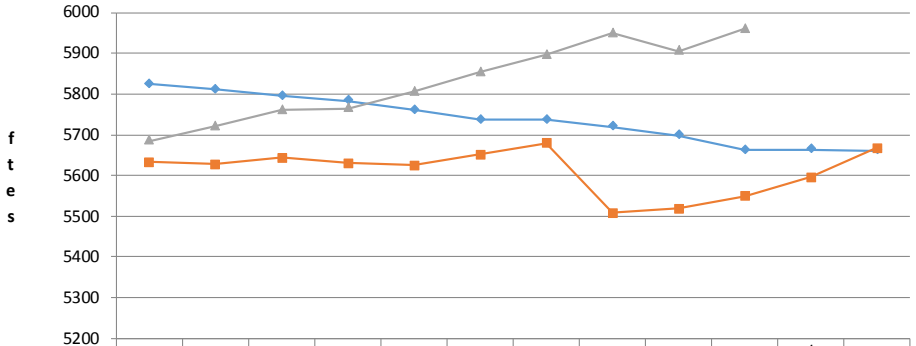
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	8.65%	8.85%	8.57%	9.16%	8.93%	8.91%	8.45%	8.17%	8.13%	7.88%	7.16%	5.80%
2016/17	9.83%	9.34%	9.77%	9.06%	7.99%	8.29%	8.01%	8.00%	7.51%	7.56%		

Starters & Leavers FTE Feb 16 - Jan 17



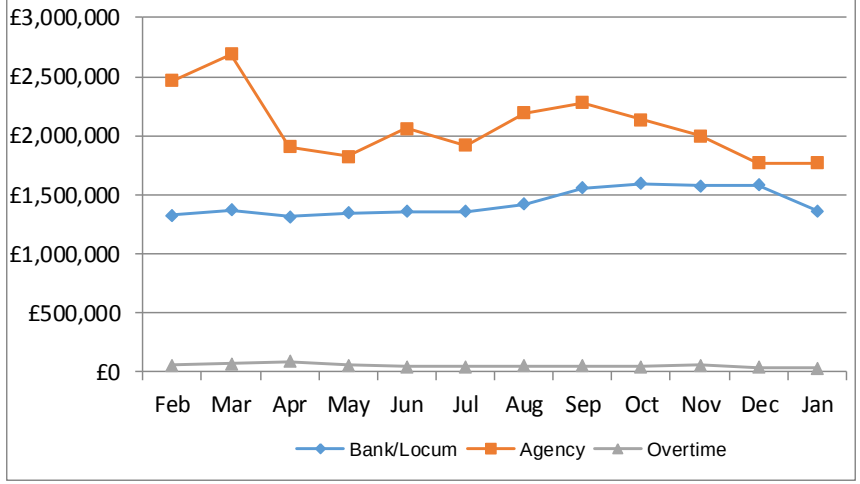
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Starters	73.22	73.23	90.57	68.55	77.47	55.43	201.9	91.12	108.7	75.78	53.53	102.7
Leavers	34.16	48.39	34.54	38.82	49.13	55.91	166.1	53.3	91.42	26.83	56.14	51.8

Substantive Workforce 2014/15 - 16/17

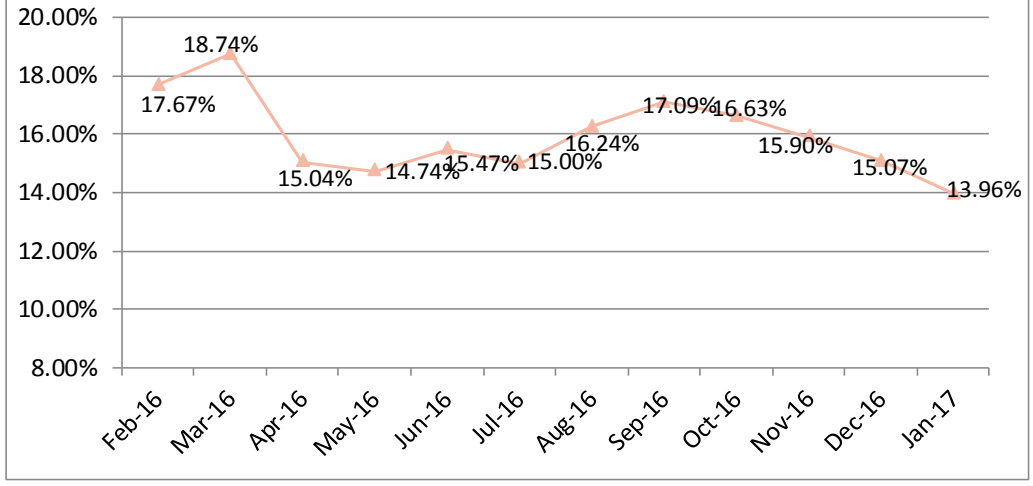


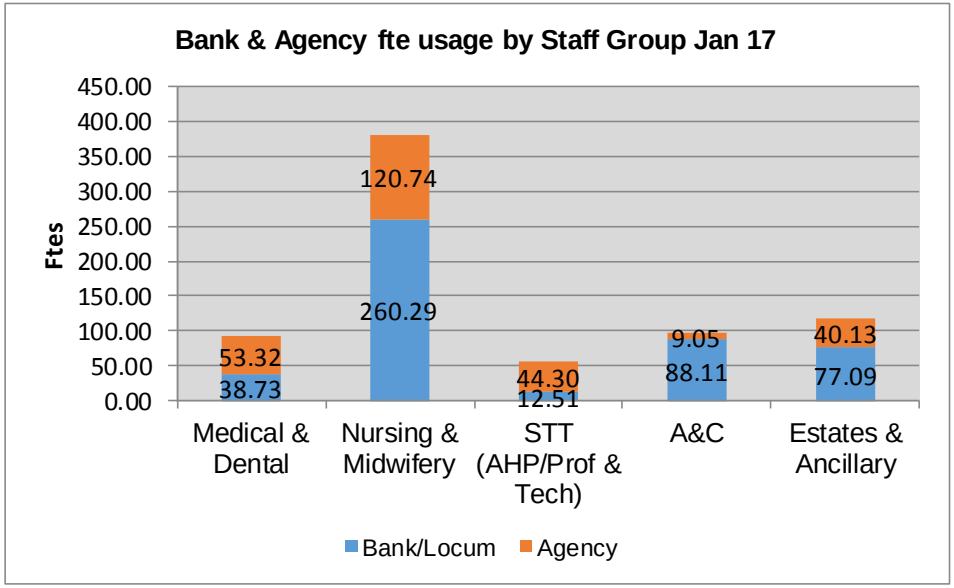
	30-Apr	31-May	30-Jun	31-Jul	31-Aug	30-Sep	31-Oct	30-Nov	31-Dec	31-Jan	28/29-Feb	31-Mar
2014/15	5824	5811	5795	5784	5760	5737	5736	5719	5698	5662	5664	5661
2015/16	5633	5628	5644	5631	5625	5651	5680	5508	5519	5550	5596	5667
2016/17	5684	5721	5760	5764	5806	5853	5895	5949	5905	5960		

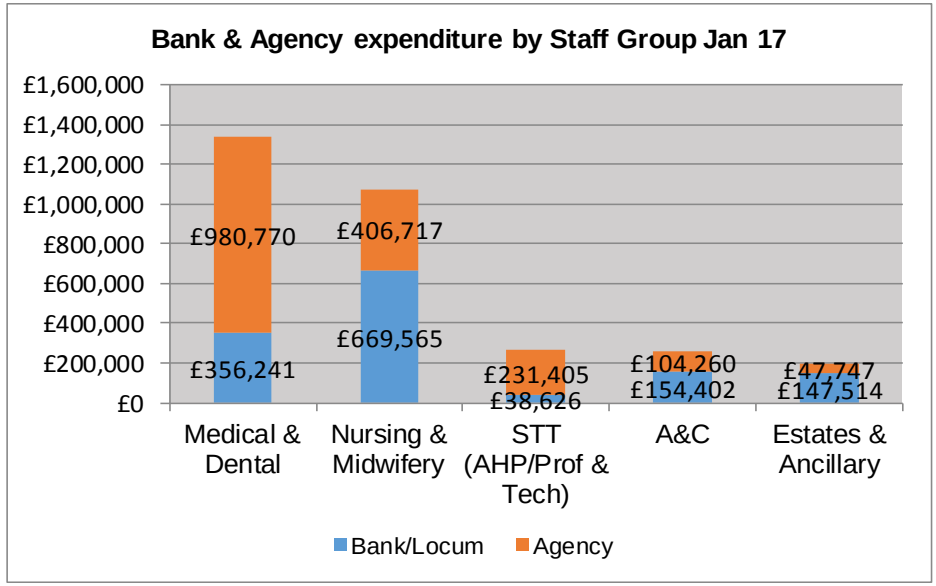
Flexible Workforce Expenditure Feb 16 - Jan 17



Temporary workforce expenditure as % total pay expenditure



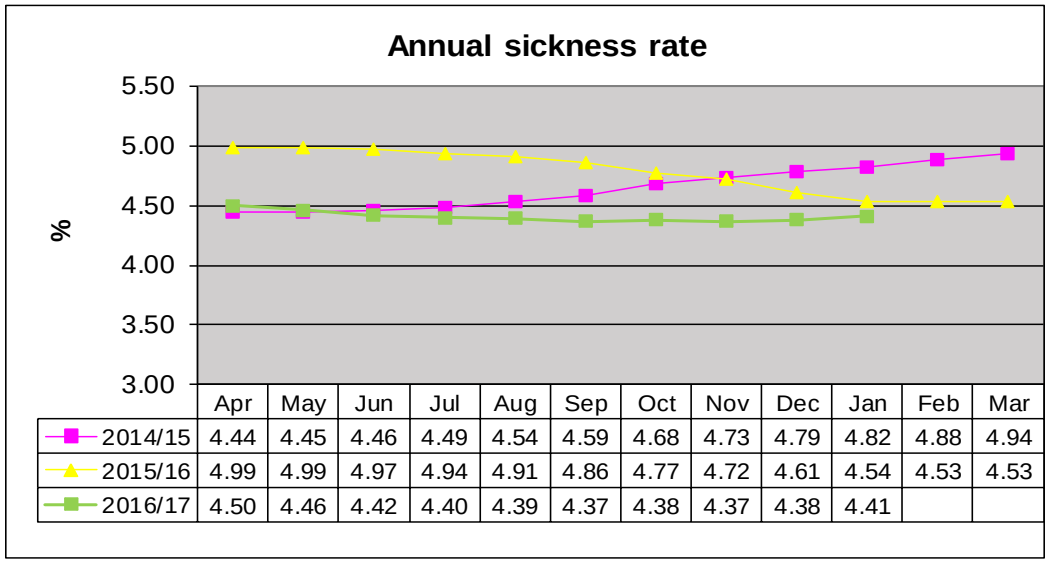




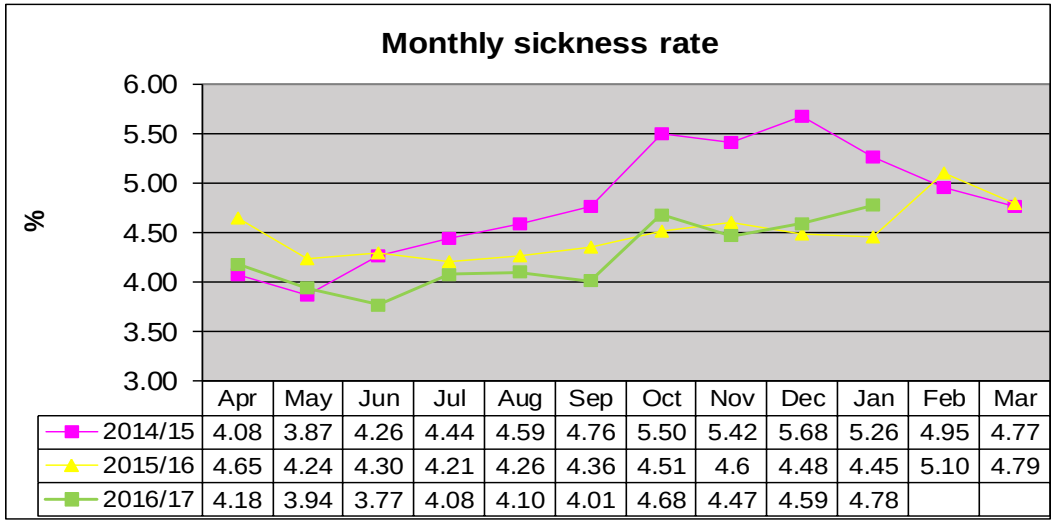
Temporary workforce expenditure has reduced by £218K compared to December. Bank expenditure decreased by £217K, agency expenditure increased by £3K, whilst overtime reduced by £4K.
Bank expenditure has reduced in some areas due to permanent recruitment, for example in Urology nursing, District Nursing and the Irvine Unit. There has also been a reduction in medical locums this month in Urology, Anaesthetics, ENT and Ophthalmology, some of which has been instead covered by medical agency. Additionally, there was an adjustment to medical locum expenditure this month for previous over accrual for ad hoc lists in Gastroenterology, Dermatology and Respiratory Medicine.
Medical Agency expenditure has increased with additional consultant vacancy cover in Cardiology and Histology, and additional junior doctor agency in Rheumatology and Gastroenterology. There have also been expenditure adjustments in Diabetes/Endocrinology where agency was previously under accrued. This has been offset by reductions in nursing, scientific, therapeutic and technical, and estates & ancillary agency. This is due to some additional recruitment as well as adjustments in agency expenditure this month, reflecting the lower rates negotiated with agencies, with some residual adjustments to November & December spend going through this month.

East Sussex Healthcare NHS Trust

6. Absence



	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	4.37	4.38	4.41		



	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	4.47	4.59	4.78		

Monthly sickness has increased this month by 0.19% to 4.78%. This is also 0.33% above the rate for January 2016 and, as a result, the annual sickness rate has risen by 0.03% to 4.41%.

The increase in sickness this month is almost wholly attributable to a large increase in Cold/Cough/Flu and Chest/Respiratory cases. 1420 full time full time equivalent (fte) days were lost to sickness for Cold/Cough/Flu, a rise of 605 fte days compared to last month, and 560 fte days for Chest/Respiratory, an increase of 275 fte days lost. Other reasons for absence were static though there was a fall of 339 fte days for Gastrointestinal illnesses.

Monthly sickness actually fell for Nursing & Midwifery staff, down by 0.28% to 5.01% and for Additional Clinical Services (mostly unregistered nurses and therapy helpers) down by 0.08% to 6.49%. The largest increases were amongst Administrative & Clerical staff, up by 0.80% to 4.47%, Medical & Dental staff, up by 0.76% to 2.37% and Allied Health Professionals up by 0.75% to 3.28%.

East Sussex Healthcare NHS
NHS Trust

7. Mandatory Training

Mandatory training course	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Induction %	93.73	94.09	92.54	92.05	93.70	93.15
Fire %	85.51	86.28	86.13	86.27	84.46	85.31
Moving & Handling %	90.09	90.99	90.12	89.75	87.98	89.06
Infection Control %	87.95	89.01	88.92	88.63	86.98	86.84
Info Gov %	83.64	84.79	84.23	84.96	84.21	85.70
Health & Safety %	87.75	88.42	88.83	88.96	88.59	89.09
Mental Capacity Act %	93.83	94.45	94.68	95.27	95.02	95.43
Depriv of Liberties %	95.64	95.64	95.97	96.61	96.89	97.42
Safeguard Vuln Adults	83.06	83.90	84.71	85.86	85.87	86.76
Safeguard Child Level 2	82.43	83.32	83.40	83.43	83.16	84.44

With the exception of Trust Induction and Infection Control, which are marginally down, all mandatory training course compliance rates have increased this month, as anticipated. The overall mandatory training compliance rate has increased by 0.77% to 88.13%

The appraisal rate has arrested its recent decline and is marginally up this month, by 0.07% to 78.42%. Managers have adapted to the new appraisal system and virtually all are now submitting information using the revised paperwork.

Clinical Unit Mandatory Training & Appraisals

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	Safeguard Children Level 3	Appraisal compliance
Urgent Care	79.23%	84.54%	95.65%	81.16%	80.19%	83.09%	85.00%	90.43%	83.05%	89.27%	67.19%	63.02%
Medicine Division	82.31%	83.71%	91.90%	82.66%	81.09%	86.78%	92.44%	96.40%	83.71%	80.75%	n/a	79.10%
Out of Hospital Care Division	89.17%	93.05%	95.00%	92.65%	85.19%	88.25%	97.47%	99.15%	87.88%	83.71%	n/a	81.20%
Diagnostics Anaesthetics & Surgery	84.90%	90.37%	94.76%	87.58%	86.71%	91.63%	96.51%	98.22%	88.60%	85.45%	n/a	77.01%
Womens Childrens & Sexual Health Division	82.41%	86.89%	95.65%	76.75%	78.69%	86.89%	95.40%	95.35%	86.37%	87.73%	87.56%	77.16%
Estates & Facilites	84.86%	85.03%	82.76%	90.82%	92.01%	91.33%	n/a	n/a	n/a	n/a	n/a	83.00%
Corporate	89.23%	93.70%	92.04%	90.24%	91.87%	89.33%	99.06%	100.00%	92.38%	85.71%	100.00%	83.07%
TRUST	**85.31%**	**89.06%**	**93.15%**	**86.84%**	**85.70%**	**89.09%**	**95.43%**	**97.42%**	**86.76%**	**84.44%**	**85.48%**	**78.42%**

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

Health & Wellbeing

50% of frontline staff have received the flu vaccination and further work is being carried out to promote the vaccination.

The NHS health checks for staff aged between 40 and 74 will begin in the week commencing 20th February. It is hoped that up to 160 staff will be seen monthly for a year. This is funded by Public Health.

'Healthy weights' sessions are being carried out at Conquest, EDGH and Bexhill hospital with good uptake from the staff. Smoking cessation sessions are also being held weekly. Monthly newsletters are issued to update staff on health initiatives.

Pilates classes continue at both sites with good numbers attending.

Staff Wellbeing roadshows have been held, with a lot of interest from staff and will be held every few months.

Schwartz rounds continue to be held monthly. In addition, emotional resilience workshops continue, with additional support provided for teams that are struggling.

The "Take a Break" campaign continues, and is now linked with Public Health and their regional hydration campaign.

Staff Engagement

The recent CQC report commented on the improvement in staff engagement within the Trust

The 4th pulse survey, asking how colleagues feel about engagement, is currently live. Feedback will be available in March. The Staff Engagement and Wellbeing newsletter has been circulated to all staff

The Annual Staff Survey results will be published on 7th March 2017.

Nominations are currently being sought for Trust Awards with a closing date of 28th February 2017.

The Management Essentials training programme is progressing well and receiving positive evaluations. 65 leaders from a range of professions have already attended, including Directors and medical staff.

Activity

ACTIVITY

1. Activity overview

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Jan-16	Var	Yr	Last Yr	Var	
Primary Referrals	M	8548	9363	9169	9249	9046	9551	8855	9164	9196	8978	9308	7633	8654	8548	1.2%	89634	87665	2.2%	
Cons to Cons Referrals	M	1278	1279	1293	1405	1422	2005	1648	1447	1501	1434	1481	1316	1510	1278	18.2%	15169	14755	2.7%	
First OP Activity	M	10297	11111	10999	10702	10882	11915	10802	11784	12104	12916	13765	11778	11933	10297	15.9%	118581	112632	5.0%	
Subsequent OP Activity	M	24751	25654	25841	25410	25679	26900	24150	25781	26390	25139	27459	24063	27227	24751	10.0%	258198	253825	1.7%	
New:FU Ratio	M	2.4	2.3	2.3	2.4	2.4	2.3	2.2	2.2	2.2	1.9	2.0	2.0	2.3	2.4	-0.1	2.2	2.1	0.0	
Elective IP Activity	M	511	604	627	596	697	656	715	649	670	682	717	618	631	511	23.5%	6631	6656	-0.4%	
Elective DC Activity	M	3630	3802	3784	3520	3837	4119	4033	4197	4207	3932	4143	3739	4059	3630	11.8%	39786	37669	5.3%	
Non-Elective Activity	M	3800	3920	4077	4038	3772	3791	3879	3801	3663	3721	3788	3964	3693	3800	-2.8%	38110	39018	-2.4%	
A&E Attendances	M	8731	8571	9398	8715	9573	9239	10144	9711	9470	9397	8989	9136	8771	8731	0.5%	93145	88907	4.5%	
Admissions Via A&E	M	2446	2357	2433	2357	2398	2363	2409	2302	2215	2381	2416	2619	2446	2446	0.0%	23906	23215	2.9%	
Ambulance Conveyances	M	3110	2879	3084	2848	3068	2995	3133	3092	3051	3138	3163	3331	3223	3110	3.6%	31042	29407	5.3%	
Average LOS Elective	M	2.7	3.0	3.0	2.7	3.4	3.0	3.1	2.4	3.1	2.7	2.5	3.1	2.6	2.7	-0.1	2.86	2.99	-0.1	
Average LOS Non-Elective	M	5.7	5.9	6.0	6.1	5.8	5.5	5.6	5.9	6.1	6.1	5.9	6.1	6.4	5.7	0.7	5.94	5.56	0.4	

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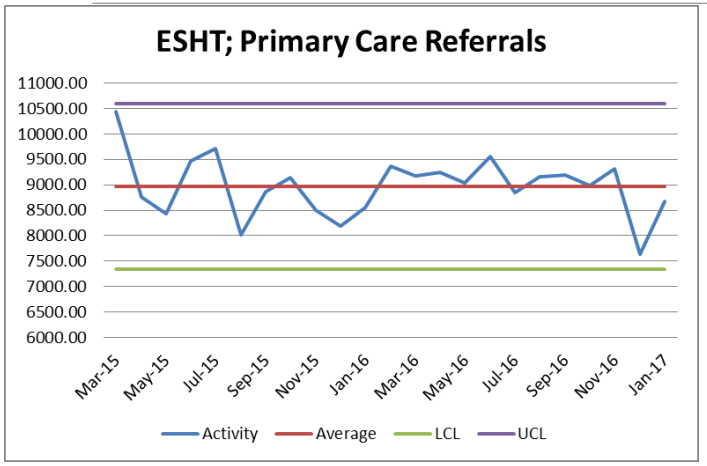

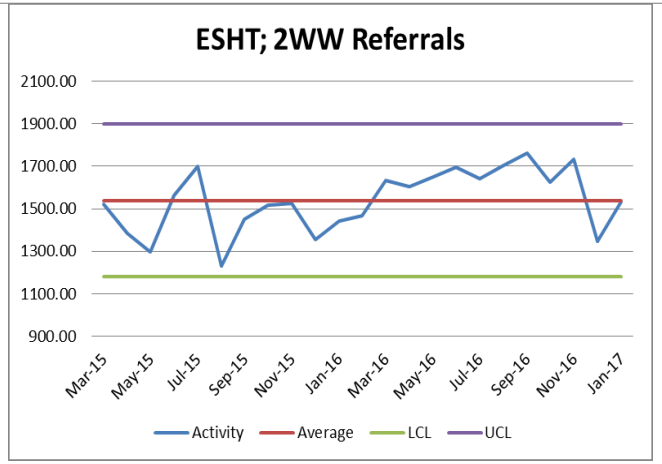

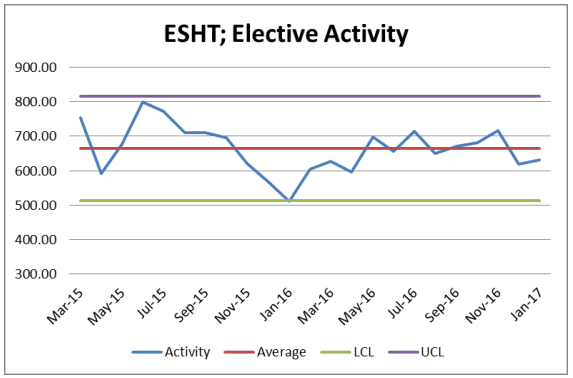

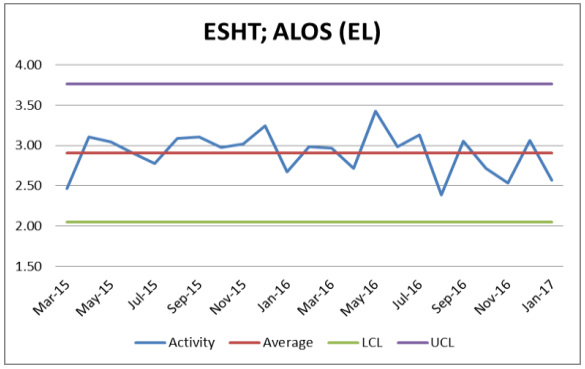

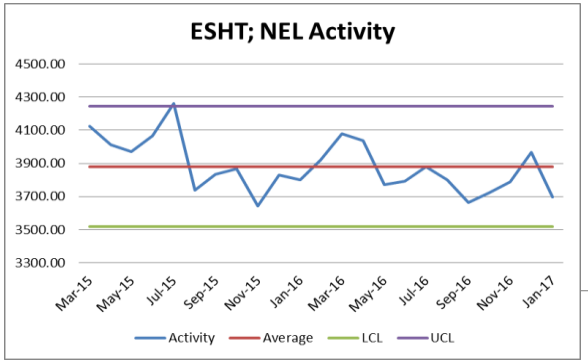

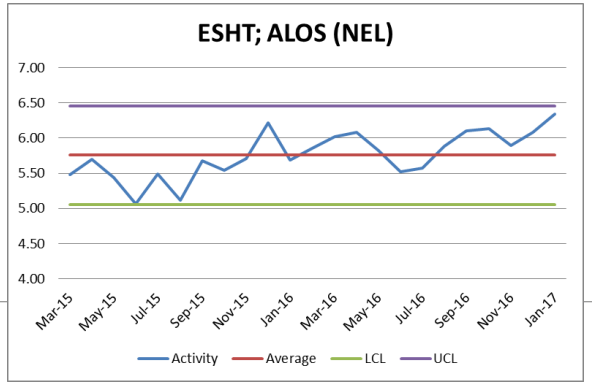

Non Elective length of stay continues to increase and is approaching the upper tolerance limits. Non elective activity in January reduced

Community

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Jan-16	Var	Yr	Last Yr	Var	
Community Nursing Referrals	M	3974	3765	3840	3900	3770	3962	3995	3974	4100	4158	4183	3995	4707	3974	18.4%	40744	30871	24.2%	
Community Nursing Total Contacts	M	34210	32706	34518	33652	35504	36020	33717	34997	32855	33546	33436	33066	36683	34210	7.2%	343476	340946	0.7%	
Community Nursing Face to Face Contacts	M	18849	18389	19536	19123	20062	19516	19056	19681	18737	19424	19242	18952	20317	18849	7.8%	194110	195403	-0.7%	
% Patient Facing Time	60.0%	55.1%	56.2%	56.6%	56.8%	56.5%	54.2%	56.5%	56.2%	57.0%	57.9%	57.5%	57.3%	55.4%	55.1%	0.3%	56.5%	56.9%	-0.4%	
Community Nursing ALOS	42.0	27.6	26.7	25.0	23.0	21.6	19.1	17.0	16.7	15.1	12.3	10.4	7.8	3.0	27.6	-24.6	14.33	31.87	-17.5	
SALT WL <13 Weeks %	85.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	0	89.0%	100.0%	-0.1102	
Podiatry WL <13 Weeks %	85.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	0	87.6%	100.0%	-0.12415	
Dietetics WL <13 Weeks %	85.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	0	89.3%	100.0%	-0.10685	
MSK WL <13 Weeks %	85.0%	96.4%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	96%	0.0362832	99.4%	97.8%	0.01564	
SALT Total WL	M	110	115	117	146	160	0	176	202	182	149	130	140	128	110	18	1413	458	955	
Podiatry WL Total WL	M	715	729	749	841	830	0	998	842	942	633	418	293	284	715	-431	6081	2726	3355	
Dietetics WL Total WL	M	246	195	146	73	32	0	43	65	54	30	64	39	43	246	-203	443	1059	-616	
MSK WL Total WL	M	1089	1143	211	101	101	0	1922	1922	105	1641	1265	1938	2087	1089	998	11082	2847	8235	
IP ALOS (including Irvine Stroke Unit)	M	27.5	32.5	31.1	30.6	33.3	25.8	30.9	36.0	28.5	27.0	26.9	32.3	34.6	27.5	7.1	30.53	25.46	5.1	
IP Activity (including Irvine Stroke Unit)	M	88	72	89	92	97	85	85	85	81	84	93	85	70	88	-20.5%	857	1386	-61.7%	

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Community overview:

Intermediate Care:

Average length of stay decreased for Bexhill Irvine Unit in M9 however an outbreak of Norovirus in M10 we anticipate will impact on LoS. Firwood increase LoS due to lack of community placement . Rye increased LoS due to acuity of patients transferred there following Christmas and new year pressures. Flow out of units remains challenging we continue to work with partner organisations to improve flow this. 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 and reduction in level of inappropriate referrals

Community Nursing:

Slight reduction in referral rates. Overall referrals remain 200+% above baseline target. Significant reduction in inappropriate referrals. Otherwise targets being maintained or improving with data accuracy and reporting initiatives. Workforce modelling and capacity demand being finalised.

Community AHPs:

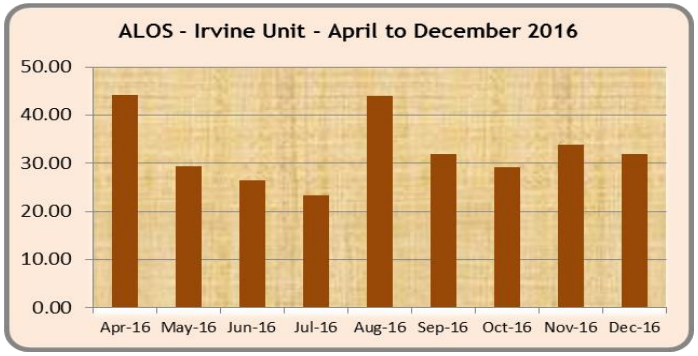
Continue to maintain 13 week waiting time target. Significant improvement in number of patients waiting for Podiatry in Eastbourne Hailsham and Seaford CCG.

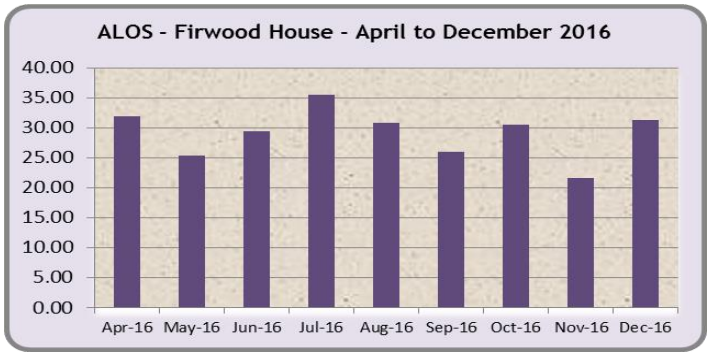
Acute AHPs:

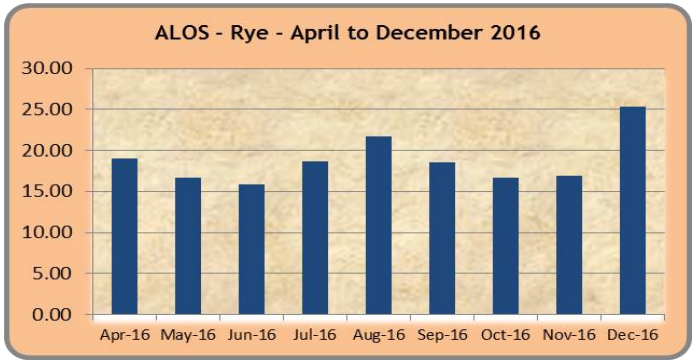
Continue with recruitment drive to fully implement Enhanced HIT – trajectory to be fully implemented by June 2017. HIT increase in conversion rates for Conquest to 74% for DGH and slight reduction to 62% - MFFD main reason.

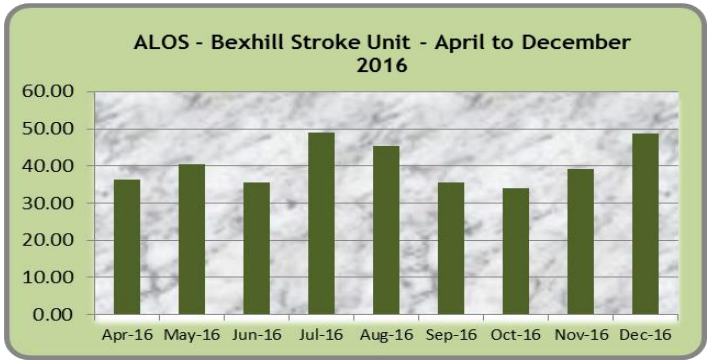
Intermediate Care

Total in Month Length of Stay (Days)	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Irvine Unit	44.20	29.43	26.36	23.32	43.93	31.84	29.23	33.82	31.94
Firwood House	31.88	25.41	29.47	35.47	30.76	26.00	30.53	21.68	31.29
Rye Memorial Care Centre	18.96	16.63	15.88	18.70	21.76	18.52	16.63	16.96	25.33
Bexhill Stroke Unit	36.44	40.33	35.50	49.00	45.46	35.60	34.06	39.25	48.80
Total YTD ALOS (average excludes Bexhill Stroke Unit)	**31.83**	**23.52**	**23.86**	**25.83**	**32.15**	**25.46**	**25.46**	**24.15**	**29.52**









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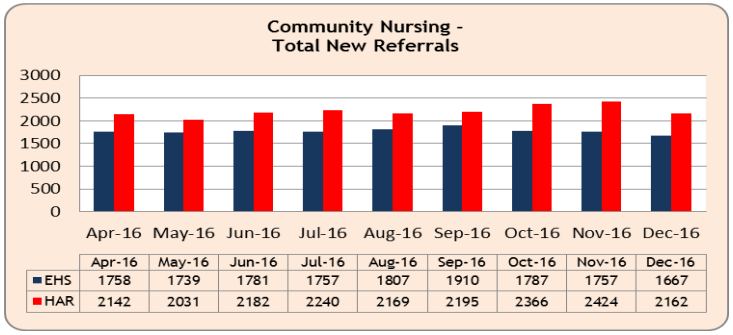
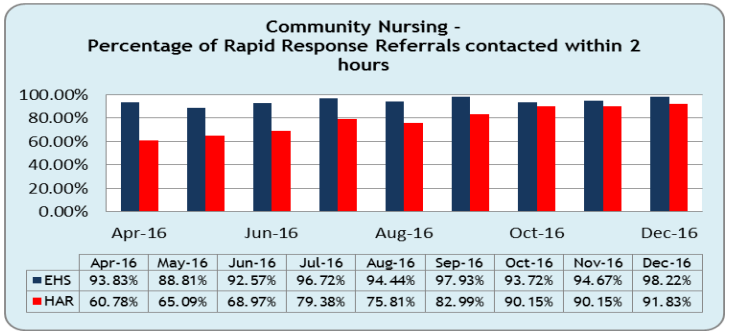
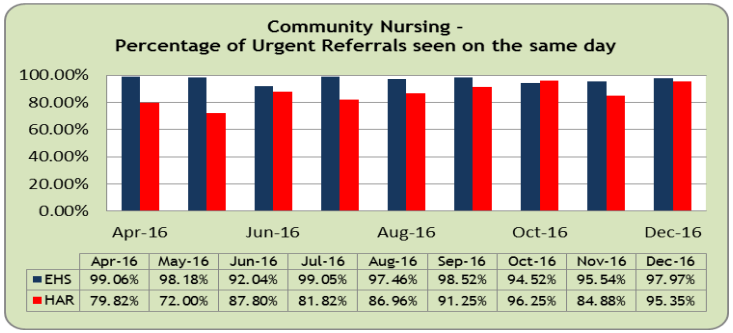
Community Nursing:



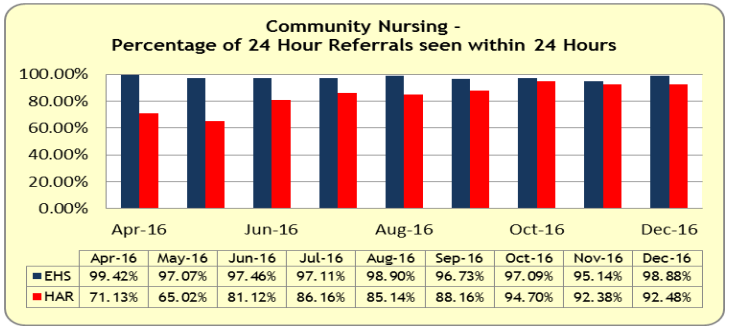
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
EHS	1758	1739	1781	1757	1807	1910	1787	1757	1667
HAR	2142	2031	2182	2240	2169	2195	2366	2424	2162



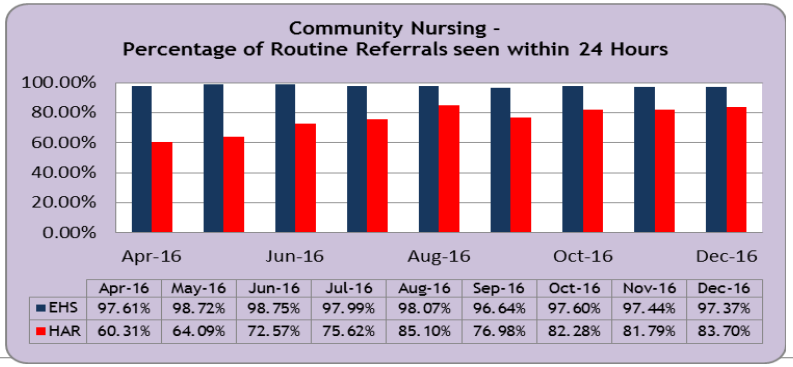
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
EHS	93.83%	88.81%	92.57%	96.72%	94.44%	97.93%	93.72%	94.67%	98.22%
HAR	60.78%	65.09%	68.97%	79.38%	75.81%	82.99%	90.15%	90.15%	91.83%



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
EHS	99.06%	98.18%	92.04%	99.05%	97.46%	98.52%	94.52%	95.54%	97.97%
HAR	79.82%	72.00%	87.80%	81.82%	86.96%	91.25%	96.25%	84.88%	95.35%



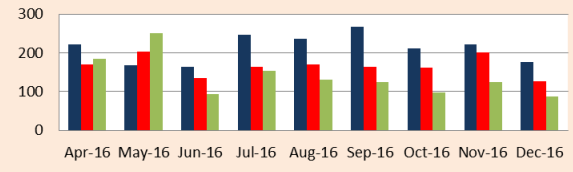
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
EHS	99.42%	97.07%	97.46%	97.11%	98.90%	96.73%	97.09%	95.14%	98.88%
HAR	71.13%	65.02%	81.12%	86.16%	85.14%	88.16%	94.70%	92.38%	92.48%



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
EHS	97.61%	98.72%	98.75%	97.99%	98.07%	96.64%	97.60%	97.44%	97.37%
HAR	60.31%	64.09%	72.57%	75.62%	85.10%	76.98%	82.28%	81.79%	83.70%

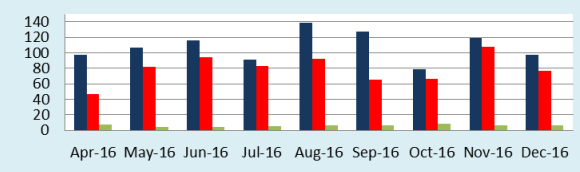
Uni-disciplinary AHP Services

Podiatry - Total New Referrals



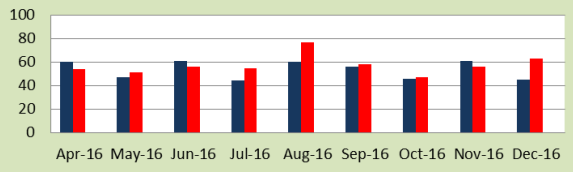
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
EHS	222	169	165	246	236	267	211	222	176
H&R	171	203	136	163	170	165	161	202	127
HWLH	184	251	93	153	130	124	97	125	88

Dietetics - Total New Referrals



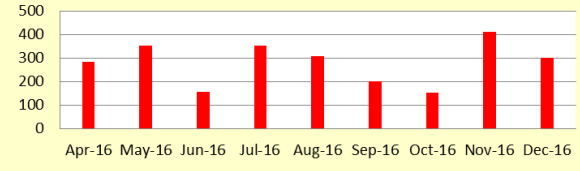
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
EHS	97	107	116	91	139	128	79	119	98
H&R	47	82	94	83	92	65	66	108	77
HWLH	8	4	4	5	6	6	9	7	6

SALT - Total New Referrals



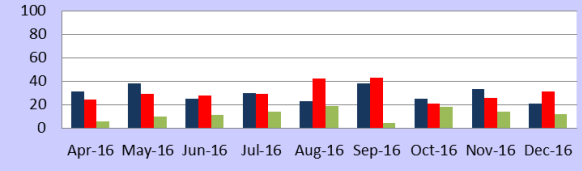
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
EHS	60	47	61	44	60	56	46	61	45
H&R	54	51	56	55	77	58	47	56	63
HWLH	0	0	0	0	0	0	0	0	0

MSK - Total New Referrals



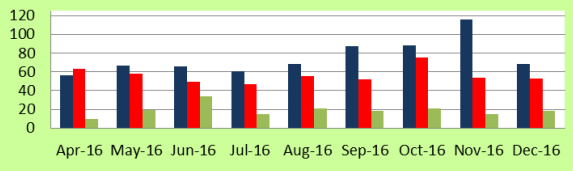
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
EHS	0	0	0	0	0	0	0	0	0
H&R	283	354	155	354	307	200	154	410	301
HWLH	0	0	0	0	0	0	0	0	0

MSK Neuro Outpatients - Total New Referrals



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
EHS	31	38	25	30	23	38	25	33	21
H&R	24	29	28	29	42	43	21	26	31
HWLH	6	10	11	14	19	4	18	14	12

MSK Womens Health- Total New Referrals



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
EHS	56	67	66	61	68	87	88	116	68
H&R	63	58	49	47	55	52	75	54	53
HWLH	10	19	34	15	21	18	21	15	18

Pharmacy Department Performance Dashboard

		Date of Latest Score	Plan by April 2017	Latest Score versus plan	Previous Score versus plan	Performance vs Plan	Good Practice Target / Trend	Trend
SAFE	% Dispensing errors reported (via DatixWeb)	Jan-17	0.02%	0.00%	0.02%	☺	↓	
	% Dispensing errors prevented (near misses)	Jan-17		0.48%	0.48%			
	Number of pharmacy risk register entries	Jan-17		5	9			
	Pharmacy risk register entries > 15	Jan-17	0	0	0	☺	↓	
	Risk register entries > 6months not at target	Jan-17	0	5	8	☺	↓	
CARING	Complaints	Jan-17	1	0	0	☺	↓	
	Plaudits	Jan-17	0	0	1	😐	↑	
	Patient Helpline Enquiries	Dec-16		18	15			
RESPONSIVE	% Medicines rec. in 24hrs (MST)	Dec-16	75.0%	71.9%	77.7%	☹	↑	
	Dispensing turnaround times (minutes)	Dec-16	60	55	58	☺	↓	
EFFECTIVE	Medicines information enquiries at level 2+	Dec-16	50.0%	54.0%	53.5%	☺	↑	
	% Inpatient issues dispensed at discharge	Jan-17	10.0%	5.8%	7.1%	☺	↓	
	% Medicines unavailable (drug chart audit)	Nov-16	2.0%	0.8%	1.1%	☺	↓	
WELL-LED	% CD audit activity in date	Jan-17	90.0%	50.0%	20.0%	☺	↑	
	% SSHM audit activity (audits completed)	Jan-17		4.0%	83.0%			
	% Mandatory training / appraisal compliance	Jan-17	90.0%	85.7%	91.2%	☹	↑	
RESOURCES	Vacancies against establishment	Dec-16	5.0%	10.8%	6.4%	☹	↓	
	% Sickness Rate (inc PMU)	Dec-16	3.3%	3.1%	2.7%	☺	↓	
	Budget Performance (£) [excl. PMU]	Dec-16	0	54773	85372	☺	↓	
	Number of days stockholding	Jan-17	20.0	17.8	20.0	☺	↓	

2020 Metrics

2020 METRICS

East Sussex Healthcare NHS
NHS Trust

2020 Metrics: Safety & Quality

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Jan-16	Var	This Yr	Last Yr	Var	
Total patients safety incidents reported	M	956	978	1054	1078	1012	1499	1799	1786	1396	1241	1394	1308	916	30.0%	13567	8934	34.1%	
Total Non-ESHT patients safety incidents reported	M	110	85	319	243	148	168	145	164	136	130	150	178	122	45.9%	1781	1127	36.7%	
Falls Assessment Compliance	M			92.2%	93.9%	89.6%	91.4%	92.5%	85.2%	90.3%	85.6%	85.3%	90.9%			90.2%			
Pressure Ulcer Assessment Compliance	M			93.4%	86.0%	87.5%	92.0%	86.7%	94.0%	91.2%	95.8%	94.4%	96.3%			91.3%			
No of MRSA cases	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	2	7	7	2	6	3	4	2	0	0	4	-4	33	40	-7	
No of MSSA cases	0	2	1	2	0	2	1	0	4	1	1	0	0	0	0	11	4	7	
Mixed sex accomodation breaches	0	29	0	0	7	0	0	0	0	0	0	0	20	27	-7	27	101	-74	
No of complaints reported	R	56	55	75	55	58	46	56	53	53	54	50	61	41	32.8%	561	592	-5.5%	
All ward moves	M	2315	2331	2303	2344	2265	2313	2304	2280	2210	2198	2323	2405	2254	6.3%	22945	22886	0.3%	
Night ward moves	M	461	512	470	434	409	416	445	399	375	407	436	395	462	-17.0%	4186	4492	-7.3%	
Crude Mortality Rate	M	1.8%	2.3%	2.0%	1.7%	1.5%	1.4%	1.4%	1.4%	1.9%	1.5%	2.1%	2.7%	2.1%	0.6%	1.8%	1.7%	0.0%	
HSMR (CHKS)	100	100	109	107	104	104	102	102	101	100									
SHMI (CHKS)	100	100	71	83	77	80	75	85	72	74	64								

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
		Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Jan-16	Var	Yr	Last Yr	Var	
A&E Performance (4 hour wait)	95.0%	84.8%	79.0%	83.9%	85.0%	83.2%	82.6%	79.5%	80.5%	78.1%	82.4%	77.6%	73.4%	84.2%	-10.8%	80.7%	89.4%	-8.7%	
A&E 12 Hour trolley waits	0	0	0	0	0	0	0	1	0	2	0	0	2	0	2	5	1	4	
A&E Unplanned re-attendance	5.0%	3.4%	3.0%	3.3%	3.3%	2.8%	3.0%	2.9%	3.0%	3.1%	3.0%	3.0%	3.2%	3.0%	0.1%	3.1%	3.1%	0.0%	
A&E Time to Initial Assessment (% Ambulance conveyances within 15 minutes)	M	92.1%	88.5%	94.3%	93.1%	90.7%	91.8%	90.1%	90.6%	89.6%	92.1%	90.2%	89.8%	92.2%	-2.4%	91.2%	95.4%	-4.2%	
A&E Time to Treatment (% within 60 Minutes)	M	48.1%	42.0%	47.0%	40.1%	36.6%	36.8%	36.7%	38.8%	39.5%	43.5%	41.6%	45.4%	52.4%	-7.0%	40.5%	50.5%	-10.0%	
A&E Left before seen	5.0%	2.6%	2.7%	2.1%	2.2%	1.3%	1.4%	1.4%	1.2%	1.2%	1.5%	1.8%	1.8%	2.1%	-0.3%	1.6%	1.8%	-0.2%	
Non Elective Conversion Rate	M	26.8%	24.8%	26.5%	24.6%	25.1%	23.5%	23.4%	23.1%	24.8%	26.6%	28.2%	27.4%	27.5%	-0.2%	25.3%	25.9%	-0.7%	
A&E Cubicle Waiters (average number per day)	M	51	51	48	51	50	51	52	53	46	47	53	56	51	5	56	57	0	
Zero Length of Stay NEL admissions	R	632	556	656	610	595	562	521	404	519	502	554	446	564	-26.5%	5369	6867	-27.9%	
% Zero LOS NEL Ambulatory admissions	M	41.5%	38.0%	43.4%	40.5%	39.6%	38.4%	36.9%	31.5%	37.6%	35.3%	37.6%	35.0%	40.8%	-14.2%	37.7%	43.2%	-5.5%	
Total Non Elective Beddays	M	24169	25698	23644	22663	21627	21927	22984	22658	22886	22562	23304	24840	25732	-3.6%	229095	223568	2.4%	
RTT Incomplete (%patients waiting over 18 weeks)	92.0%	92.2%	90.5%	90.2%	90.7%	89.5%	88.5%	87.5%	86.7%	85.7%	85.6%	85.6%	#DIV/0!	92.1%	#DIV/0!	87.7%	93.3%	-5.6%	
RTT 52 Week waiters	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%	2.4%	6.7%	2.9%	2.7%	2.6%	2.2%	3.0%	2.5%	0.9%	1.6%	0.8%	#DIV/0!	3.8%	#DIV/0!	97.8%	98.0%	-0.2%	
Cancer 2WW standard	93.0%	94.9%	96.9%	96.0%	95.6%	96.5%	97.1%	97.3%	97.1%	97.2%	98.7%	98.0%				97.1%	90.8%	6.3%	
Cancer 2WW standard (Breast Symptoms)	93.0%	93.0%	90.0%	93.2%	98.5%	96.9%	95.8%	95.8%	96.9%	97.2%	98.2%	97.3%				96.7%	89.2%	7.5%	
Cancer 31 Day standard	96.0%	98.8%	99.3%	98.5%	99.4%	98.3%	97.7%	99.1%	98.8%	98.7%	99.5%	98.3%				98.7%	97.4%	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%	0.0%	
Cancer 31 Day subsequent surgery	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	100.0%	100.0%	100.0%				99.1%	100.0%	-0.9%	
Cancer 62 day urgent referral standard	85.0%	70.5%	79.4%	67.6%	68.3%	82.3%	75.3%	79.5%	72.6%	82.5%	78.3%	84.1%				76.8%	75.2%	1.7%	
Cancer 62 day screening standard	90.0%	100.0%	42.9%	100.0%	66.7%	62.5%	100.0%	88.9%	85.7%	91.7%	100.0%	100.0%				89.2%	79.1%	10.1%	
Delayed Transfer of Care	3.5%	10.8%	9.4%	5.3%	5.7%	7.0%	7.7%	8.0%	9.7%	9.7%	7.6%	7.1%	#DIV/0!	7.5%	#DIV/0!	7.5%	7.0%	0.5%	
Outpatient appointment cancellations < 6 weeks	R	21	18	14	29	47	34	37	30	41	44	64	24	21	12.5%	364	332	8.8%	
Outpatient appointment cancellations > 6 weeks	R	1130	1551	1121	1014	1259	1407	1500	1272	1246	1230	1235	1166	1060	9.1%	12450	12096	2.8%	

East Sussex Healthcare NHS
NHS Trust

2020 Metrics: Leadership &Culture

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Jan-16	Var	Yr	Last Yr	Var	
Trust Turnover rate	10.0%	11.3%	10.6%	10.3%	10.0%	10.0%	10.0%	9.8%	9.7%	9.9%	9.5%	9.7%	9.8%	11.8%	-2.0%	9.9%	12.5%	-2.6%	
Temporary costs and overtime as a % of total paybill	10.0%	17.7%	18.7%	15.0%	14.7%	15.5%	15.0%	16.2%	17.1%	16.6%	15.9%	14.9%	#DIV/0!	17.2%	#DIV/0!	15.7%	16.7%	-1.0%	
Proportion of staff with up to date annual appraisal	85.0%	85.3%	87.3%	88.5%	89.8%	88.1%	86.3%	87.0%	83.2%	81.7%	79.3%	78.5%	78.8%	83.2%	-4.4%	84.1%	77.5%	6.6%	

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
NHS Trust

March 2017

FINANCIAL HIGHLIGHTS REPORT – MONTH 10

East Sussex Healthcare NHS
NHS Trust

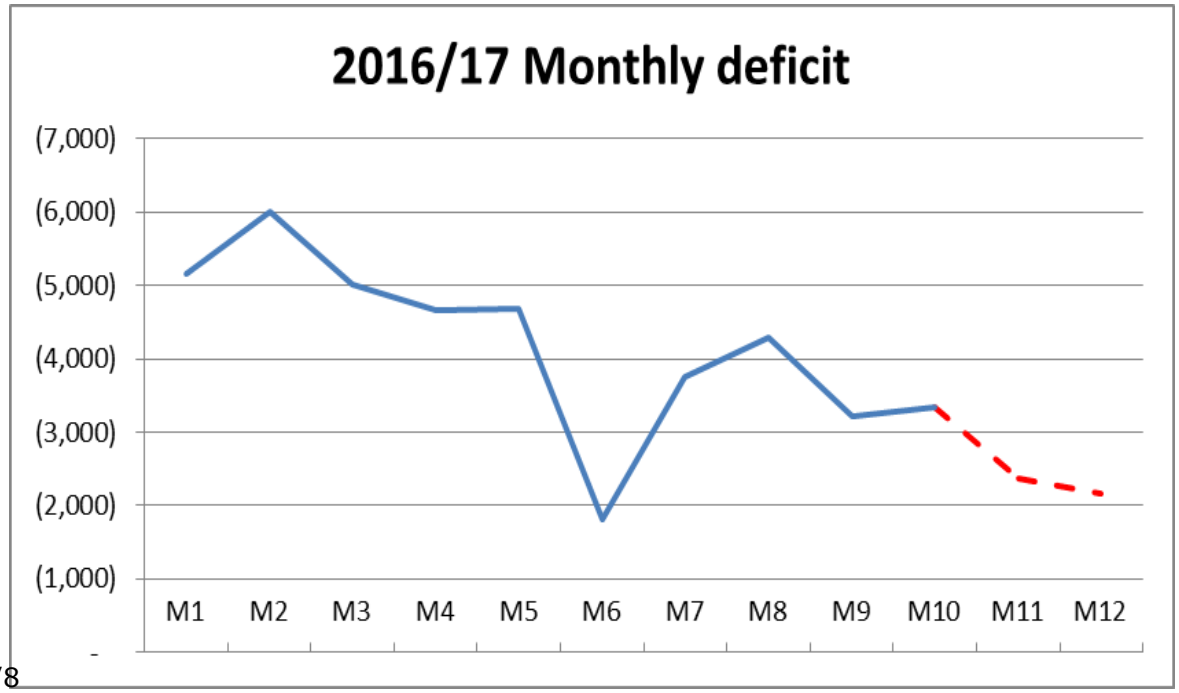
Executive Summary

- The Trust has an agreed control total, excluding Sustainability and Transformation Funding (STF), of £41.7m deficit – an improvement on the £48m deficit of 2015/17, and a challenging target in the context of significant operational pressure. In October, the Trust identified risks to delivery of the financial plan of £16m. Supported by the Financial Special Measures process, the Trust developed a Financial Recovery Plan (FRP) to address these risks, which was presented to the Board in December 2016. Strong progress has been made and the Trust is now forecasting £4.8m non-delivery of the target - a deficit of £46.5m excluding STF funding. Collective focus within the organisation is now on bridging the residual gap and delivering the best outcome for 2016/17, as well as planning for 2017/18.
- Of the forecast shortfall in delivery, £3.5m relates to shortfall in FRP delivery. £1.3m relates to escalation costs from winter pressures. The Trust has identified additional savings to bridge the gap, but is also managing income risks and contract challenges, and the most recent meeting of the Finance and Investment Committee did not change the forecast.
- The financial position of the Trust has meant additional pressure on the cash and capital budgets for the organisation. The Trust is managing, with support from NHS Improvement, cash on a monthly basis, drawing down working capital from Department of Health funds in line with the forecast deficit. This places suppliers under pressure and the Trust is working carefully with suppliers across the board to maintain supply of key goods and services. The most recent cash flow forecast shows the Trust ending the year with £2.1m in cash, and a significant increase in creditor balances.
- Capital budgets are being delivered to plan, but remain below the required levels of investment for the Trust. The most recent capital forecast is attached, showing the Trust will meet its targets. However, the demand for capital funding remains high, with £22m of bids received within the current planning round against £11m of available funds.

East Sussex Healthcare NHS
NHS Trust

Forecasting to Month 12 - £4.8m variance

£000's	M6 YTD	M7	M8	M9	M10	M11	M12	Full Year
Pay	(133,596)	(22,697)	(22,797)	(22,468)	(22,701)	(22,601)	(22,635)	**(269,495)**
Non Pay	(75,742)	(12,433)	(13,279)	(13,076)	(12,269)	(11,716)	(11,723)	**(150,237)**
Income	19,414	3,100	3,657	3,330	3,556	3,060	3,159	**39,275**
Contract Income	162,589	28,286	28,124	28,996	28,077	28,884	29,035	**333,991**
Deficit	**(27,335)**	**(3,744)**	**(4,295)**	**(3,217)**	**(3,338)**	**(2,373)**	**(2,164)**	**(46,466)**
FRP Trajectory	(27,335)	(3,612)	(4,450)	(2,031)	**(1,501)**	(1,277)	(1,496)	**(41,701)**
Variance to FRP Trajectory Nov 2016	**-**	**132**	**(155)**	**1,186**	**1,837**	**1,096**	**668**	**4,765**
Cumulative Deficit	**(27,335)**	**(31,079)**	**(35,374)**	**(38,591)**	**(41,929)**	**(44,302)**	**(46,466)**	



The YTD deficit at Month 10 is £41.9m. To deliver the plan of £41.7m, the Trust would need to deliver better than breakeven for the last 2 months of the year.

The trend continues to improve with an overall reduction in run-rate supporting the forecast of £46.5m deficit. The Trust is not meeting the challenging FRP trajectory, but is demonstrably improving delivery.

East Sussex Healthcare NHS
NHS Trust

What has driven the shortfall in forecast?

- **The shortfall of £4.8m is made up of 2 elements, escalation costs from Winter (£1.3m) and Financial Recovery Plan shortfall (£3.5m).**

- The £3.5m FRP element is made up of 3 strands – a reduction in anticipated benefits from improved data recording of £1.3m, and delays in the delivery of savings from the patient flow and elective care schemes, described in more detail overleaf. Overall, the Financial Recovery Plan is forecasting delivery of £12.5m benefits, against an initial risk assessment of £16m. Colleagues across the Trust have supported delivery, and clinical and managerial leaders should be praised for the significant achievements against this plan. The FRP is reviewed in detail on a monthly basis by the Executive Team (through the Financial Improvement and Sustainability Committee) and by Finance & Investment Committee on behalf of the Trust Board.

- 'Winter' in this case is used as shorthand for the increased demand faced by the Trust over the last few months of the financial year, which has driven increased use of additional escalated capacity and an additional cost of £1.3m. The 'true' cost of winter is considerably in excess of this amount, but additional funding from clinical commissioners was reflected in the Month 7 forecast used as the baseline for developing the Financial Recovery Plan and trajectory. The local health economy has worked collectively to develop and deliver a robust system resilience plan, although a number of funding components are yet to be finalised as the Trust moves towards year end. The Trust and the CCG are working towards amicable resolution of the key contract challenges and issues.

What is the Trust doing to respond?

- **The Trust is focusing on securing the best possible financial position for 2016/17, to act as a springboard for continued financial recovery into 2017/18.**

- An additional pipeline of schemes has been identified, which has been reviewed in detail by the Finance and Investment Committee. The 'best case' value is £2.5m, but this is offset by existing risks within the Trust's income forecast for the year end, reflecting ongoing dialogue with Clinical Commissioners around the application of national rules on readmissions, and on 'contractual QIPP' assumptions which the Trust does not recognise – with a total value of £4.9m. The Finance and Investment Committee reviewed these opportunities and risks in detail at its last meeting, and the forecast remained unchanged, although the Committee noted the risks to income recovery.

- The Trust is also working with colleagues across the organisation to strengthen the financial position. 'Grip and Control' measures – including focus on pay and non-pay expenditure – continue to be in place, although there is no bar on recruitment for clinical posts given the Trust's improvement trajectory in respect of quality. These measures are a particular area of focus for the Executive Team and the Finance and Investment Committee, and are reviewed on a regular basis.

- The Trust is also focusing on management of escalation capacity, which is creating additional pressures reflected in the forecast. Although the medically fit for discharge list is reviewed daily, there remain challenges around community capacity, which are creating delays in reducing escalation. The Trust is working on a detailed analysis of acute and community bed requirements to inform a robust plan for capacity moving into 2017/18.

Managing the Cash Position

East Sussex Healthcare NHS
NHS Trust

Cash Flow Statement April 2016 to March 2017 £000s	Jan Actual	YTD Actual	Feb Forecast	Mar Forecast
Cash Flow from Operations				
Operating Surplus/(Deficit)	-2,878	-34,287	-1,800	-1,600
Depreciation and Amortisation	1,036	10,330	1,048	1,130
Operating Surplus/(Deficit)	-1,842	-23,957	-752	-470
Interest Paid	-184	-1,205	-180	-258
Dividend (Paid)/Refunded	0	-2,209	0	-2,922
Trade and Other Receivables	5,033	-9,845	500	394
Cash Advance from CCGs	-4,000	8,000	-4,000	-4,000
Trade and Other Payables	-7,164	-2,631	-606	2,846
Provisions Utilised	-9	-160	-40	-243
Net Cash Inflow/(Outflow) from Operating Activities	**-8,166**	**-32,007**	**-5,078**	**-4,653**
Cash Flows from Investing Activities:				
Interest Received	1	15	3	10
Property, Plant and Equipment	-794	-8,905	-2,560	-717
Net Cash Inflow/(Outflow) from Investing Activities	**-793**	**-8,890**	**-2,557**	**-707**
Net Cash Inflow/(Outflow) before Financing	**-8,959**	**-40,897**	**-7,635**	**-5,360**
Revolving Working Capital Facility	0	31,300	0	0
Revenue Support Loans (6%)	8,925	10,544	8,000	4,600
Loan Repayments	0	-214	0	-338
Net Cash Inflow/(Outflow) from Financing Activities	**8,925**	**41,630**	**8,000**	**4,262**
Net Increase/(Decrease) in Cash	**-34**	**733**	**365**	**-1,098**
Opening balance	2,867	2,100	2,833	3,198
Closing balance	2,833	2,833	3,198	2,100

- The Trust forecasts cash flow for the next 13 weeks on a daily and weekly basis, with the Finance and Investment Committee receiving a detailed report on cash flow each month.
- Cash remains a significant challenge for the Trust, with the ability to 'fund the deficit' driven by national borrowing rules for NHS Trusts. The Trust has received strong support from NHS Improvement and has drawn down cash working capital support in line with the deficit forecast, and has used this to maintain minimum supplier payments.
- The Treasury and Payments teams maintain a constant dialogue with suppliers to ensure continued provision of key goods and services into the organisation. Suppliers of key clinical services and support equipment are prioritised within the weekly payment runs.
- Financial planning for 2017/18 is key to the future cash flow for the Trust. The run-rate of the Trust is above the control total set for the organisation, which will lead to an early shortfall in cash until and if the Trust delivers the required efficiency savings. The Executive Team are reviewing the detailed financial plans for 2017/18 to ensure that appropriate account is taken of cash flow requirements.

East Sussex Healthcare NHS
NHS Trust

Managing the Capital Budget

Capital Investment Programme £000s	2016/17 Capital Programme	Expenditure at Month 10
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	759
IT Systems	2,187	1,108
Electronic Document Management	948	582
Estates Strategy	1,600	1,140
Backlog Maintenance	2,285	950
Minor Capital Schemes	1,000	2,055
Pathology CLD	797	821
Vital Pac	338	165
Project Management	106	138
Brought Forward Commitments - Various	1,183	1,261
Sub Total	**11,325**	**8,979**
Donated Asset Purchases	1,000	480
Donated Asset Funding	-1,000	-480
Net Donated Assets	**0**	0
Sub Total Capital Schemes	**11,325**	**8,979**
Overplanning Margin (-) Underplanning (+)	-358	1,988
Net Capital Charge against the CRL	**10,967**	**10,967**

- The Trust has a capital budget, before loans and grants of £11m, reflected in its annual capital resource limit.
- Capital budgets are managed within the Capital Review Group, with a monthly meeting reviewing and monitoring delivery of the capital plans.
- The Trust is forecasting delivery of the capital budgets in year. However, the level of demand for capital expenditure has been significant, and the Trust has seen pressure against some of the key budget lines. As a result of expenditure undertaken in year, a number of items of investment in-year have had to be deferred or delayed into 2017/18 – and the Executive Team has noted the need for a greater level of robustness in the review of the deferral/delay decision, with a new clinically-led process under development for 2017/18 planning and delivery.
- The Trust has not applied for a significant capital loan, but continues to work up a series of supporting business cases for smaller capital funding applications. An application for ambulatory care development, with a total value of £1.6m is under review by NHS Improvement and the Trust is hoping to secure a decision before the end of the financial year.

East Sussex Healthcare NHS
NHS Trust

Planning for 2017/18

- The draft financial plan for 201718 was considered by the Trust Board in January 2017. However, it continues to be refined and developed to reflect a number of key issues:
  - Forecast outturn for 2016/17
  - Ongoing contract discussions with clinical commissioners
  - Development of the efficiency programme
  - Identified cost pressures and required quality investments

- The key components of the plan remain unchanged. However, the full year effect of the shortfall in FRP delivery for 2016/17 means that delivery of the control total for 2017/18 – which would require a £22m efficiency programme – is challenging. The Trust is in dialogue with NHS Improvement around finalisation of a robust plan for 2017/18.

- Development of divisional and Clinical Unit budgets is continuing, and is progressing well, with sign-off of budgets anticipated before 31 March 2017, and a presentation by each Clinical Unit to the Trust Board scheduled for early April 2017.

- The Trust continues to discuss the implementation of the system financial plan with both Clinical Commissioners and the local authority, and the key regulatory bodies. East Sussex Better Together remains the key delivery vehicle for clinically and financially sustainable health and social care, and the Trust remains fully committed to delivering the system plans for 2017/18 and future years.

ESHT 2020 Improvement Programme

Meeting information:			
Date of Meeting:	21st March 2017	Agenda Item:	12J
Meeting:	Trust Board	Reporting Officer:	Alice Webster

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

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

Executive Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES 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. **Programme Highlights and Milestones**
   This defines the highlights and milestone progress of the programme
2. **Project Highlights, Milestones and KPIs**
   For each projects in the programme this shows the highlights, milestones and KPIs where appropriate.
3. **Key activities and Significant Risks**
   Risks that potentially seriously threaten the progress of the Improvement Programme
4. **Improvements**
   Updates on improvement initiatives

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Quality Improvement Steering Group 20th February 2017

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Board is asked to review and note the progress in implementing the ESHT 2020 improvement plan.

East Sussex Healthcare NHS
NHS Trust

March 2017

ESHT TRUST BOARD REPORT

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. The initial goal for the Trust of being rated "Good" during 2017 is subject to the latest CQC inspection report but the implications of being in Financial Special Measures may threaten this goal as well as A&E target performance, medical staffing and patient flow problems.

ESHT 2020 Improvement programme Status

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

1. Programme Highlights and Milestones
2. Project Highlights, Milestones and KPIs
3. Programme next key activities and Significant Risks
4. Improvements

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

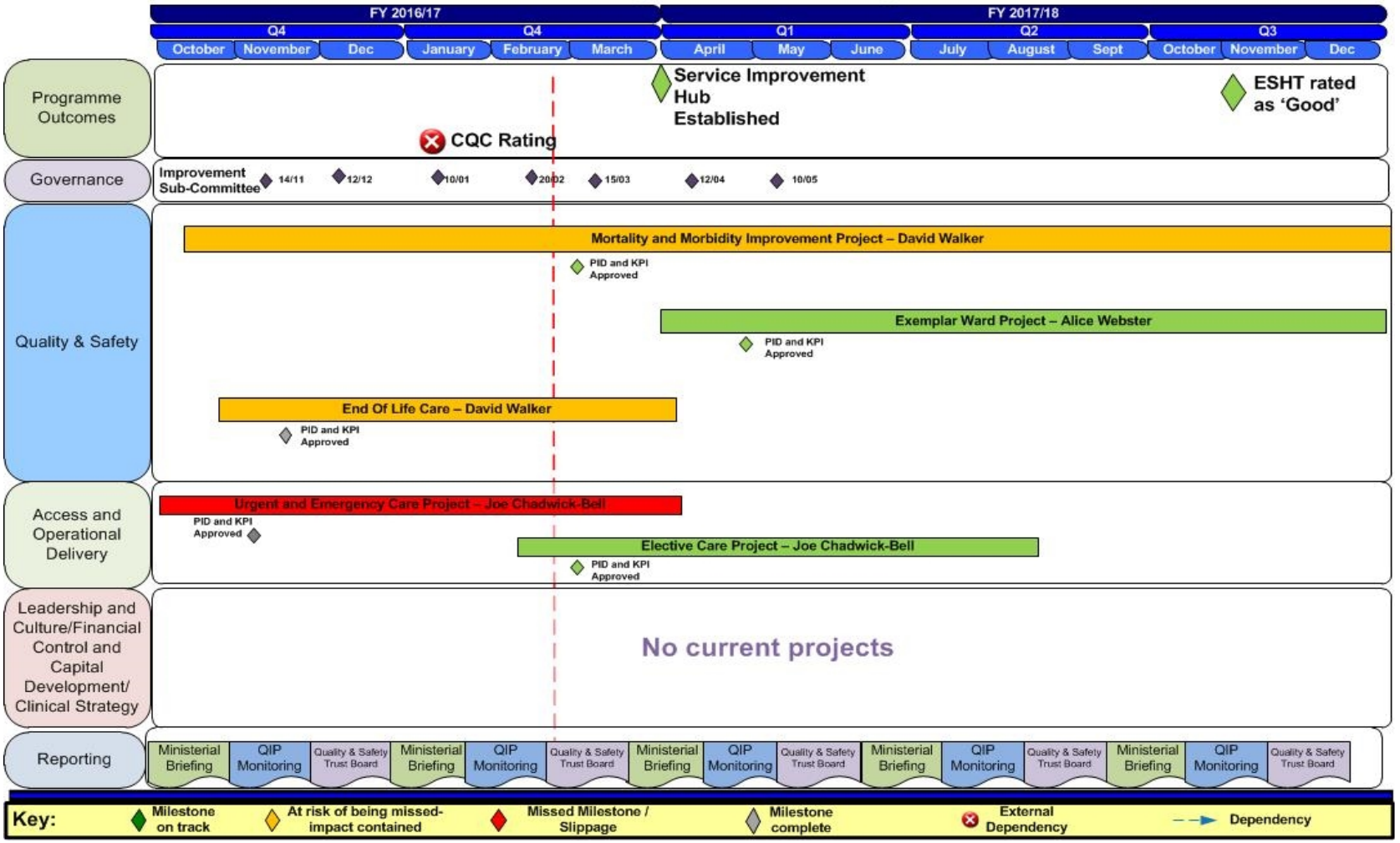
Key highlights are:

- Quality Improvement Steering Group chaired by Dr. Adrian Bull met in February and continues to meet, monthly embedding the governance to ensure challenge to the ESHT 2020 Improvement Programme projects and continual improvement at ESHT.
- Six main projects are now the key focus within progress; Urgent & Emergency Care Improvement Project, Mortality and Morbidity Assurance Project, End of Life Care Project, Elective Care, and two projects awaiting resource allocation; Exemplar Ward Project, Expert Patient
- The initial goal for the Trust of being rated “Good” during 2017 is on track following publication of the latest CQC inspection report which rated the Trust “Requires Improvement”, however the Trust remains in Special Measures.
- Ward Improvement Facilitator to support Red to Green Rollout and Exemplar ward project started 6th February
- Mortality Governance workshop held to agree further improvements and visit to Western Sussex to share best practice
- Nursing lead seconded for AKI improvements until September 2017

Milestone Name	Forecast Completion Date	Responsible	RAG	Comments
SRO - Alice Webster				
Delivering The Capabilities - PROJECT DOSSIER				
Mortality and Morbidity Project Complete	31-Dec-17	David Walker	A	Key mortality indicators, SHMI, RAMI and HMSR are within the required levels, however, the sustainability and robustness of improvement needs to be evidenced. AKI clinical lead is required. Mortality cases reviewed within three months has reduced from 67% to 61%. Mortality cases reviewed within one month has reduced from 60% to 43%
Urgent and Emergency Care project Complete	31-Mar-17	Joanne Chadwick-Bell	R	The 4 hour waiting standard is not being met and progress in delivery of improvements through the workstreams is slow. The 4 hour waiting standard has also been impacted by the reduction in availability of care home places which has increased the number of MFFD patients reducing bed availability for non-elective patients.
Elective Care Board Complete		Joanne Chadwick-Bell	U	PID being developed due for completion end of February 2017.
Exemplar Ward Project Complete		Alice Webster	U	Ward Improvement Facilitator appointed
End Of Life Care Complete	31-Jul-17	David Walker	A	Uncertainty in team membership has created a delay in progressing some work streams this is now resolving, as recruitment to key positions takes place.
Expert Patient Project Complete		Alice Webster	U	Project Manager Capacity not yet available

East Sussex Healthcare NHS
NHS Trust

ESHT 2020 High Level Programme Plan



1. Project Summary

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

- **Zero avoidable deaths**
- **Harm Free 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 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.

2. Project Status

AMBER	Key mortality indicators, SHMI, RAMI and HMSR are within the required levels, however, the sustainability and robustness of improvement needs to be evidenced. Mortality cases reviewed within three months has reduced from 67% to 61% but is showing a rise to approx. 80% for the latest report. Mortality cases reviewed within one month has reduced from 60% to 43%

3. **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. Logic Models have been created and refined for overall project and all workstreams. Options paper drafted to review whether new role of Doctors' Assistants can contribute towards M&M improvements. Key highlights are:

- Mortality cases reviewed within three months has reduced from 67% to 61% since last period. Cases reviewed within one month has fallen from 60% to 43% but this month is showing an increase up to approx 80%
- Key mortality indicators, SHMI, RAMI and HMSR are now down within the required levels, however, the sustainability and robustness of improvement needs to be evidenced and further impacts have been identified e.g. palliative care recorded accurately in health records.
- Mortality Governance workshop part 2 held and further improvements agreed e.g. Junior doctor induction training for coding variable in content and quality depending on how much time the doctors have. Decision to ensure 1 hour is completed and all aspects of coding covered.
- Meeting held on 17th January with Karen Henderson, who is leading the Medical Examiners' service on behalf of BSUH. Deaths are reviewed by a small team of in-house consultants who receive crematorium funds as remuneration. BSUH SHMI is below average. Further models at Sheffield and Gloucester to be investigated. Visit made to Western Sussex Hospitals NHS Foundation Trust for 17th February 2017

3. Respiratory have agreed in principle to trial peer mortality reviews. Peer reviews are already being trialled in A&E and Cardiology
4. Trust has applied to be an early adopter for a new national mortality programme, the National Mortality Case Record Review Programme
5. Audits for CAP and AECOPD workstreams in progress to inform improvements and nursing lead seconded for AKI workstream until September 2017
6. Revised Sepsis screening tool signed off and being piloted in four wards and now expect compliance to improve. Technical solutions also being investigated e.g. Vitalpac.

Project Milestones

Milestone Name	Agreed Milestone Date	% complete	Forecast Completion Date	Responsible	RAG	Comments for Unplanned/Red/Amber Status (In no more than 255 characters)
Project Initiation Document Approved	31-Oct-16	90%	28-Feb-17	Malcolm Catchpole	A	PID can now be finalised with AKI Nurse Lead.
New Mortality Review governance structure embedded and sustainable	31-Mar-17	40%	31-Oct-17	Dr. Walker	G	
Best Evidence Base Care for Sepsis embedded	31-Dec-17	50%	31-Dec-17	Dr Vondras	G	
Best Evidence Base Care for CAP embedded	31-Dec-17	5%	31-Dec-17	Dr. Kankam	G	
Best Evidence Base Care for VTE embedded	31-Dec-17	30%	31-Dec-17	Dr. Berliti	G	
Best Evidence Base Care for AKI embedded	31-Dec-17	0%	31-Dec-17	AKI Clinical Lead	A	Clinical Lead to be identified
Best Evidence Base Care for AECOPD embedded	31-Dec-17	5%	31-Dec-17	Dr Perera	G	
Project Closed	31-Dec-17	0%	31-Dec-17	Dr. Walker	G	

Project KPIs

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-Oct-17	26	14	
	Increase percentage of Mortality Cases reviewed within one months of death	31-Oct-17	90%	43%	
	Increase percentage of Mortality Cases reviewed within three months of death	31-Oct-17	95%	61%	
	Increase Percentage of Code E Deaths Reviewed as Serious Incidents	31-Oct-17	100%	None recorded	
	% of Dr completed health record training within rolling year	31-Oct-17	90%	TBC	
	Reduction in number of care episodes coded without health record available per month	31-Oct-17	100%	TBC	
	% of coded Cs reviewed at Mortality Review Group	31-Oct-17	100%	None recorded	
	Percentage of coded Ds that have has an internal investigation	31-Oct-17	100%	100%	
	SHMI within UCL and LCL consistency	31-Oct-17	Within UCL/LCL (89-112)	111	
	RAMI within UCL and LCL consistency	31-Oct-17	Within UCL/LCL (93-108)	100	
	HSMR within UCL and LCL consistency	31-Oct-17	Within UCL/LCL (98-116)	106	
	Audit compliance with VTE Guidance (IP 37)				
	Increase Rate of VTE Assessments undertaken within 24h of admission	31-Oct-17	95%	96.5%	
	Percentage of Fatal PE RCAs undertaken within 3 months	31-Oct-17	98%	100%	
	Percentage of backlog Fatal PE RCAS completed	31-Dec-16	100%	100%	n/a
	Percentage of CHKS identified Non-Fatal RCAs undertaken within 3 months	31-Oct-17	98%	100%	
	Percentage of CHKs Non-Fatal PE RCAS	31-Oct-17	100%	100%	
	Number of preventable CHKs Non-Fatal PEs	31-Oct-17	0	0	
	Number of preventable Fatal PEs	31-Oct-17	0	0	
	VTE monthly audits on wards covered by Pharmacists embedded	31-Oct-17	100%	42%	
	EQ Sepsis				
	Increase sepsis Screening Compliance	31-Oct-17	100%	31%	
	Increase Antibiotics prescribed and administered within 1 hour of red flag sepsis pathway triggered	31-Oct-17	100%	63%	
	Increase Antibiotics reviewed within 72 hours	31-Oct-17	100%	90%	
	Increase Oxygen administered within 1 hour of red flag sepsis pathway triggered	31-Oct-17	100%	79%	
	Increase Blood cultures taken within 1 hour of red flag sepsis pathway trigged	31-Oct-17	100%	77%	
	Increase Intravenous fluids administered within 1 hour of red flag sepsis pathway trigged	31-Oct-17	100%	63%	
	Increase Serum lactate's tested within 1 hour of red flag sepsis pathway triggered	31-Oct-17	100%	79%	
	Increase Urine Output monitored hourly once red flag sepsis pathway triggered	31-Oct-17	100%	36%	
	Reduction in sepsis admissions to Critical Care	31-Oct-17	Monitoring	16	
	Sepsis audit embedded within ESHT (number of notes)	31-Oct-17	100%	70%	
	Reduction of sepsis as 1a Cause of Death	31-Oct-17	Monitoring	27	
	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-Oct-17	95%	Data Source tbc	
	Chest X-ray within 4 hours of hospital arrival	31-Oct-17	95%	Data Source tbc	
	Initial antibiotic received within 4 hours of hospital arrival	31-Oct-17	95%	Data Source tbc	
	Appropriate initial antibiotic regimen received in adherence to local antibiotic guidelines	31-Oct-17	100%	Data Source tbc	
	Oxygenation assessment within 1 hour of admission	31-Oct-17	95%	Data Source tbc	
	Respiratory failure recognised within 1 hour	31-Oct-17	95%	Data Source tbc	
	Oxygenation appropriately prescribed	31-Oct-17	95%	Data Source tbc	
	CURB-65Score documented within 4 hours of admission	31-Oct-17	95%	Data Source tbc	
	Percentage of Fatal CAP RCAs undertaken within 1 month	31-Oct-17	100%	Data Source tbc	
	Number of preventable Fatal CAP	31-Oct-17	0	Data Source tbc	
	Number of in-patients admitted to ITU with serious Sepsis following an initial diagnosis of CAP	31-Oct-17	Monitoring	Data Source tbc	
	EQ AECOPD				
	Correct diagnosis of AECOPD confirmed	31-Oct-17	95%	Data Source tbc	
	Respiratory Level 2 Beds	31-Oct-17	Monitoring	Data Source tbc	
	Oxygen Assessment and target range prescribed within 30 minutes	31-Oct-17	95%	Data Source tbc	
	Recognise and respond to respiratory acidosis within 1 hour of admission	31-Oct-17	95%	Data Source tbc	
	Medication (Steroids and nebulisers) to be administered within 4 hours of admission	31-Oct-17	95%	Data Source tbc	
	Number of front Line staff trained in respiratory admission bundle	31-Oct-17	Monitoring	Data Source tbc	
	Review by Respiratory team to take place within 24 hours of admission	31-Oct-17	95%	Data Source tbc	
	Junior and senior doctors trained in how to write up AECOPD patient treatment	31-Oct-17	Monitoring	Data Source tbc	
	Number of on-floor Snap-train AECOPD sessions	31-Oct-17	Monitoring	Data Source tbc	
	Number of AECOPD Training Sessions held	31-Oct-17	Monitoring	Data Source tbc	
	Number of preventable Fatal AECOPD (low risk)	31-Oct-17	0	Data Source tbc	

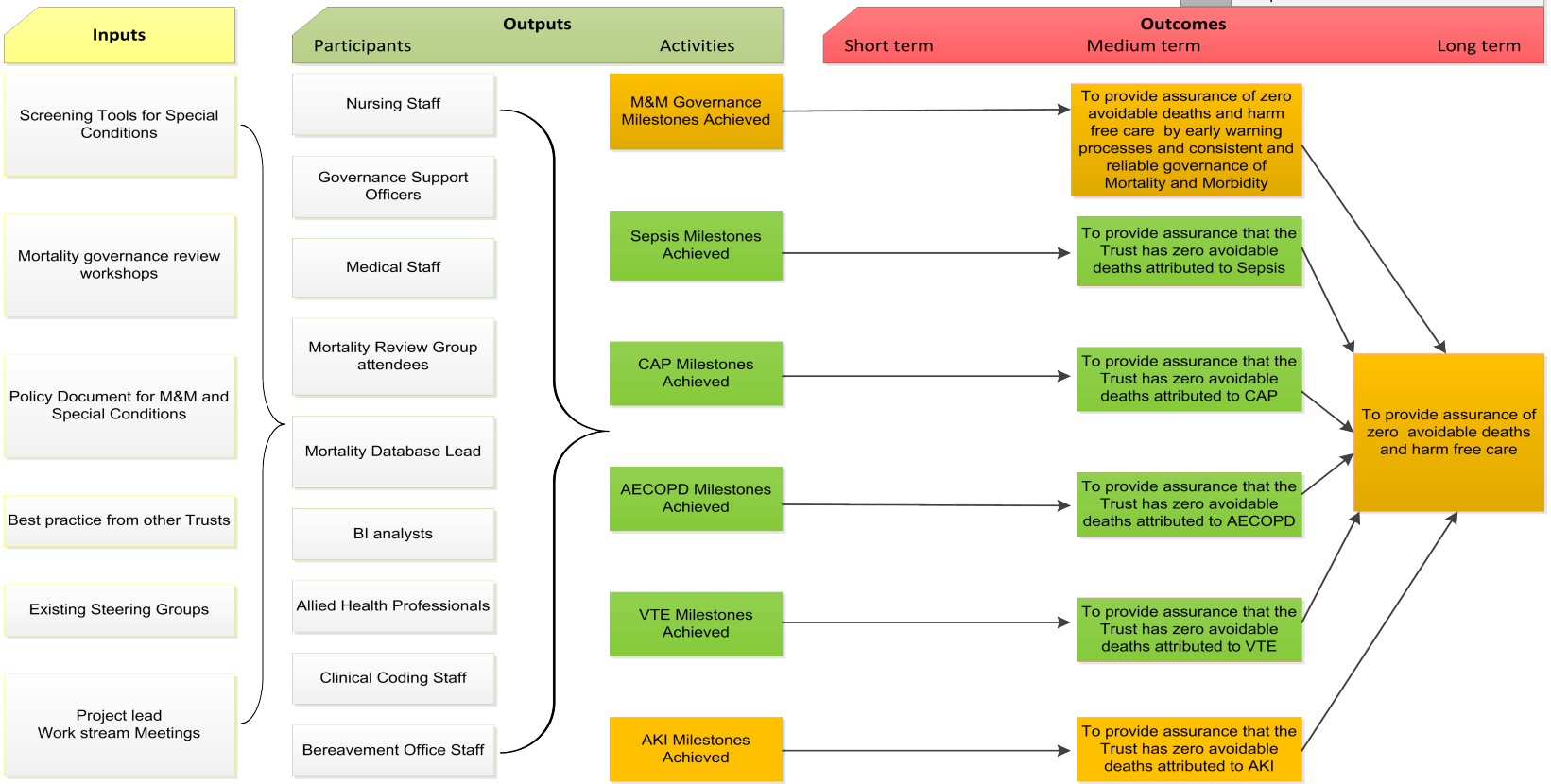
East Sussex Healthcare NHS Trust

M&M Assurance Project Logic Model

Project: Mortality and Morbidity Assurance Project

Situation: CQC Report, Trust High Mortality Rates, National Performance Targets, Unwarranted variation of Mortality Governance

G	Project delivering – no concerns
A	Project delivering with concerns being managed
R	Project not delivering- serious concerns
U	Unplanned
C	Complete



Assumptions:
Engagement and commitment from relevant staff groups including clinical and nursing

External Factors:
Capacity within the organisation to deliver improvements whilst facing severe operational pressure
Government initiatives including Medical Examiners' model

1. Project Summary

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:

- Ensure patient safety
- Improve patient experience
- Improve clinical outcomes
- Address staff concerns

The project is being delivered through 5 workstreams – A&E improvements, revised medical model, discharge planning, capacity planning and governance arrangements.

2. Project Status

Red	The 4 hour waiting standard is not being met and progress in delivery of a number of improvements is slow and being impacted by operational pressures with increasing A&E attendances, continued high number of delayed transfers of care and the increased number of MFFD patients reducing bed availability for non-elective patients.

3. Project Highlights

The main focus since the last report to the Committee has been the progression of activities. Key highlights are:

- ☐ Communications around 4hr waiting time launched
- ☐ SRO reviewing project and re-aligning to focus on five priority areas
- ☐ Meeting with Finance to identify financial benefits arising from project and KPIs required to track delivery
- ☐ Improvement Lead at EDGH commenced in post to support implementation of improvements in A&E
- ☐ ECIP support agreed for roll-out of Red to Green flow bundle
- ☐ Pilot phase of Red to Green on medical wards EDGH commenced 06.02.17 and kick-off meeting for implementation across the rest of the Trust held 20.02.17
- ☐ Review of baseline medical and surgical bed requirement completed
- ☐ Feedback from Back to Green week presented to February Urgent & Emergency Care Board
- ☐ New governance changes agreed with Chief Operating Officer to drive progress

4. Project Milestone Update

Milestone Name	Agreed Milestone Date	% complete	Forecast Completion Date	Responsible	RAG	Comments for Unplanned/Red/Amber Status (In no more than 255 characters)
Project Plan in place	01.07.16	**100%**	01-Jul-16	Trish Richardson	C	
Project Group Set Up	15.07.16	**100%**	15-Jul-16	Matt Hardwick	C	
Communications Plan in place	30.09.16	**100%**	30-Sep-16	Simon Purkiss	C	
A&E Improvements	31-Jan-17	**50%**	31-Jan-17	Matt Hardwick	A	There are a number of issues with delivery of some of the improvements (issues 004, 005, 006, 009, 012, 016 and 017) and priorities are being reviewed by SRO
Medical Model	31-Mar-17	**25%**	31-Mar-17	Simon Merritt	R	There have been delays with the implementation of the medical model due to a number of issues (issues 004, 012, 018) and implementation now to be phased and timescales to be revised
Discharge Improvements	30-Apr-17	**50%**	30-Apr-17	Kate Murray	A	There have been delays with the implementation of the SAFER patient flow bundle (issues 010, 011, 012). Kick-off meeting for phased implementation of SAFER across Trust planned for 20.02.17
Capacity	31-Dec-16	**50%**	31-Dec-16	Matt Hardwick	R	Escalation beds still open
Governance	30-Sep-16	**100%**	30-Sep-16	Pauline Butterworth	C	

5. KPI Dashboard

R	URGENT & EMERGENCY CARE FLOW PROJECT	Due Date	Target	Latest Metric	Six-Month Trend
	Trust				
	4 hour waiting performance (all)	31-Mar-17	95.0%	77.5%	
	Accident & Emergency				
	4 hour waiting performance (minors)	31-Jan-17	95.0%	88.7%	
	4 hour waiting performance (majors)	31-Jan-17	95.0%	62.1%	
	Time to Initial Assessment (% within 15 minutes)	31-Jan-17	95.0%	89.7%	
	% of ambulance conveyances triaged within 30 minutes	31-Jan-17	100.0%	93.5%	
	Time to treatment A (% within 60 minutes)	31-Jan-17	80.0%	41.6%	
	Time to treatment B (% within 120 minutes)	31-Jan-17	100.0%	69.2%	
	% of CDU patients with LOS <12 hours	31-Jan-17	95.0%		
	Medical Model				
	% of AMU patients with LOS <72 hours	31-Mar-17	95.0%		
	Number of direct admissions from GPs to AMU	31-Mar-17	TBC	234	
	Number of direct admissions from GPs to wards	31-Mar-17	TBC	242	
	% zero length stay admissions (ambulatory care wards)	31-Mar-17	TBC	36.8%	
	Medical outliers (average per day)	31-Mar-17	TBC	62	
	Surgical outliers (average per day)	31-Mar-17	TBC	20	
	Orthopaedic outliers (average per day)	31-Mar-17	TBC	0	
	NEL Average length of stay	31-Mar-17	TBC		
	Discharge Planning				
	% of discharges admitted to Discharge Lounge by midday	30-Apr-17	40.0%	32.9%	
	% of patients with EDD linked to CDD within 14hrs of admission to ward	31-Dec-16	50.0%		
	% of patients with EDD linked to CDD within 14hrs of admission to ward	28-Feb-17	75.0%		
	% of patients with LOS >7 days	30-Apr-17	TBC		
	Delayed transfers of care	31-Mar-17	3.5%	7.1%	

Logic Model – A&E Improvements

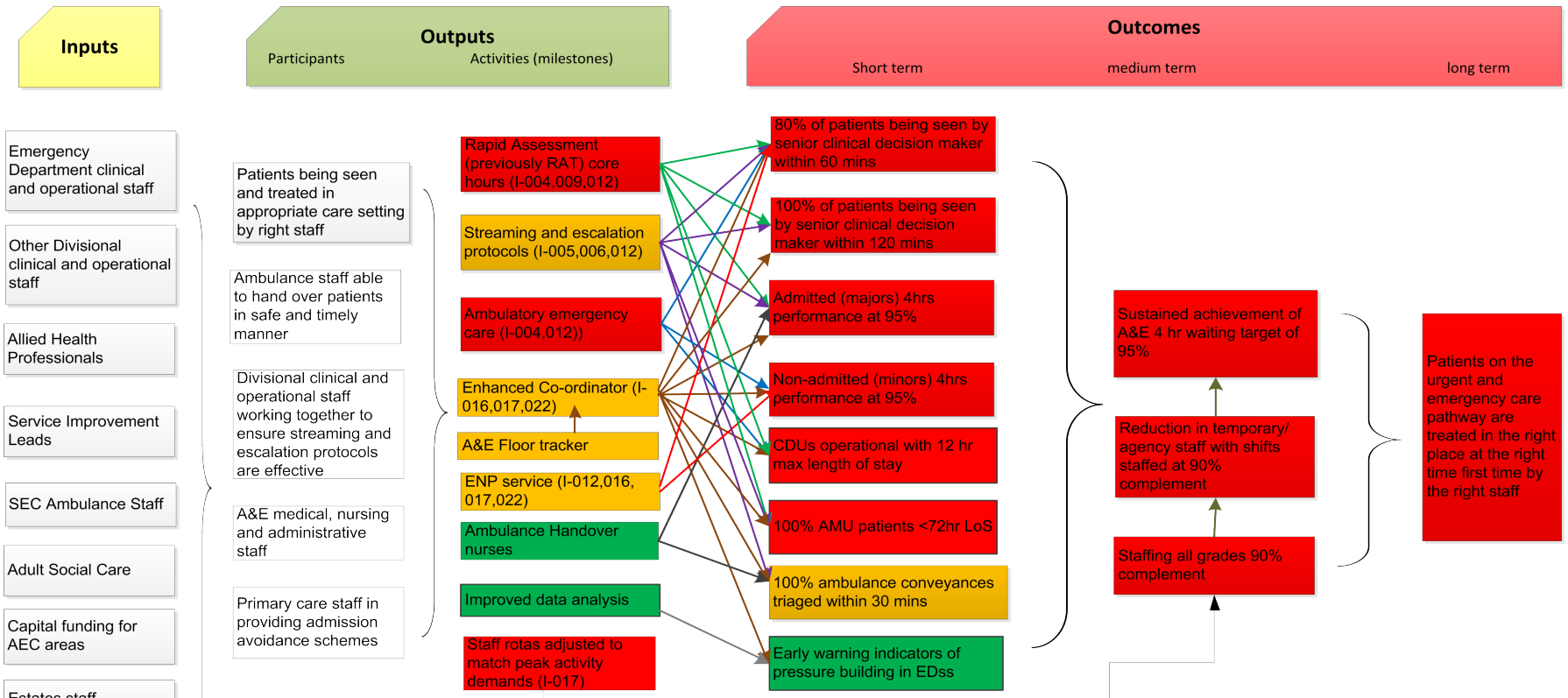
PMO_Urgent & Emergency Care_000043
Workstream Level: A&E Improvements

Workstream Lead: Matt Hardwick, Hospital Director
Clinical Leads: Paul Cornelius, Clinical Lead, Amy Collis, Head of Nursing

Key to RAG status

G	Project delivering – no concerns
A	Project delivering with concerns being managed
R	Project not delivering- serious concerns
U	Unplanned
C	Complete

Situation:
Local A&E Rapid Implementation Guidance
AHSN Review
ECIP Review



Assumptions
Able to recruit to 90% complement at all grades of staff

External Factors
Schemes to develop the avoidance of admission to the emergency departments may not be developed at the same pace
National issue in recruiting Emergency Department medical staff
Capacity within the Emergency Departments to deliver improvements whilst facing severe operational pressure

Project Summary

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 care aims'.

Project Status

Amber	The PID has been approved, one work-stream is starting, and others planned to commence January. Some uncertainty in team membership may create delay in progressing actions.

Project Budget

There is no allocated budget for this project. However, ESHT special measures funding is providing £7.500 to fund the development of improved skills in recognising dying patients and advanced communication skills for medical staff to enhance confidence to broach the subject of end of life care planning with patients and families and £5000 to support further facilitation for the specialist palliative care team.

I

Project Highlights: The main focus since the last report to the Committee has been the roll out of the last days personalised care plan, Key highlights are:

- Established work stream lead for specialist palliative care
- Some project KPI's reporting (SCR, training)
- Established medical leadership for Specialist Palliative Care
- Framework for future of SPC options paper with manager for completion
- Local end of life care standards drafted
- Focussed weekly audit of implementation of care plan commenced 30/01/2017
- Monthly acute site audit of implementation commenced and reported
- Quality audit of the last days personalised care plan to commence 17th February
- Mapping of EoLC information flows commenced
- Staff access to summary care record by department now being reported monthly
- First draft of audit plan produced
- Presented overview of project to the EoLC Clinical Reference Group 5th January
- Poster presentation at KSS EoLC workshop

East Sussex Healthcare NHS Trust

Milestone Name	Forecast Completion Date	Responsible	RAG	Comments for Unplanned/Red/Amber Status
Project Start Up/Initiation Complete	5th Dec 2016	Jacky Thomas	G	-
PID approved	28th December 2016	David Walker	G	-
KPI's developed	30th Jan 2017	Angela Colosi	A	Delay down to overambitious timetabling
Agreed standard operating procedures for specialist palliative care teams	30th Jan 2017	Sandra Field/Angela Colosi	A	Delay possible due to staff changes in January/February
Agreed clinical care pathways	31st Jan 2017	Angela Colosi	A	As above
Quality Monitoring of end of life care plans	13th February	Jo Thorpe and Sarah Callaghan	G	
Implement/embed last days of life personalised care plan	31st March 2017	Jo Thorpe and Sarah Callaghan	G	
80% Staff complete end of life care training	31st March 2017	Jo Thorpe and Sarah Callaghan	G	-
Project Complete	31st May 2017	Jacky Thomas	A	Unlikely to complete project by end of March given the team turbulence and complexity in scope

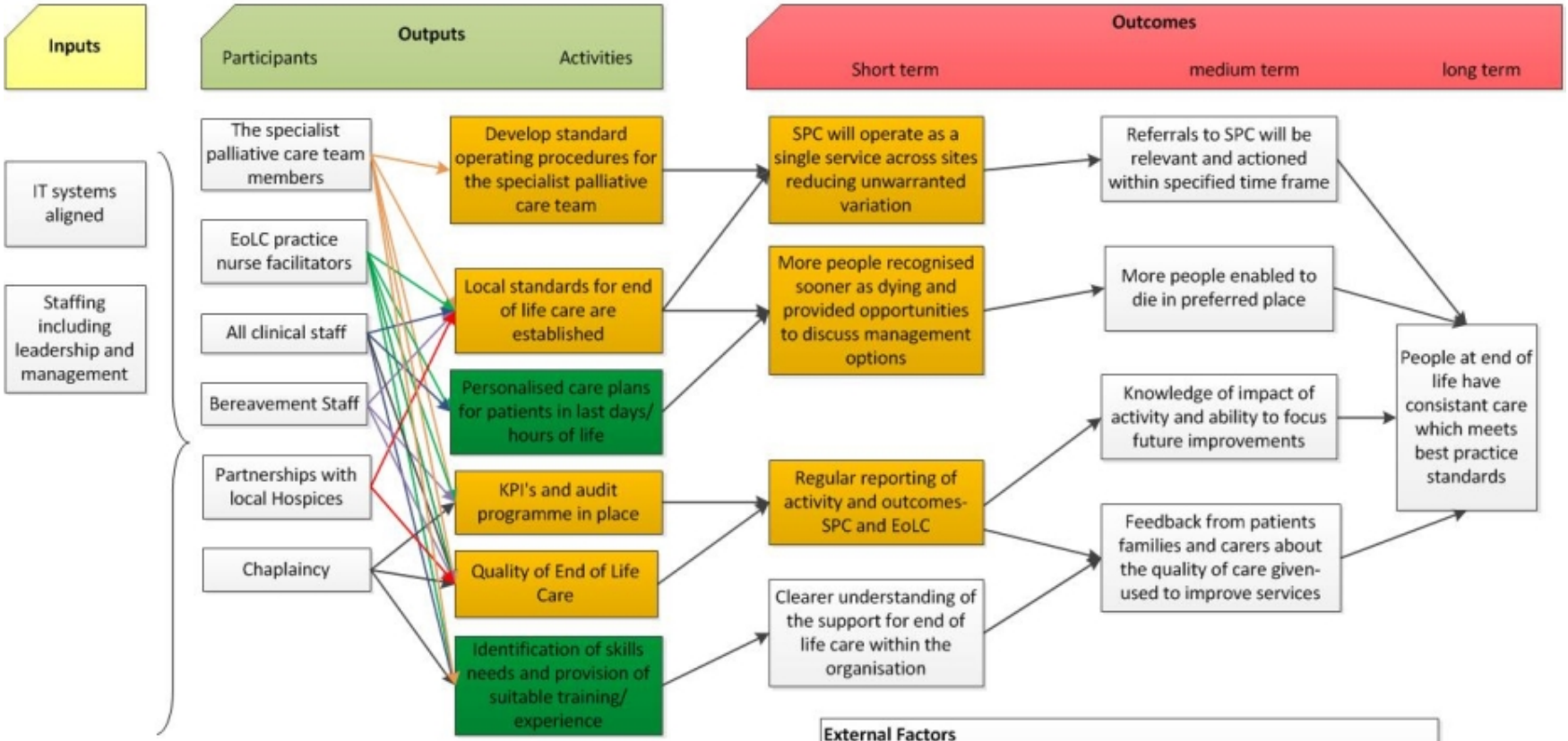
East Sussex Healthcare NHS Trust

LOGIC MODEL: EoLC_HIGH LEVEL

East Sussex Healthcare NHS Trust

Situation:
CQ report 2015 2016 awaited
TiAA audit recommendations
NICE guidance 31, 13
EoLC transformation programme recommendations

G	Project delivering – no concerns
A	Project delivering with concerns being managed
R	Project not delivering- serious concerns
U	Unplanned
C	Complete



Assumptions
Clinical engagement

External Factors
Local patient groups and the voluntary sector
Local CCG End of life care strategic intentions,
National drivers for transformation of End of Life Care, Local Hospice partnerships

East Sussex Healthcare NHS Trust

1. Project Summary

The aim of the Project is to ensure that systems and processes are improved so that patients on the elective care pathway are treated in the right place at the right time first time by the right staff thereby ensuring that constitutional standards relating to access are met and income is maximised.

2. Project Status

Green	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.

3. Project Budget

There is no budget aligned to this project.

Project Highlights: The main focus since the last report to the Committee has been the roll out of the last days personalised care plan, Key highlights are:

- ☐ Scoping meetings held with Project Executive and General Manager – Surgery, Anaesthetics and Diagnostics
- ☐ First meeting of Elective Care Board held
- ☐ First draft of Project Initiation Document (PID) being developed
- ☐ First draft of KPI dashboard being developed
- ☐ Approval of PID by Elective Care Board
- ☐ Approval of KPI dashboard by Elective Care Board
- ☐ Development of project plan
- ☐ Meeting with Finance to identify financial benefits arising from project and KPIs required to track
- ☐ Support for 'Make it your Decision' campaign luanched. The Trust is supporting a campaign to encourage people to think about the medical treatment they would want if illness or injury left them unable to make those decisions for themselves.

Next Key Programme Activities

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

- Implement new governance arrangements to improve pace of change for Urgent and emergency Care Project and timescales for achievement of five priority areas to be reviewed with SRO
- Pilot revised Sepsis adult screening tool in four areas
- Complete audit for CAP and AECOPD to inform improvements required for these conditions
- Red to Green to be rolled in a phased way across Trust to be completed by end Mar17
- Kick-off meeting for development of Integrated Discharge Team and Discharge to Assess to be held
- Standard operating procedures for specialist palliative care completed
- Options paper for Specialist Palliative Care Service to start consultation
- Confirmation of line management for EoLC mid-February
- Revision of the EoLC strategy
- Complete EOLC local standards
- Commence monthly EoLC patient survey on wards

East Sussex Healthcare NHS
NHS Trust

Improvements:

Last Days of Life Plan in use across Conquest and EDGH

Quality Account Priorities for 2017/18

Meeting information:			
Date of Meeting:	21st March 2017	Agenda Item:	13
Meeting:	Trust Board	Reporting Officer:	Alice Webster

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

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

Executive Summary:

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

A list of priorities for the Trust's Quality Account for 2017/18 were identified following the review of last year's Quality Account, the outcome of the CQC inspection and known areas requiring improvement. This paper outlines the suggested priorities for the 2017/18 financial year all of which link to the Trust Quality and Safety Strategy in order to achieve the goal of becoming rated as an outstanding organisation by 2020. These priorities have been developed and prioritised through public and staff engagement with a clear aim to include plans and improvement aims already identified rather than commit to additional priorities as this could result in reduced focus on key areas.

There are a number of priorities that were not chosen for inclusion in the Quality Account for 2017/18 but will still be taken forward as part of the Trust's ongoing improvement projects.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Quality and Safety Committee (includes the progress to 16/17 priorities).

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Trust Board are asked to approve the proposed Quality Account priorities for 2017/18.

Proposed Quality Account Priorities 2017/18

A list of proposed priorities for the Trust's Quality Account 2017/18 were identified following a review of last year's Quality Account, the outcome of the CQC inspection and known areas requiring improvement. There were 11 suggested priorities identified with the aim to reduce to 2 or 3 priorities for each quality domain. To achieve this we consulted the public through a dedicated engagement event and requested staff to provide feedback through a staff survey to rate the priorities they believed to be most important and to consider other ideas that may have been omitted from the list. From the analysis the following have been selected for approval by the Board to include in the Quality Account 2017/18.These were:

Patient Safety

1. Safety Huddles will be introduced and developed across the Trust through an effective implementation programme, the safer care bundle (source – Quality and Safety Strategy);
2. Department Accreditation Programme introduced to provide the framework and ongoing review for quality care and leadership;
3. Mortality and Morbidity reviews will be regularly undertaken and clinical pathways adjusted according to lessons learned. All deaths in the hospital and within 30 days of discharge will be clinically reviewed within 30 days. Learning and actions from these will be tracked and completed. (source – 2020 strategy and national requirement for improving death reviews)

Clinical Effectiveness

1. Continue with the End of Life Care Improvement work (source Quality and Safety Strategy, Care Quality Commission improvements)
2. To improve patient flow and reduce our length of hospital stay for non-elective patients. This will ensure patients are treated in the right place by the right team through a review of wards and theatre usage to enable sufficient capacity to treat all patients in the correct environment from the start of their treatment (source – 2020 Strategy)

Patient Experience

1. Develop patient feedback forums where experience of care can be discussed and possibly share patient stories on the wards
2. Respond to all complaints within the timescales of 30 days (non-complex) or 45 days (complex) and ensure actions identified are implemented with demonstrable improvements (Quality and Safety Strategy, Healthwatch East Sussex reports)

Staff Engagement and Wellbeing

1. Identify three corporate priorities for improvement following the publication of the national Staff survey in February 2017 with a view to improving staff engagement and involvement in decisions that impact them.

The following priorities will not be included in the Quality Account for 2017/18 but they will still be taken forward by the Trust as part of other improvement work and the Quality and Safety Strategy or the Staff Engagement and Wellbeing Programme.:

Patient Safety

1. Patient fall reduction (fall from harm) – Focus work on highest wards with falls (Incident analysis - improvement work). This priority was rated highly in the staff survey, but as it will be a feature of Sign up to Safety, there is assurance it will be taken forward.

Clinical Effectiveness

1. Improve the recognition and treatment of Sepsis – this project will be ongoing as part of the mortality project and a national CQUIN for 2017/18.

Patient Experience

1. Improve 3 areas from patient experience feedback questionnaire for in patient stays which are receiving understandable answers to important questions about care, provision of information about clinical condition and feeling involved in decisions about discharge from hospital – this will be part of the work programme for the Patient Experience Steering Group.
2. Actions from complaints - We are conducting a deep dive into the highest complaint themes of communication and overall care on the 22nd Feb 2017 to determine exact issues. Once done we will identify 2 actions /work streams to resolve – this will be part of the work programme for the Patient Experience Steering Group.

Staff Engagement and Wellbeing

1. Introduce Health checks for staff aged between 40-70 with a view to improving /maintaining the physical and psychological welfare of our staff
2. Continue to improve the findings from the Staff family and Friends test which demonstrate that staff would recommend the trust as a place for treatment and as a place to work to their family and friends

Both of these priorities will be taken forward by the Staff Engagement and Wellbeing team.

Once the Board has approved the recommended priorities each priority will have outcome measures identified and established with baseline data where possible. This will then be collected from May 17 at the latest to allow us to track and report progress throughout the year.

ESBT Alliance Arrangements

Meeting information:			
Date of Meeting: 21st March 2017		Agenda Item:	14
Meeting:	Trust Board	Reporting Officer:	Catherine Ashton, Director of Strategy

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

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

Executive Summary:

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

This paper provides a high level overview of the recent progress in developing the ESBT Alliance model as we move towards the test-bed year in 2017/18. It covers the Alliance Agreement, Governance Structure and Outcomes Framework.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

ESBT Alliance Governing Board and Alliance Executive.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Board is asked to review and note the ongoing progress in developing the Alliance Model.

ESBT Alliance Arrangements - Update

1 Introduction

The recent learning from the Kings Fund[1] [2] based on the UK NHS Five Year Forward View Vanguards, and international examples of best practice indicates that forming a commissioner-provider alliance for the test-bed phase puts us in a strong position to make significant progress within the current regulatory framework. Our Alliance will create the space and time to undertake the necessary learning and development, with support from NHSI and NHSE as the system regulators, to design our full ESBT Alliance accountable care model, which in the longer-term would be structured around a single organisation, alliance or partnership holding the capitated budget to make sure we have integrated delivery of services for our population.

This paper provides a high level overview of the recent progress in developing the ESBT Alliance model as we move towards the test-bed year in 2017/18.

2 Progress

2.1 Alliance Agreement

The Alliance Agreement is nearing final draft for approval. It provides the framework to enable us to rapidly develop our capacity to manage the health and social care system collectively as an Alliance partnership, operating 'as if' we are an accountable care system, in order to test ways of working, configure resources more flexibly, and improve services for the population in 2017/18 and in the longer-term.

The final draft takes into account all the comments and feedback to date and sets out the principles and planned work to be taken forward in the first phase of 2017/18, further work will take place to agree the Strategic Investment Plan (SIP) 2017/18 aligned budget; arrangements for citizen leadership and lay oversight; an overarching conflicts of interest policy, and data-sharing agreement.

The initial signatories as Full Members to the Agreement will be:

- Eastbourne Hailsham Seaford CCG
- Hastings and Rother CCG
- East Sussex County Council
- East Sussex Healthcare NHS Trust

It is anticipated that Sussex Partnership Foundation Trust will be an Associate Member of the ESBT Alliance.

2.2 The ESBT Alliance Governance Structure

The governance structure for our ESBT Alliance is in line with what has been shared and discussed previously at meetings of the Trust Board. It includes a Strategic Commissioning Board, an ESBT Alliance Governing Board, and an ESBT Alliance Executive, as well as the ESBT Clinical Leadership Forum that was established in October 2016. A new ESBT Accountable Care Development Group (task and finish) has been established to undertake an appraisal of the structural form for the future ESBT alliance model post the test-bed year by July 2017. A roadmap and implementation plan for the recommended option will also be produced

[1] New care models – emerging innovations in governance and organisational form (Kings Fund, 2016)
[2] The Quest for Integrated Health and Social care, A case Study in Canterbury New Zealand (Kings Fund, 2013)

and this will inform ESBT work programmes to ensure an integrated approach to IT and Digital, estates, communications and engagement, and workforce development.

The governance structure takes into account the feedback and comments made at previous meetings as follows:

- Terms of reference and proposed membership for the ESBT Alliance Governing Board representing the key organisation signatories to the Alliance Agreement. This includes provision for CCG Governing Body GP and Lay Member representation, Healthwatch representation to provide public and patient voice in lieu of establishing a Citizen Leadership Council, and for every other meeting to be held in public;
- Terms of reference and proposed membership for the ESBT Alliance Executive, including options for clinical provider representation and local General Practice Federation membership. A meeting has been arranged with the Local Medical Committee representatives (LMC) during April to further discuss these arrangements and ensure views are taken on board;
- Terms of reference and proposed membership for the ESBT Accountable Care Development Group. This includes provision for the LMC to attend to support discussions around the practical interface between General Practice and the future ESBT Alliance accountable care model, as well as Healthwatch representation to ensure the public and patient voice is central to consideration of structural design of the future model. In addition a stakeholder engagement plan is being developed to all providers in the local health and care system to inform the options appraisal exercise, including independent care sector and voluntary and community sector organisations.
- The proposed Strategic Commissioning Board with CCG Governing body GP and lay membership (including public and patient involvement lead). More detail about the Strategic Commissioning Board is set out in section 3 of this report, and the proposed terms of reference for the Board are included in Schedule X of the Alliance Agreement.
- A commitment to develop a CCG lay, ESHT non-executive and ESCC member oversight group to scrutinise the activity of the ESBT Alliance during the test-bed year
- A commitment to put in place a citizen leadership board for the test-bed year, as well as explore the options for citizen governance in the future ESBT Alliance accountable care model to secure ownership, influence and insight of the population covered by the ESBT footprint.

Elements of the new Alliance Governance structure have started to operate partially, and in shadow form, since February 2017. To support this, the Alliance Executive has had an Away Day to begin to develop the shadow working arrangements for the operational platform of the Alliance, and the Alliance Governing Board has a workshop planned for 20th March. The Accountable Care Development Group has had two planning meetings to undertake project planning for the appraisal of organisational forms in order that recommendations can be made to the governing bodies of sovereign organisations in the July 2017, together with a roadmap for implementation.

It is anticipated that a first meeting of the Strategic Commissioning Board will take place in April, where the details of the 2017/18 SIP and aligned funds will be presented and discussed.

2.3 Outcomes Framework

A draft pilot integrated Outcomes Framework for the test-bed year is in development, informed by a data review of existing local intelligence about what matters to local people about their health and care services. A small group of whole-system outcome measures is being developed across four domains:

- population health and wellbeing;
- the experience of local people;
- safe and quality care services, and;
- transformed services

This will be further tested with local people, to enable finalisation of a short list of outcome measures and supporting indicators to pilot during the 2017/18 test-bed year and inform the design of an integrated outcomes and performance incentivisation framework for the future ESBT Alliance new model of care. This will be presented to the Strategic Commissioning Board for consideration at its first meeting, alongside the 2017/18 SIP.

Eliminating Mixed Sex Accommodation Declaration

Meeting information:			
Date of Meeting:	21st March 2017	Agenda Item:	15
Meeting:	Trust Board	Reporting Officer:	Alice Webster, Director of Nursing

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

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

Executive Summary:

The NHS Operating Framework 2012/13 requires all providers of NHS funded care to confirm whether they are compliant with the national definition to eliminate mixed sex accommodation except whether it is in the overall best interests of the patient, or reflects their patient choice. The Trust is required to routinely report breaches of sleeping accommodation and declare each year that they are compliant. The Trust has a policy for Mixed Sex Accommodation which is reviewed and in date.

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

The Operating Framework 2012/13 states that:

All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, in accordance with the definitions set out in the Professional Letter CNO/2010/320.

From April 2011, all providers of NHS funded care were required to routinely report breaches of sleeping accommodation, as set out in national guidance, and will attract contract sanctions in respect of each patient affected. Each year, on or by 1 April, all such organisations must declare that they are compliant with the national definition or face financial penalties.

In respect of the above requirements the Trust Board has received details of any breaches as part of its performance reporting and this practice will continue.

The Trust Board is asked to declare compliance and ratify the declaration (below) to continue to be displayed on the Trust website

Benefits - Single sex accommodation supports the provision of privacy and dignity for patients.

Risks - Non-compliance could result in poor patient experience and a financial penalty.

Assurance - Performance reported to the Board on a monthly basis.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Quality and Safety Committee.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Board is asked to note the requirements and ratify the declaration for display on the Trust website.

Declaration of compliance

We are proud to confirm that our hospitals are compliant with the requirements of same sex accommodation. We are committed to providing every patient with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

Patients who are admitted to any of our hospitals will only share the room where they are cared for with members of the same sex. In addition same sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen by exception based on the best interests of the person e.g. where specialist skills or equipment are needed such as critical care units.

What does this mean for patients?

Patients admitted to our hospitals can expect to be provided with accommodation in each room that only accommodates people of the same sex. There will be same sex toilet and wash facilities nearby.

If you need help to use the toilet or take a bath (e.g. you need a hoist or special bath) then you may be taken to a "unisex" bathroom used by both men and women, but a member of staff will be with you to ensure your privacy is maintained.

It is possible that there will be both men and women patients on the ward, but they will not share your sleeping area. You may have to cross a ward corridor to reach your bathroom, but you will not have to walk through opposite-sex areas.

You may share some communal space, such as day rooms or dining rooms, and it is very likely that you will see both men and women patients as you move around the hospital e.g. on your way to an x ray.

It is probable that visitors of the opposite gender will come into the room where your bed is, and this may include patients visiting each other.

It is almost certain that both male and female nurses, doctors and other staff will come into your bed area.

The NHS will not turn patients away just because a "right-sex" bed is not immediately available.

How will we measure success?

Every day we will make an assessment of all our hospitals and review any incident where same sex accommodation has not been provided. Should this occur it will be rectified as soon as possible. This information will be reported to and monitored by senior management and Trust Board in conjunction with feedback from patient experience surveys.

Future plans

To date the Trust has invested in a number of projects to enhance privacy and dignity across it sites. Most recently we have redeveloped a ward on the Eastbourne site to increase the number of single rooms with en-suite facilities. Following evaluation of the design it is our intention to expand this project on a rolling programme across both acute sites.

What do you do if you think you are in mixed sex accommodation?

If you have any concerns or queries please feel free to discuss this with the nurse in charge of your area or our Patient Advice and Liaison team.

Title of Report

Meeting information:			
Date of Meeting:	21 March 2017	Agenda Item:	16N
Meeting:	Trust Board	Reporting Officer:	Dr Tuhin Goswani

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

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:		Funding from NHSBT…	
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? No	

Executive Summary:

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

Potential Donor Audit: 4 solid organ donors leading to 9 transplant recipients. Policy and pathways in place. Room for improvement in referral, neurological testing and consent.

Organ Donation Committee: Lack of Specialist nurses for Organ donation (SN-ODx1 for ESHT and BSUH).

New chair for organ donation committee 4x/Year (?NED).

Finances: Transparent finances and easier route for ODC to use funding appropriately to support ITU and other areas such as ED – education etc.
Publicity team need volunteer contracts with Trust.

Emergency Department: No senior medical staff involved in ODC – need to encourage involvement

BENEFITS: Improve End of Life Care.
Facilitate wishes of Donor and Donor family
Improve Transplantation rates in UK

RISK & IMPLICATIONS: Missed referrals result in missing potential donors and therefore not respecting or fulfilling their wishes after death.

Reduction of organ donors leads to reduction of transplants.

Potential for poor End of Life Care

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

EOLC – Angela Colosi

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

Organ donation forum to improve education and ability for staff views, ideas and concerns

Trainee role in organ donation and quality improvement project

Improve financial information: Allow ODC to use organ donation finances to improve education as well as patient experience in various critical care, theatre, mortuary and ED areas.

For further information or for any enquiries relating to this report please contact:	
Name: Dr Tuhin Goswami	**Contact details: tuhingoswami@nhs.net** **01323 417400 ext 3745 sec** **01323 413745 direct sec**

East Sussex Healthcare NHS Trust

Organ Donation ESHT

1. Introduction

1.1 Organ donation is becoming an integral part of end of life care planning.
1.2 All ESHT patients and families should be given the opportunity to express their wishes around organ and tissue donation and where possible we will try to honour these wishes.
1.3 ESHT organ donation committee oversee policy, education and publicity to educate and support organ donation within ESHT and East Sussex.

2. Background

2.1 In 2008, the organ donation taskforce produced a report which revolutionised organ donation and therefore transplantation in the UK. The taskforce made 14 recommendations which the government of the day and Department of Health wholeheartedly accepted.
2.2 3 people die every day waiting for a transplant. This is a national problems but the solution exists by improving the donation pathway in local hospitals. Making donation a usual rather than an unusual occurrence, and removing the barriers to donation.
2.3 NHS Blood and Transplant was formed to roll out the recommendations.

14 Recommendations are

1. UK Wide Organ Donation Organisation
2. Responsibility for ODO falls to NHSBT
3. UK Wide donation ethics committee
4. Creation of Donation champions and committees
5. National notification criteria
6. Trusts made responsible for monitoring donation activity
7. BSD should be carried out in every case
8. Appropriate reimbursement
9. Central employment and embedded DTCs (now called SN-OD ead.2.5)
10. National network dedicated retrieval teams
11. Mandatory training for those directly involved
12. Public recognition of those who have donated
13. Research into best way to promote donation
14. Formal guidelines for HM Coroners

2.4 ESHT appointed Donation Champion; Clinical Lead in Organ Donation (CLOD) in 2009.
2.5 CLOD formed Organ Donation Committee along with Specialist Nurse for Organ Donation(SN-OD) in 2009. Multidisciplinary team with representation from Critical Care, theatres, A&E, Mortuary, Bereavement, Chaplaincy. Donation Committee Chair is a layperson.
2.6 ESHT Organ Donation Committee have:

1. Educated the public around ESHT with many events, and increased membership of the organ donation register (ODR).
2. Introduced guidance for critical care and theatres and A&E
3. Introduced a WHO checklist for organ donation
4. Developed a policy for organ and tissue donation 2014
5. Invited a trainee representative for organ donation (TROD) to train them in organ donation as well as management issues i.e. policy, committee, setting up educational meetings

6. Used donation finances to further education of nurses and doctors and ancillary medical staff in donation; representation of ESHT ODC in regional and national meetings
7. Created organ donation films for promotion and education of staff and public
8. Created separate publicity group with lay members to continue public engagement in organ donation around ESHT.
9. ESHT has been part of the national increase in organ donation and therefore transplantation by 50% in 5 years from 2008 – 2014.

3. Main content of the report

3.1 Potential Donor Audit (PDA) April 2015 – March 2016

East Sussex Healthcare NHS Trust had 4 deceased solid organ donors, resulting in 9 patients receiving a transplant. 13 organs were donated but 3 were not transplanted.

Figure 2.1.1 Key rates on the potential for organ donation, 1 April 2015 - 31 March 2016 (1 April 2014 - 31 March 2015 for comparison)

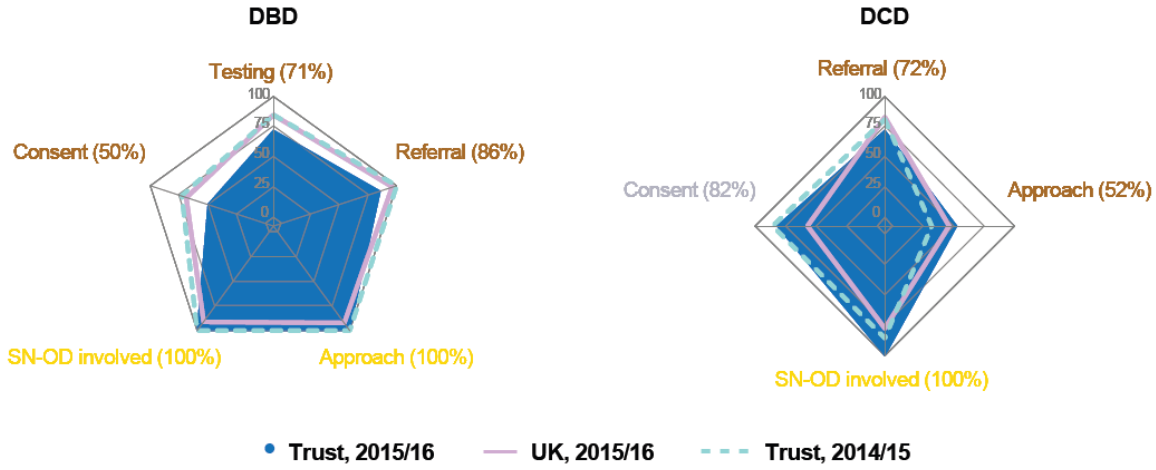
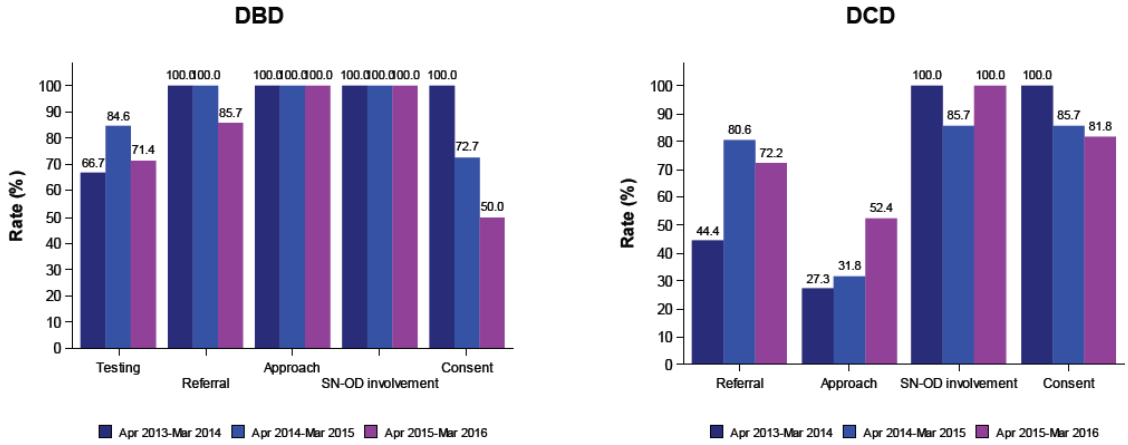


Figure 2.1.2 Key rates on the potential for organ donation, 1 April 2013 - 31 March 2016



DBD=Donation after brainstem death, DCD=Donation after circulatory death

Table 2.2.1 Key numbers, rates and comparison with national targets, 1 April 2015 - 31 March 2016 (1 April 2014 - 31 March 2015 for comparison)

	DBD						DCD					
	2015/16			2014/15			2015/16			2014/15		
	Target	Trust	UK	Trust	UK		Target	Trust	UK	Trust	UK	
Patients meeting organ donation referral criteria[1]		7	1,742	13	1,734			36	6,502	31	6,755	
Referred to SN-OD		6	1,679	13	1,671			26	5,399	25	5,154	
Referral rate %	*96%*	*B 86%*	*96%*	*100%*	*96%*		*79%*	*B 72%*	*83%*	*81%*	*76%*	
Neurological death tested		5	1,472	11	1,445							
Testing rate %	*82%*	*B 71%*	*85%*	*85%*	*83%*							
Eligible donors[2]		4	1,399	11	1,373			21	4,204	22	4,284	
Family approached		4	1,293	11	1,284			11	1,941	7	2,018	
Approach rate %	*94%*	*G 100%*	*92%*	*100%*	*94%*		*47%*	*B 52%*	*46%*	*32%*	*47%*	
Family approached and SN-OD involved		4	1,177	11	1,113			11	1,511	6	1,459	
% of approaches where SN-OD involved	*87%*	*G 100%*	*91%*	*100%*	*87%*		*75%*	*G 100%*	*78%*	*86%*	*72%*	
Consent given		2	888	8	859			9	1,112	6	1,046	
Consent rate %	*73%*	*B 50%*	*69%*	*73%*	*67%*		*59%*	*S 82%*	*57%*	*86%*	*52%*	
Expected consents based on ethnic mix		3		6				7		4		
Expected consent rate based on ethnic mix %		*74%*		*64%*				*61%*		*55%*		
Actual donors from each pathway		1	784	6	780			3	566	1	493	
% of consented donors that became actual donors		*50%*	*88%*	*75%*	*91%*			*33%*	*51%*	*17%*	*47%*	

Colour key - comparison with funnel plot confidence limits: G Gold; A Amber; S Silver; R Red; B Bronze

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

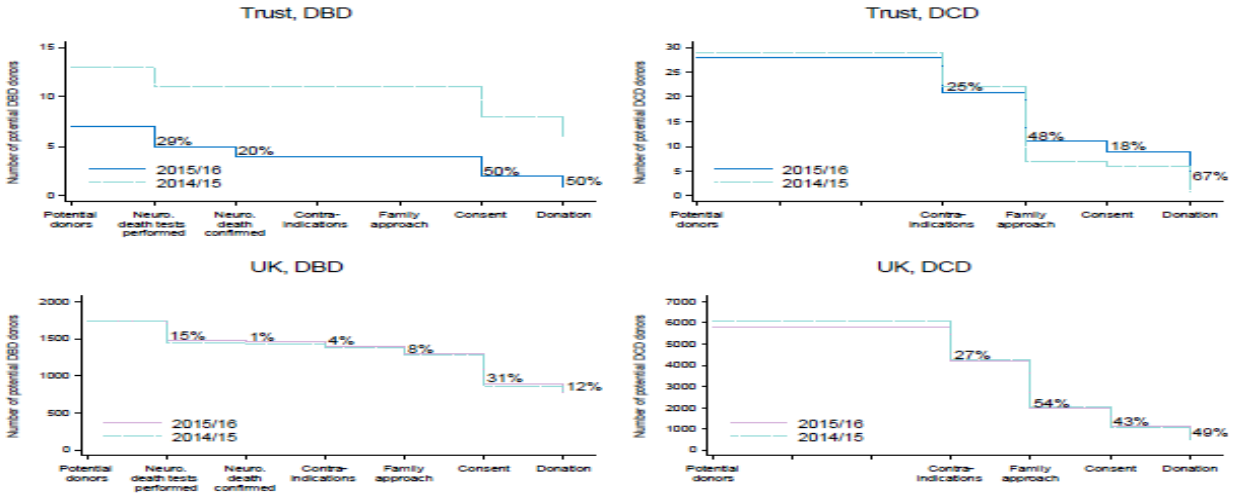
[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that from 1 April 2015 to 31 March 2016 there was one eligible DCD donor whose family consented to donation who is not included in this section because they were either over 80 years of age or did not die in a unit participating in the PDA.

3.2 Lost opportunities

Of the 7 potential DBD donors with suspected neurological death, 1 proceeded to donation and 6 did not proceed. Of the 21 eligible DCD donors, 3 proceeded to donation and 18 did not proceed.

Figure 3.1.1 Stages at which potential donors lost the opportunity to become actual donors, 1 April 2015 - 31 March 2016 (1 April 2014 - 31 March 2015 for comparison)



3.2.1 Neurological testing

3.2 Neurological death testing

A funnel plot of neurological death testing rates is displayed in Figure 3.2.1. The national target for 2015/16 of 82% is also shown on the funnel plot, for information, but the goal is to ensure that neurological death tests are performed wherever possible. For information about how to interpret the funnel plots, please see Appendix A.6.

Figure 3.2.1 Funnel plot of neurological death testing rates, 1 April 2015 - 31 March 2016

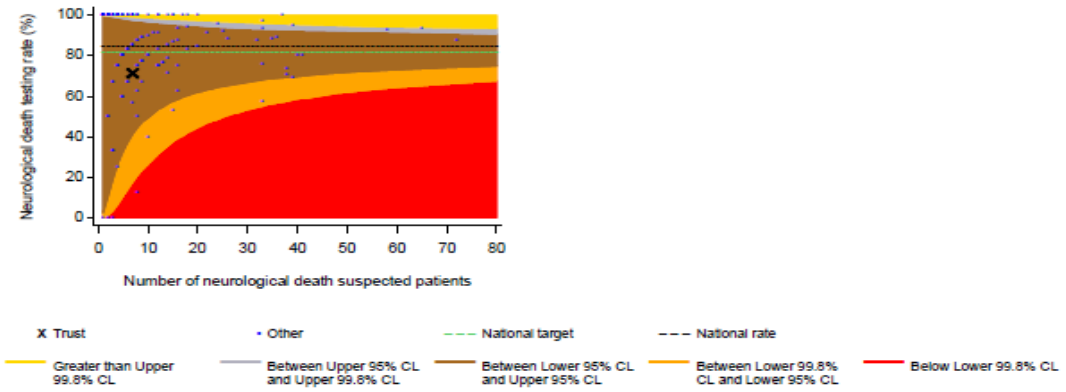


Table 3.2.1 shows the reasons why neurological death tests were not performed, if applicable, for your Trust. Patients for whom the reason for not performing neurolgical tests is given as 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', or 'neonates - less than 2 months post term' are now excluded from the calculation of the neurological death testing rate and Table 3.2.1.

Table 3.2.1 Reasons given for neurological death tests not being performed, 1 April 2015 - 31 March 2016

	N	%
Treatment withdrawn	1	50.0
Patient haemodynamically unstable	1	50.0
Total	**2**	**100.0**

If 'other', please contact your local SN-OD for more information, if required.

5 out of 7 patients tested = 71% (85% = 6/7 last year)
The 2 patients who dropped out; 1 unstable for testing; 1 treatment withdrawn

We did educate the team involved with treatment withdrawn as we should have tested and / or referred to the DCD pathway.

3.2.2 Referral to Specialist Nurse – Organ Donation (SN-OD)

1 missed DBD and 4 missed DCD

3.3 Referral to Specialist Nurse - Organ Donation (SN-OD)

Funnel plots of DBD and DCD referral rates are displayed in Figure 3.3.1. The 2015/16 national targets of 96% and 79% for DBD and DCD, respectively, are also shown on the funnel plots, for information. Every patient who meets the referral criteria should be identified and referred to the SN-OD, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Figure 3.3.1 Funnel plots of referral rates, 1 April 2015 - 31 March 2016

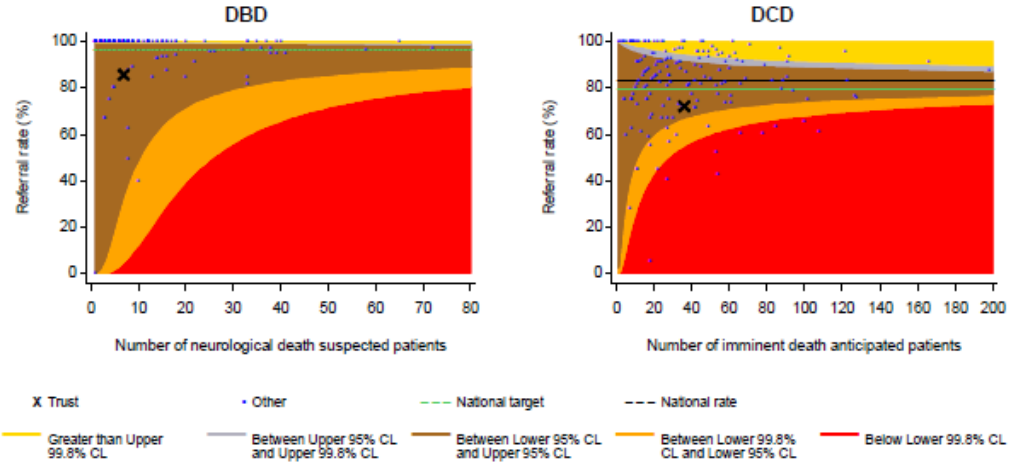


Table 3.3.1 shows the reasons why patients were not referred to a SN-OD, if applicable, for your Trust.

Table 3.3.1 Reasons given why patient not referred, 1 April 2015 - 31 March 2016

	DBD		DCD	
	N	%	N	%
Not identified as a potential donor/organ donation not considered	1	100.0	4	40.0
Medical contraindications	-	-	4	40.0
Thought to be medically unsuitable	-	-	1	10.0
Other	-	-	1	10.0
Total	**1**	**100.0**	**10**	**100.0**

If 'other' or 'medical contraindications', please contact your local SN-OD for more information, if required. Please note that patients may appear in this table more than once if they met the referral criteria for both DBD and DCD donation.

Another 6 DCD were too unstable or medically unfit to be considered for donation.

Consultants and teams referred to NICE CG135 guidance. Also guidance from UK donation ethics committee (UKDEC, 2011) to say it is not unethical to refer a patient before withdrawal decision made. This is all part of planning of EOLC.

3.2.3 This is a recurring theme as the 24/26 patients referred for DCD were referred after withdrawal of life sustaining treatment (WLST) decision made.

Early referral to the SN-OD is important to enable the opportunity for donation to be maximised. Early referral triggers should be in place to ensure all donors are identified to the SN-OD to allow the family the option of organ donation. For patients who were referred, Table 3.3.2 shows the timing of the first contact with the SN-OD by the clinical staff. All patients meeting the referral criteria should be referred as early as possible to enable attendance of the SN-OD to assess suitability for donation and ensure that a planned approach for consent to the family is made in line with NICE CG135[1] and NHSBT Best Practice Guidance on approaching the families of potential organ donors[3].

Table 3.3.2 Timing of first contact with a SN-OD by clinical staff, for patients who were referred, 1 April 2015 - 31 March 2016

	DBD		DCD	
	N	%	N	%
Before sedation stopped	1	16.7	1	3.8
Absence of one or more cranial nerve reflexes and GCS of 4 or less not explained by sedation	3	50.0	1	3.8
No sedation or after sedation stopped, decision made to carry out BSD tests, before 1st set of tests	1	16.7	-	0.0
After 1st set and before 2nd set of BSD tests	-	0.0	-	0.0
After neurological death confirmation	-	0.0	-	0.0
Clinical decision to withdraw life-sustaining treatment has been made, before treatment withdrawn	1	16.7	24	92.3
After treatment withdrawn	-	0.0	-	0.0
Not reported	-	0.0	-	0.0
Total	**6**	**100.0**	**26**	**100.0**

NB, 2 patients with suspected neurological death also went on to meet the referral criteria for DCD donation, and are therefore included twice.

[1] NICE, 2011. *NICE Clinical Guidelines - CG135* [online]. Available at: <http://publications.nice.org.uk/organ-donation-for-transplantation-improving-donor-identification-and-consent-rates-for-deceased-cg135/recommendations> [accessed 9 May 2016]

[2] NHS Blood and Transplant, 2012. *Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice* [online]. Available at: <http://www.odt.nhs.uk/pdf/timely-identification-and-referral-potential-donors.pdf> [accessed 9 May 2016]

[3] NHS Blood and Transplant, 2013. *Approaching the Families of Potential Organ Donors – Best Practice Guidance* [online]. Available at: <http://www.odt.nhs.uk/pdf/family_approach_best_practice_guide.pdf> [accessed 9 May 2016]

3.2.4 I proposed an ICU nurse-consultant handover sheet where all patients being considered for EOLC are flagged up and consideration given to getting information regarding donation from SN-OD. This is an information gathering exercise and doesn't definitely put the patient on a WLST pathway. There is a generic handover sheet being used at present but unfortunately does not include EOLC/ organ donation questions.

Despite this, the last 4 months of this year (after this report) we have had 100% referral rate.

3.2.5

3.4 Contraindications

Table 3.4.1 shows the primary absolute medical contraindications to solid organ donation, if applicable, for potential DBD donors confirmed dead by neurological death tests and potential DCD donors in your Trust.

Table 3.4.1 Primary absolute medical contraindications to solid organ donation, 1 April 2015 - 31 March 2016

	DBD	DCD
Any cancer with evidence of spread outside affected organ (including lymph nodes) within 3 years	-	3
Active haematological malignancy (myeloma, lymphoma, leukaemia)	-	4
Total	-	7

7 potential DCD had absolute contraindications to donation.

3.2.6 Family Approach

We have above UK average for family approach, with 100% DBD and 62% DCD families approached to find out about organ donation wishes.

3.5 Family approach

Funnel plots of DBD and DCD family approach rates are displayed in Figure 3.5.1. The 2015/16 national targets of 93.5% and 47% for DBD and DCD, respectively, are also shown on the plots, for information. All families of eligible donors should be formally approached for a decision about organ donation.

Figure 3.5.1 Funnel plots of approach rates, 1 April 2015 - 31 March 2016

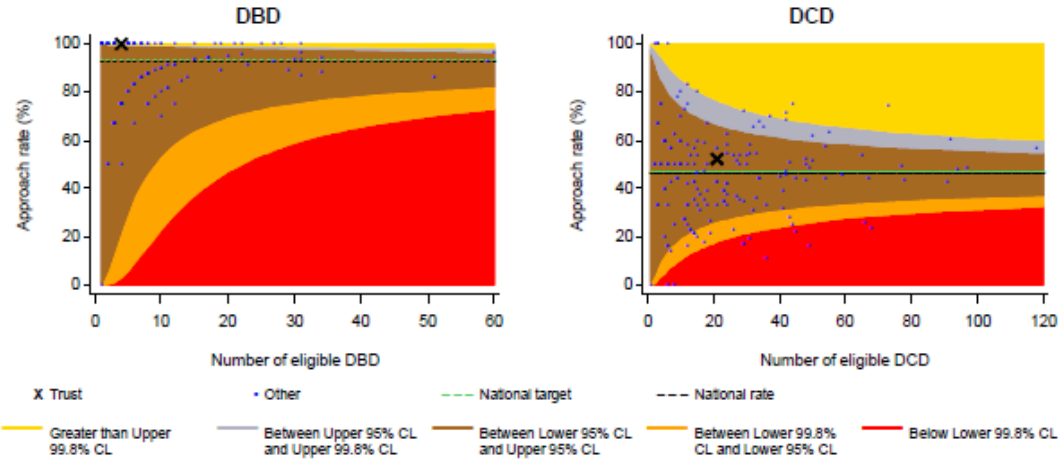


Table 3.5.1 shows the reasons why patients were not formally approached for a decision about organ donation, if applicable, for your Trust.

Table 3.5.1 Reasons given why family not formally approached, 1 April 2015 - 31 March 2016

	DBD		DCD	
	N	%	N	%
Family untraceable	-	-	1	10.0
Coroner/Procurator Fiscal refused permission	-	-	1	10.0
Patient's general medical condition	-	-	2	20.0
Other	-	-	1	10.0
Not identified as a potential donor / organ donation not considered	-	-	5	50.0
Total	-	-	10	100.0

If 'other', please contact your local SN-OD for more information, if required.

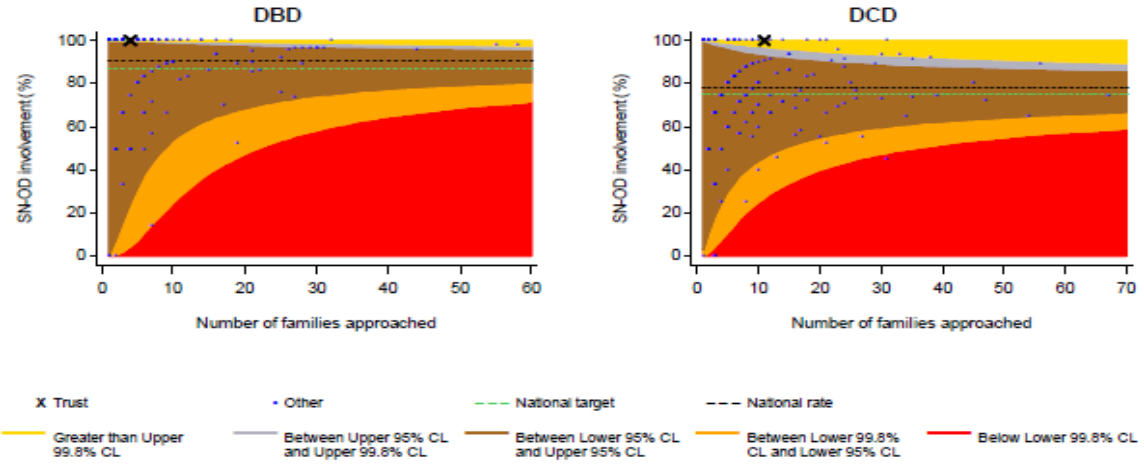
In both scenarios we have 100% collaborative approach with the SN-OD.

3.6 Proportion of approaches involving a SN-OD

In the UK, in 2015/16, when a SN-OD was not involved in the approach to the family for a decision about organ donation, DBD and DCD consent rates were 51% and 24%, respectively, compared with DBD and DCD consent rates of 70% and 67%, respectively, when a SN-OD was involved. NICE CG135[4] and NHSBT Best Practice Guidance on approaching the families of potential organ donors[3] reinforces that every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SN-OD and should be clearly planned taking into account the known wishes of the patient. The Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Funnel plots of DBD and DCD SN-OD involvement rates are displayed in Figure 3.6.1. The 2015/16 national targets of 87% and 75% for DBD and DCD, respectively, are also shown, for information. A SN-OD should be actively involved in the formal approach to the family and an approach plan made and followed.

Figure 3.6.1 Funnel plots of SN-OD involvement rates, 1 April 2015 - 31 March 2016



3.2.7 Consent

3.7 Consent

Funnel plots of DBD and DCD consent rates are displayed in Figure 3.7.1. The 2015/16 national targets of 72.5% and 58.5% for DBD and DCD, respectively, are also shown, for information.

Figure 3.7.1 Funnel plot of consent rates, 1 April 2015 - 31 March 2016

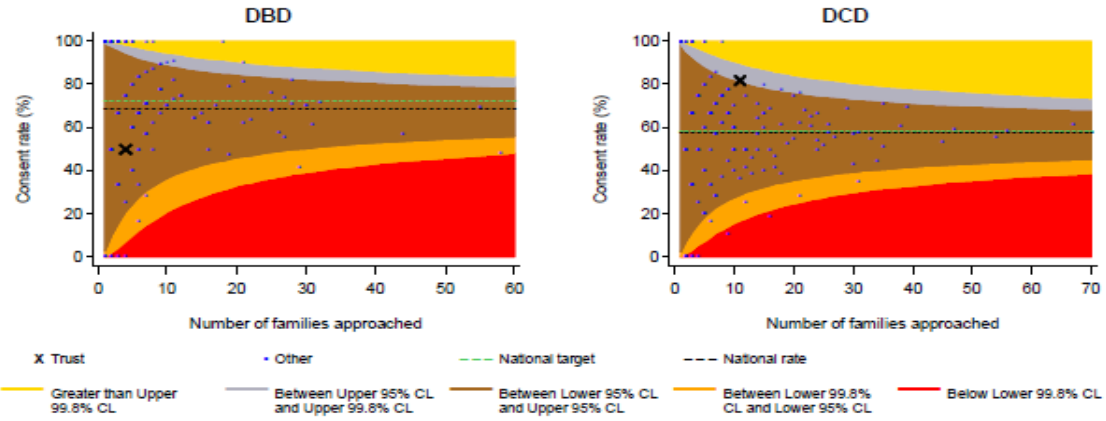


Table 3.7.1 shows the reasons why families did not give consent, if applicable, for your Trust.

Table 3.7.1 Reasons given why family did not give consent, 1 April 2015 - 31 March 2016

	DBD		DCD	
	N	%	N	%
Patient previously expressed a wish not to donate	1	50.0	1	50.0
Family felt the length of time for donation process was too long	1	50.0	1	50.0
Total	2	100.0	2	100.0

If 'other', please contact your local SN-OD for more information, if required.

Despite our 100% collaborative approach, we had a 50% consent rate in DBD and 82% consent to DCD. Of note, nationally 4/10 families in the UK refuse donation even if their loved ones are on the ODR.

3.2.8 After consent unfortunately only some of the potential donors went onto donating actual solid organs. Of these, one donor's organs were not transplantable but they were used for research.

3.8 Reasons why solid organ donation did not occur

Table 3.8.1 shows the reasons why solid organ donation did not occur, if applicable, for your Trust.

Table 3.8.1 Reasons why solid organ donation did not occur, 1 April 2015 - 31 March 2016

	DBD		DCD	
	N	%	N	%
Organs deemed medically unsuitable by recipient centres	1	100.0	1	16.7
Prolonged time to asystole	-	-	4	66.7
General instability	-	-	1	16.7
Total	**1**	**100.0**	**6**	**100.0**

If 'other', please contact your local SN-OD for more information, if required.

3.2.9 PDA data by Hospital for DBD and DCD with comparison to last year

4.1 Key numbers and rates by unit where the patient died

Tables 4.1.1 and 4.1.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Caution should be applied when interpreting percentages based on small numbers. For each of the units tabulated in Tables 4.1.1 and 4.1.2, the national key rates from the PDA are displayed in Appendix A.2 to aid comparison with equivalent units. For example, neurosurgical ICUs can be compared against the average rates achieved nationally for neurosurgical ICUs.

Table 4.1.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2015 - 31 March 2016 (1 April 2014 - 31 March 2015 for comparison)

Unit where patient died	Patients where neurological death was suspected	Patients that were tested	Neurological death testing rate (%)	Patients where neurological death was suspected that were referred to SN-OD	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors (Death confirmed by neurological tests and no absolute contra-indications)	Eligible DBD donors whose family were approached	DBD approach rate (%)	Families consenting donation	DBD consent rate (%)	Actual DBD and DCD donors from eligible DBD donors	DBD SN-OD involvement rate (%)
1 April 2015 to 31 March 2016													
Eastbourne, Eastbourne District General Hospital													
A&E	1	0	0	0	0	0	0	0	-	0	-	0	-
Gen. ICU/HDU	5	4	80	5	100	3	3	3	100	1	33	1	100
Hastings, Conquest Hospital													
A&E	0	0	-	0	-	0	0	0	-	0	-	0	-
Gen. ICU/HDU	1	1	100	1	100	1	1	1	100	1	100	0	100
1 April 2014 to 31 March 2015													
Eastbourne, Eastbourne District General Hospital													
A&E	0	0	-	0	-	0	0	0	-	0	-	0	-
Gen. ICU/HDU	8	6	75	8	100	6	6	6	100	4	67	3	100
Hastings, Conquest Hospital													
A&E	0	0	-	0	-	0	0	0	-	0	-	0	-
Gen. ICU/HDU	5	5	100	5	100	5	5	5	100	4	80	3	100

Table 4.1.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2015 - 31 March 2016 (1 April 2014 - 31 March 2015 for comparison)

Unit where patient died	Patients for whom imminent death was anticipated	Patients for whom imminent death was anticipated that were referred to SN-OD	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors (Imminent death anticipated and treatment withdrawn with no absolute contra-indications)	Eligible DCD donors whose family were approached	DCD approach rate (%)	Families consenting donation	DCD consent rate (%)	Actual DCD donors from eligible DCD donors	DCD SN-OD involvement rate (%)
1 April 2015 to 31 March 2016											
Eastbourne, Eastbourne District General Hospital											
A&E	1	0	0	1	1	0	0	0	-	0	-
Gen. ICU/HDU	23	19	83	19	13	7	54	5	71	2	100
Hastings, Conquest Hospital											
A&E	0	0	-	0	0	0	-	0	-	0	-
Gen. ICU/HDU	12	7	58	8	7	4	57	4	100	1	100
1 April 2014 to 31 March 2015											
Eastbourne, Eastbourne District General Hospital											
A&E	1	0	0	0	0	0	-	0	-	0	-
Gen. ICU/HDU	12	11	92	11	10	5	50	4	80	1	80
Hastings, Conquest Hospital											
A&E	1	0	0	1	0	0	-	0	-	0	-
Gen. ICU/HDU	17	14	82	17	12	2	17	2	100	0	100

Tables 4.1.1 and 4.1.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total, for East Sussex Healthcare NHS Trust in 2015/16 there were no such patients.

It is acknowledged that the PDA does not capture all activity. In total there were 3 patients referred in 2015/16 who are not included in Section 2 onwards because they were either over 80 years of age or did not die in a unit participating in the PDA. None of these are included in Section 1 because they did not become a solid organ donor.

The above is a summary of the NHSBT PDA report that we get every year. I am expecting an intermediate quarterly report this month for our recent figures.

3.3 Organ donation committee

In our last ODC meeting we decided to streamline the committee meetings and use them as a forum for all staff to attend and ask questions as well as using the forum as a means for education around certain aspects of donation.

Therefore from this October we will be holding biannual Organ Donation Forum. Our business meeting will either be before or after the forum. We have separate groups looking at publicity and link nurses throughout critical care and theatres on both sites to improve education.

Unfortunately over the past 2-3 months we have lost our committee chairperson who has become chair at BSUH ODC. Also we have lost our embedded SN-OD and have had 2 SN-ODs from Brighton sharing ESHT workload. Recently one has resigned and at present we will only have one SN-OD for ESHT but she also has responsibilities in BSUH Trust.

3.4 Publicity

We have 3 lay members of the ODC who have formed their own publicity group to educate and publicise the organ donor register at various local and regional events around East Sussex.

3.5 Education

I would like to have a rolling education program for ICU Consultants and trainees. This would involve management and testing of DBD donors as well as breaking bad news. This is still work in progress.

3.6 Finances

NHSBT employ our SN-OD but they have a dual contract with the Trust who should guarantee them a private work area to carry out their duties around donation on both sites in the Trust. Clinical Lead Organ Donation (CLOD) gets 1PA from NHSBT and is appraised by the regional CLOD annually.

NHSBT pays the Trust £2000p.a for ODC expenses. However £1000 of this is held to support a regional collaborative which anyone from the Trust can attend at no expense. This also supports education of new CLODs, and is a forum for sharing knowledge and ways of working to improve donation.

NHSBT also pays the trust approximately £2000 per donation consent. This money is kept by the ODC per financial year to help with education, publicity and can be used to improve the donor and donor families experience. It has been used to supply care after death materials to theatre as well as refreshments for relatives in theatre waiting for a DCD donor. At present we are redecorating a room in Eastbourne DGH which is dual purpose for the nurse educator and also for private conversations with relatives of ICU patients.

Although the ODC can use these monies, they are taken back into the Trusts finances end of each financial year.

The finances are presented to me via CrystalEntertprise listing which I cannot understand. It is very hard to find a finance person who understands the OD finances. I cannot easily get expenses and sign off for staff or equipment without need for other authorisation.

3.7 Emergency Department

We have little visibility in the Emergency department. We have link nurses but are unable to provide education as they have no education time allocated to them. After a brief spell with an enthusiastic ED consultant (left during re-organisation), we have had no input from ED senior medical staff into identifying barriers to donation in ED.

4. Conclusion/Recommendation

4.1 ESHT critical care and theatres have a good working knowledge of organ donation and have delivered excellent care to donors and their families.

4.2 We need to keep up with 100% referral rate to SN-OD for all potential donors. This requires:

- Education – NICE CG135 /UKDEC 2011
- Working staff handover form in ICU (see 3.1.5)
- Using a Standard operating procedure for all EOLC/organ donation

4.3 We need to aim 100% Neurological testing

- Consultant and Trainee education
- TROD role

4.4 ODC required a chairperson – would be beneficial to have someone from Trust Board. Otherwise I have a ODC member who could step up to this role.

4.5 Our publicity team needs volunteer contracts so they can more easily claim back expenses, as well as have easier parking and identity badges

4.6 Finance – please can we have a named person and transparent accounting of the organ donation finances as well as a clear pathway to authorise monies for expenses and equipment/ education which is agreed by the organ donation committee.

4.7 We need a named senior ED staff member to identify barriers to donation and work with the ODC to improve donation potential in ED.

4.8 Improve Tissue Donation in all clinical areas – this will need a separate sub group led by medical / nursing staff on the wards.

4.9 Organ donation is improving in this Trust. We are very proactive in critical care areas and theatre to facilitating and supporting donors and their families though the donation process. Further education and inclusion of donation into everyday activity will make donation more usual and improve the staffs' experience of donation. ODC can help with education and publicity as well as providing financial help to improve patient experience in critical care, theatres and potentially ED areas.

Name of Author **Dr Tuhin Goswami**
Title of Author **Consultant Anaesthetist**
Clinical Lead for Organ Donation

Date **20 September 2016**

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EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 25 January 2017 at 9am – 11.30am, in The Committee Room, Conquest

Present

Mr Barry Nealon, Non-Executive Director (Chair)
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Mr Jonathan Reid, Director of Finance
Mrs Joe Chadwick-Bell, Chief Operating Officer
Mrs Lynette Wells, Director of Corporate Affairs
Miss Tracey Rose, Associate Director of Planning & Business Development (representing Catherine Ashton)

In attendance

Mr Philip Astell, Deputy Director of Finance
Mr Chris Hodgson, Associate Director for Estates & Facilities
Miss Chris Kyprianou, PA to the Director of Finance, (minutes)

001/17	**Welcome and Apologies** Mr Nealon opened the meeting by welcoming members to the Finance & Investment Committee and recording his congratulations to Dr Bull, the Executive Team and all the staff for the CQC report which showed that the Trust resources were being put good use and that the outcome for patients was improving. Apologies were received from Dr Adrian Bull.	**Action**
002/17	**Minutes of Meeting of 21 December 2016** The minutes of the meeting held on 21 December 2016 were agreed as an accurate record.	
003/17	**Matters Arising/Action Log** (i) Financial Recovery Plan It was noted that a full establishment review was being undertaken as part of the budget setting process. (ii) EBITDA Quarterly Report Mr Reid reported that Mrs Brandt had been engaged in a round of deep dive reviews covering around 30 specialties in partnership with	

	colleagues from strategy over the next few months and was producing information packs to support each of those. At an aggregate level, she has pulled together some of the information that was seen by the Finance & Investment Committee and some more updated information based on reference cost analysis which was being used for budget setting discussions. It was agreed that it would be useful to undertake a deep dive on the top 5 areas so that they could be analysed in a greater depth. <u>(iii) Commercial Strategy and Market Developments (MSK)</u> A paper around the financial propositions was discussed under minute item 012/17 below. <u>(iv) Laundry Service</u> An update on the future provision of the Laundry Service was provided under minute item 014/17 below.	**JB**
004/17	**Integrated Performance Report/Finance Report - Month 9** Mr Reid presented the month 9 finance report and highlighted the key issues. The full month 9 Integrated Performance Report was not ready to be shared with the Committee at this stage. The Committee noted that the Trust performance at month 9 was a run-rate deficit of £3.2m with an adverse variance against the original plan of £0.09m. Year to date the deficit stood at £36.0m, which was £8.8m worse than plan. Performance in the month represented a £1.2m adverse variance against the Financial Recovery Plan. A revised forecast had been submitted to NHSI with a deficit of £43.9m against the £31.3m control total. The adverse variance of £12.6m included £7.8m shortfall on STF. Liquidity remained a significant risk. The Committee noted the risks in delivery of the revised forecast and the associated impact on liquidity It was noted that the month 9 outturn and revised forecast were discussed at the Trust Board, Executive Directors meeting, and at the Integrated Delivery Meeting with NHS Improvement. NHS Patient Income in month was £1.0m above the TDA plan, increasing the cumulative favourable variance to £5.1m. The Committee noted the main variances in performance. Mr Reid highlighted the good progress on agency expenditure which was as a result of the grip and control measures. It was noted that	

	operational colleagues working with the Temporary Workforce Team had been moving many of the external staff across to direct engagement contracts. **Action** **The Committee noted the financial performance for month 9 and the revised forecast, and noted the risks associated with the current and projected financial position and the steps being taken to mitigate those risks as far as possible**	
005/17	**Financial Recovery Plan – update** Mr Reid presented the Committee with an update on progress against the Financial recovery plan (FRP), project documentation, reporting and grip and control measures. The Trust was placed into Financial Special Measures(FSM) on 28 October 2016. This process ensures continued focus and support on improving the financial position without adverse impact on the quality of services. The Trust had developed a FRP to address an identified £16m of risk to delivery at Month 6, and this plan was, and remains, based on the operational plans of the Trust to improve patient flow and ensure continued and improved delivery of access targets. Delivery of the FRP, included the following actions: • Accelarating 'Grip and Control' measures that include Vacancy Control Panel, Non-Pay Group, Waiting List Initiative controls, agency controls and greater compliance with policies around the use of additional clinical staff and rostering; • Progressing Cultural Change – building on the existing work to improve organisational and individual understanding of the financial position, and the financial consequences of clinical and operational decisions; • Strengthening the already robust financial governance and reporting arrangements • Developing £20m of projects supported by PIDs, and delivering £16m of savings by 31/3/2017; and • Implementing strengthened programme and project management arrangements, including a refreshed Programme Management Office, new governance arrangements and weekly PMO meetings review with the key workstreams The Committee received an update on the position at month 9. The Trust has a shortfall against the FRP of £440k in the month and £742k year to date. The reported position included technical schemes that had exceeded the planned value. The latest assessment of the forecast was that the FRP will under deliver by £3.5m but this could rise to £4.5m depending on the delivery of Theatres and Patient Flow. The Committee noted the actions required to secure the FRP.	

	It was noted that the Trust would need to deliver the FRP of £16.1m to achieve the operational deficit plan of £14.7m. There was still a lot of work to be done to ensure that the FRP is delivered each month to the end of the year. Internal resources, such as PMO, were being re-prioritised to deliver in year financial benefits. Mr Reid highlighted the grip and control measures that that Trust had put in place. It was reported that the confidence in deliverability of the plan had been discussed at the Trust Board the previous day and the risks were noted. The Trust Board had given delegated authority to the Finance & Investment Committee to form a view on the full year forecast position now that the M9 financial position was finalised. The Committee reviewed the various scenarios and discussed the main areas of risk and challenge and the actions taken against each of these. The Committee felt that the likely case of £46.5m outturn deficit was aspiration but would be challenging to deliver. Some Committee members felt that 48m was the more realistic outturn but the Committee collectively agreed to approve the 46.5m forecast and maintain a careful watch on development. Mr Reid gave an update on support for the financial efficiency PMO. The Committee noted that a business case had been submitted and approved by NHS Improvement, for a scaled down external support team to support the delivery of the schemes until the end of February. The Committee were in support of this proposal. External senior PMO support had been sought from an individual with significant experience as a PMO Programme Manager and had previously worked at a Trust in FSM. He started with the Trust on 16 January 2017. The Executive Directors will continue to monitor and support delivery of the FRP throughout January, through the PMO. Pipeline schemes will continue to be developed and NHS Improvement will continue to observe a number of Trust meetings. **Action** **The Committee noted the progress on the financial recovery plan, and the importance of delivering the schemes in full.**	
006/17	**Contracts – Monthly Report** Mr Reid presented the Committee with an update on the arrangements for managing contract income in 2016/17, performance to month 9 and the forecast for the full year. The report highlighted the key risks and opportunities and described steps being taken to mitigate the risks.	

	It was noted that the Trust had set an ambitious income plan for the year and at month 9 remained ahead of plan. Levels of activity growth in the year to date were significant and the Trust expected this to be reflected in income performance, both against the commissioners (CCG & NHSE) contract values and plan. In addition to this there were a number of schemes which had been identified in the work the Trust had undertaken along with PA Consulting. **Action** **The Committee noted the current position regarding NHS income and the steps being taken to ensure the best outcome for the year.**	
007/17	**Cash flow – Monthly Report** Mr Reid presented the Committee with an update on the cash flow position for the Trust. At month 9 a revised income and expenditure forecast had been declared to NHS Improvement. The update presented was based on a projected net deficit for the year of £43.9m, although consideration was also give to the implications of the outturn being worse than that projected. It was predicted, in previous reports, that the liquidity position would reach critical levels without additional financing in excess of the agreed £31.3m working capital facility. In response to this, an application for 'exceptional working capital' had been made and a total of £8.9m was agreed by NHS Improvement and the Department and Health. The Committee noted that a number of risks, opportunities and mitigations had been identified and the position was kept under constant scrutiny. The Trust's latest monthly cash flow forecast was summarised in two scenarios, showing movements for month 9 and the position for the year to date. In Scenario 1 it was assumed that the revised forecast will enable the Trust to apply for an additional working capital facility for the difference between the £31.3m deficit control total and £43.9m i.e. an extra £12.6m. It is further assumed in this scenario that the additional funding will be drawn as cash during February and March. In Scenario 2 it was assumed that no additional working capital facility will be made available, significantly worsening the outlook for liquidity. Based on these assumptions, Scenario 1 showed a favourable impact	

	on the forecast creditor balances to the end of February. The Trust will seek confirmation from NHS Improvement that £12.6m of additional cash funding will be made available and, if so, the process to be followed. The pace of this will be critical due to the need for cash to pay suppliers in February. The Committee acknowledged that £13m additional cash funding does not get the Trust to a compliant situation. Mr Reid reported that the Trust was managing to maintain relationships with suppliers with ongoing dialogue, and he gave an update on Supplier engagement meetings that were taking place. It was noted that NHS Improvement were meeting with the Finance team later in the week to review the cash position and forecast. **The Committee noted the ongoing management of cash and capital within the Trust.**	
008/17	**Capital Programme Quarterly Report** The Committee received an update on the position of the Capital Programme and noted that this remains a challenge. At the end of Q3, the year to date capital expenditure incurred amounts to £8.2m and the programme had an over planning margin of £0.4m. The programme currently forecast expenditure of £12.3m which exceeded the available resource. A review of the schemes was on-going to ensure that the programme was controlled, the risk mitigated and the programme delivered as planned. It was noted that the team were doing a good job trying to manage this on constrained budgets. Mr Reid reported that there a couple of applications had gone in for extensions to ambulatory care. **Action** **The Committee noted the current performance of the capital programme and the risks associated with limited capital.**	
009/17	**Budget Setting 2017/18** Mr Reid presented the Committee with a paper giving assurance on the budget setting process. The Committee received information on the key timeframes, the progress so far and the next steps to complete 2017/18 budget	

	setting process. Mr Reid stressed that this was a financially driven plan but it would need three months of engagement so that any assumptions within it were realistic. Although led by finance, the detailed service planning would be led by Clinical Division leads with appropriate clinical input and support from the knowledge management team and HR. The sign off of plans is key to ensure they were owned by the project leads and, as such, are more likely to be successful in delivery of the financial control total. **Action** **The Committee noted the approach to budget setting 2017/18**	
010/17	**Business Planning Update 2017-19** The Committee received a report setting out the approach and timetable for the business planning process. The report had been discussed by the Trust Board at its meeting on 24 January 2017. Mr Reid reported that Tracey Rose, Associate Director of Planning & Business Development, who had only been with the Trust for a month, was very embedded and had been enormously supportive and was working with in partnership with Finance and HR. The Trust should see a more integrated approach as it moves towards the final business plan. **Action** **The Committee noted the process and the dates that had been designated for updates and decisions, and approved the Operational Plan submitted to NHSI on the 23 December 2016.**	
011/17	**Sussex and East Surrey STP and East Sussex Better Together** Mr Reid provided the Committee with an update on STP and East Sussex Better together (ESBT). It was noted that The Trust continues to work within the Sussex and East Surrey STP footprint, participating in key workstreams. The STP financial plan was submitted in December 2016, and a further submission was anticipated in February 2017. The STP financial gap remains challenging, and the Programme Board has agreed a refreshed set of workstreams aimed at bridging the gap. The Committee received a copy of the latest report to the STP Programme The position in ESBT, reflecting a differential between Trust and CCG	

	assumptions, was echoed across the STP. The Committee received a paper highlighting the differences in planning assumptions across each of the key localities. Mr Reid reported that a new acute alignment workstream within the STP had commenced. The Committee received the scope and key outputs for the STP and noted that this will be a key opportunity for the Trust. Within the STP, the Trust continues to work within the emergent accountable care system framework, with the Alliance Executive who will secure delivery of the ESBT plan once agreed. The ESBT Financial Plan remains challenging, with an overarching savings requirement of £56m across £890m expenditure. For the Trust and system partners, the impact of the £56m would lead to a challenge in delivering the system control total, which comprises the Trust's control total, the CCG control and the local authority budget allocation. ESBT representatives continue to debate the control total issue with NHSI and NHSE, aimed at securing agreement on the overarching system plan. **Action:** **The Committee noted the Sussex and East Surrey STP and ESBT update.**	
012/17	**Commercial Strategy and Market Developments** Mr Reid presented the Committee with an update on the current status of business cases and tenders. It was noted that these will be incorporated within the annual business planning process. Failure to monitor benefits realisation and key performance indicators (KPIs) or to identify opportunities for service developments which are sustainable and in line with the Trust's strategic direction and business model may have an impact on the Trust's financial recovery and impact on quality and safety. The Committee noted that Business cases and tenders are monitored by the Business Case Approvals Group (BCAG) on a fortnightly basis. The process is being reviewed and will be updated to ensure alignment with revised operational and corporate structures and incorporates the monitoring of benefits realisation and Key Performance Indicators (KPIs). Mr Reid reported that the Trust should be notified whether it had won the MSK tender by the end of January. The financial consequences of this were discussed under item 013/17 below. Mr Nealon said it would be helpful to have a better understanding on diagnostics. It was reported that Mr Rod Smith was working on the	

	Diagnostics case. There was a lot of work ongoing and the different workstreams were all being pulled together. It was noted that Mr Smith had produced a number of internal working papers and was exploring the market for large scale diagnostics partnership and would be happy to bring a paper to the next Finance & Investment Committee. **Action** **The Committee noted the update on Commercial Strategy and Market Developments.**	**JR**
013/17	**MSK Tender Update** Mr Reid presented the Committee with an update on the financial impact of the MSK paper and highlighted that there were financial and operational delivery risks associated with the contract. Strong contract management and project management support will be required to monitor the implementation and keep track of performance should the Trust be successful in winning the bid. There were also risks of not winning the tender which would need to be considered. A follow up paper may be required to review cost assumptions and update risks and mitigation once the outcome of the tender was known and detailed implementation plans were in place. The report presented assured the Committee of the approach to financial modelling, shared the understanding of the assumptions made within the bid, and described the next steps, depending on the outcome and also explained the possible risks within the contract. **Action** **The Committee noted the financial impact of the MSK tender.**	**JR**
014/17	**Future Provision of Laundry Service** A discussion took place in respect of the provision of the Laundry Service – this has been removed from the public minutes due to the commercially confidential nature of the discussion.	
015/17	**2016/17 Revised Work Programme** The Committee received the updated work programme. **Action** **The Committee noted the changes to the Work Programme.**	
016/17	**Date of Next Meeting** The next meeting will take place on Wednesday 22 February 2016 at 9am – 11.30am in St Mary's Board Room, Eastbourne DGH.	

Quality and Safety Committee

Minutes of the Quality and Safety Committee Meeting

Wednesday 23 November 2016
Bob Webster Room, EDGH

Present:
Mrs Sue Bernhauser, Chair
Mrs Jackie Churchward-Cardiff, Non- Executive Director
Mrs Alice Webster, Director of Nursing
Dr Adrian Bull, Chief Executive
Dr James Wilkinson, Assistant Medical Director, Quality
Mrs Lynette Wells, Company Secretary
Monica Green, Director HR
Mr Ashley Parrott, Associate Director of Governance
Mrs Janet Colvert, Ex-Officio Committee Member

In attendance:
Sue Allen – for Item 2.0 (Patient Story)
Millie Allen – for Item 2.0 (Patient Story)
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.

Apologies for absence were noted:

Dr David Walker, Medical Director
Mr David Clayton-Smith, Chair, ESHT
Anne Wilson, Director of Infection Prevention and Control
Miranda Kavanagh, Chair of People and Organisational Development Group
Joe Chadwick-Bell, Chief Operating Officer
Catherine Ashton, Director of Strategy

2.0 Patient Story

Millie Allen and her mother Sue attended the meeting to talk about Millie's patient experience. Millie was diagnosed with a long term condition in her mid-teens and, a few years later, was diagnosed with a serious illness from which she had recovered. Millie talked about what it had been like to be cared for as an adolescent. Much of the care had been very good, particularly at ESHT. The paediatric service had been excellent and she had particularly appreciated the care and concern shown to her mother by all staff on the ward, at what was a very stressful time for the whole family,

Millie had experienced 'misbelief' at another Trust and had felt that she had been 'talked down to'. She felt that due to her age, (and in some cases her gender) symptoms had not been taken seriously soon enough. It had led to her feeling that Trust staff had determined 'who she was' rather than listening to what she had to say. When she reached an age

where she received adult care she had found a significant and positive difference in attitude to her. She also commended the #hellomynameis initiative.

The Committee acknowledged that it was important for young people (and older people) to be heard and to be seen as a person and not a representation of an age group. It was noted that Millie had spoken at other events, advocating for young people. The Committee thanked Millie for taking the time to share her and family's story.

3.0 **Minutes of the Previous Meeting**

The minutes of the 21 September 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 31 – In the absence of a Trust preferred rating the action plan would continue to use the BRAG rating. Action completed. Agreed to close.
QSC 34 – Confirmed that 'lack of stability' related to the use of long term locums. This had now been reworded. Action Completed. Agreed to close.
QSC 35 – Alice Webster confirmed that the pneumatic tubes had a known issue of occasional failure. This was on the risk register and being monitored but it was not something that could be solved due to the age of the equipment. Ward staff were aware and incidents were being recorded appropriately. The score related to the risk of ward staff not noticing a failure in the system. Action completed. Agreed to close.
QSC 36 – Alice Webster confirmed that accessibility issues regarding toilets and car parking had been referred to the Estates Team. The team had been asked to talk to those affected. Action completed. Agreed to close.
QSC 38 – Document circulated. Action Completed. Agreed to close.
QSC 39 – Amendments made, action completed. Agreed to close.
QSC 40 to QSC 45 – Actions completed. Agreed to close.
QSC 46 – A statement had been added to the Annual Report stating that the recommendations from the report would be incorporated into the Infection Prevention and Control Annual Programme of Work for 2016/17 with key performance indicators. Action completed. Agreed to close.
QSC 47 – Agreed to close. The Chair advised the Committee that the Never Event report due to be circulated after the 21 September meeting had been subsumed into a formal Never Event report and presented to the Patient Safety and Quality Group on 31 October. This report would be forwarded to members for confirmation that the format and content provided assurance to the Committee.

Action – Karen Salt to forward Never Event Learning Report – Closing the Loop to members to confirm that the format and content provided assurance to the Committee through the Patient Safety and Quality Group.

QSC 50 – Report received and action complete. Agreed to close.
QSC 51 – Item on the agenda of 23 November 2016 meeting. Agreed to close.
QSC 52 – Invitation issued, Action completed. Agreed to close.

The Chair noted the following:

- Matt Hardwick, Hospital Director had been unable to join the meeting but had submitted an interim report on Urgent Care. The topic would be fully discussed at the scheduled Deep Dive in January 2017.
- Due to a change in Committee dates earlier in the year the Annual Safeguarding Report had been presented to Trust Board without confirmation of comments from members of the Quality and Safety Committee. The report would be forwarded to all members for further comment before the next Trust Board meeting on 14 December 2016.

Action – Karen Salt to circulate Annual Safeguarding Report to be circulated to all members for further comment to be submitted for the next Trust Board meeting on 14 December 2016.

4.1 **High Level Risk Register**

Lynette Wells presented the report noting that the 3rd line of '**Analysis of Key Issues and Discussion Points Raised by the Report**' should read as follows:

… has reduced to 76. There are no risks scored above 20; 10 risks are scored at 20 and 6……

There were two 2 new risks:

- IT and data flow completion was being 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.

The risk register had been reviewed externally including working with HR, Estates and the IT team. Scores had been challenged and some amalgamated where there were repetitions.

- A system redesign on Datix had allowed it to align with the new structure.

Each corporate risk had been allocated to a Committee and from December each Committee would get a report of its own risks.

It was noted that the Chief Pharmacist, Simon Badcott had reported to the Audit Committee a concern over a new chemotherapy system.. It was felt that the risk was unacceptable and a plan was in place to address it. The Quality and Safety Committee would need to monitor this.
It was noted that the diabetic podiatry risk was being addressed and that one of the earlier risks (588 – backlog of plain film xrays) needed to be challenged.

4.2 **Board Assurance Framework**

Lynette Wells presented the Board Assurance Framework. Three areas remained red but Mortality and Morbidity had reduced to Amber.

There was work ongoing to ensure that the handover of patient transport to South Central Ambulance was handled effectively and the Trust had been invited to contribute to lessons learned. It was noted that the letter from the Chair of the Quality and Safety Committee, despite the lack of a reply, had helped.

The Weekly Patient Safety Summit continued to monitor incidents related to patient transport and a Serious Incident had been recorded for a breach of the 104 day cancer pathway. A failure to attend (3 missed appointments leading to a possible missed opportunity for curative treatment) had been linked to the patient transport issue and was being followed up with the CCG.

4.3 **Quality Improvement Plan**

Alice Webster presented the update noting the following key highlights:

- 8 project had been delivered and transferred into Business as Usual.
- Focus on 4 main projects, Urgent and Emergency Care Improvement Project, Mortality and Morbidity Assurance Project, End of Life Care Project and Exemplar Ward Project.
- An Expert Patient Project proposal had been presented to the Improvement Sub Committee.

Programme Gateway Assurance Project was showing red - In the absence of external support the project was being supported by Lesley Walton.
Urgent and Emergency Care Project was also showing red due to a number of Ambers rendering the project red overall.

Adrian Bull reported that work had been done to look at the issues regarding the Urgent and Emergency Care Project. There was a high level of patients presenting at A & E and although the Trust had the right strategies there were gaps in ward level processes that were impacting. There was commitment to changing the mindset – particularly in relation to discharge information.

Some of the 'Next Activities' on page 17 had already been implemented. Sock it to Sepsis was due to be rolled out to the community.

Risks were around capacity to lead on improvement and recruitment of senior clinical roles. Financial Special Measures was having an impact on this.

5.1 **Governance Quality Report**

Key highlights were:

- Floor to Board dashboard – was live and available for each Ward.

- Complaints – still a challenge but an escalation plan was in place. Surgery and Urgent Care were showing the highest numbers.
- A feedback process for patients who had made complaints had been rolled out.
- FFT – response rate was slightly up in October. Falls and Pressure Ulcers were the highest areas of concern.
- A deep dive of the 4 wards with the highest issues aimed to achieve some reductions and then move on to a further group.
- Improvement to the Serious Incident process.
- Ophthalmology was the main specialty concern for Never Events and Serious Incidents.

Jackie Churchward –Cardiff commented that the triangulation was helpful and allowed an understanding that issues were being managed. It would be useful to have oversight of where issues had been solved.

Ashley Parrott reported that a working group would be looking at admission and discharge information on one ward and would then use that template for other wards. The aim was to understand the patient experience of communications. It was noted that Cookson Devas had a positive model of phoning patients post-discharge.

5.2 **Patient Safety and Quality Group Report**

The report noted that the Group had been meeting since August 2016 with reasonable representation at each meeting. Work plans and Terms of Reference for the sub groups had been agreed.

Key points to note were:

- Ward Accreditation Programme - the ward improvement role had gone out to advert again and the new Deputy Director of Nursing would take on responsibility for this work.
- The Floor to Board dashboard was in place.
- Patient Falls – some concern over numbers.
- Root Cause Analysis and Duty of Candour training had been delivered with very good feedback.
- Consent and Clinical Record Keeping would be addressed through a newly merged group (chaired by Simon Walton) with support from the Clinical Effectiveness Team. Lynette Wells noted that it had been difficult to evidence for the CQC that Consent training had been delivered – particularly to consultants. It was agreed that the new group should look at this.

Action – Ashley Parrott to ask the Consent and Clinical Record Keeping Group to address the lack of evidence of Consent training.

- Quality Account priorities for 16/17 – the Head of Governance was following up to ensure that there were measures of improvement in place.
- It was noted that Discharge Planning would, going forward, be on the Patient Safety and Quality Group work plan.

It was noted that a Board Report regarding the Quality Account had been requested and

that patient engagement needed to be planned. It was agreed that Ashley Parrott would produce the report and given the short timeframe it would be seen by the Chair and approved as a Chair's Action.

Action - Sue Bernhauser to approve Quality Account planning report as a Chair's Action.

5.3 **External Visits and Reviews Report**

The Committee members noted the External Visits and Reviews Report with no comments.

5.4 **Urgent Care Update**

The Committee members noted the brief update paper. The Senior Responsible Officer for Urgent Care was the new Chief Operating Officer, Joe Chadwick-Bell who would be part of discussions going forward. It was noted that the paper had been to the Trust Board and a Deep Dive was scheduled for the January 2017 Quality and Safety Committee Meeting.

6.1 **Deep Dive – People and Organisational Development**

Monica Green presented the Deep Dive. The People and Organisation Development Committee had formed in March 2016 to provide assurance to the Trust Board on all workforce and organisational development issues within the Trust.

The aim was to have strategic oversight over workforce issues such as dignity at work, metrics, performance, culture and disciplinary issues. A number of sub committees reported into the Group.

The People and Organisation Development Committee had looked the following 3 levels :

National context relating to workforce issues
Workforce regional issues
Workforce issues within the Trust

The Committee had focussed on recruitment, junior doctor contracts, staff surveys, equality and diversity, and staff engagement. Organisational development policies were presented to the Committee prior to going to Trust Board.

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The Committee covered the workforce related topics that had previously been considered at the Quality and Safety Committee. It was noted that there was an overlap with quality and safety issues and the aim was to develop an integrated approach to looking at safety – triangulating those wards with high levels of trips, falls and complaints with levels of sickness and other absences or staff issues. The arrival of a new Deputy Director of Nursing would present an opportunity to work on integrated governance over workforce

and quality and safety metrics.

Ashley Parrott highlighted for the first time at the October Patient Safety and Quality Group a triangulation of Trust wide quality reports had shown that one ward, that had experienced quality and safety issues, was without a Matron. It was agreed that this kind of triangulation sat well with the Patient Safety and Quality Group. In answer to a question from Jackie Churchward-Cardiff it was confirmed that the way the organisation knew if it wasn't meeting standards was through the Patient Safety and Quality Group and into the Quality and Safety Committee.

It was noted that a recent TIAA report had gone straight to the Audit Committee without being presented to any of the other Groups. It would then be expected to go to the End of Life Steering Group, Clinical Outcomes Group and then Patient Safety and Quality Group.

Action – Alice Webster, Ashley Parrott and Lynette Wells to discuss further and ensure that there was a process for TIAA reports , where appropriate, to be owned by one of the sub-groups reporting into the Patient Safety and Quality Group so that the Quality and Safety Committee had assurance that issues were being acted upon.

Following a discussion it was agreed that there was a key link between quality, workforce and staff engagement that would be addressed by ensuring that someone sat on both Committees. It was noted that Jackie Churchward-Cardiff was a member of both Committees.

7.0 **Any Other Business**

Alice Webster reported that Healthwatch would be conducting another '24 Hours – Round the Clock' activity on 28/29 November. There would be a feedback session with a formal report issuing in due course.

Escalation Ward at EDGH – following concerns, there had been a change in management and staffing levels increased. The families concerned had been offered, but declined, care elsewhere which had been noted as reassuring in the circumstances. It was noted that there were environmental and temporary staffing issues which were being addressed and a Deputy Head of Nursing had been allocated to support.

8.0 **Terms of Reference for Sub Committees – for noting.**

Terms of reference were noted.

9.0 **Date of the Next Meeting** - 18 January 2016, Princess Alice Room, EDGH

Use of Trust Seal

Meeting information:			
Date of Meeting:	21st March 2017	Agenda Item:	18
Meeting:	Trust Board	Reporting Officer:	Lynette Wells, Director of Corporate Affairs

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

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

Executive Summary:

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

The purpose of this paper is to provide an overview of the use of the Trust Seal since the last Board meeting.

28th February 2017 – Agreement between ESHT and H Wilson Ltd for building works to take place on the crèche at EDGH.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Not applicable.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

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