EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 25th July 2017, commencing at 09:30 in the St Mark's Church Hall, Bexhill

	AGENDA		Lead:	Time:
1.	1 Chair's opening remarks 2 Apologies for absence 3 Monthly award winner(s)		Chair	0930 - 1015
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 9th May 2017	A	Chair	
4.	Matters arising	B		
5.	Quality Walks	C	Chair	
6.	Board Committee Feedback *Including F&I Committee Annual Review of Effectiveness*	D	Comm Chairs	
7.	Board Assurance Framework	E	DCA	
8.	Chief Executive's Report	F	CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
9.	Quality Special Measures Update	Assurance	G	DCA	1015 - 1130
10.	Integrated Performance Report Month 2 (May) 1. Quality & Safety 2. Access & Responsiveness 3. Finance 4. Sustainability 5. Leadership & Culture	Assurance	H	DN/MD COO HRD DF	

STRATEGY

					Time:
11.	Financial Special Measures Update	Assurance	I	DF	1145 - 1230
12.	ESBT Alliance Options Appraisal	Decision	J	CEO	

13	Proposed STP governance and leadership model for system wide transformation	Decision	K	CEO	

GOVERNANCE AND ASSURANCE

					Time:
14.	Annual Reports: 14.1 WRES 14.2 Organ Donation 14.3 Complaints	Assurance	L	Various	1230 - 1315
15.	Nursing and Medical Revalidation	Assurance	M	MD	
16.	Board sub-committee minutes: 16.1 Audit Committee 16.2 Finance & Investment Committee 16.3 People and Organisational Development Committee 16.4 Quality & Safety Committee	Assurance	N	Comm Chairs	

ITEMS FOR INFORMATION

				Time:
17.	Questions from members of the public (15 minutes maximum)		Chair	1315 - 1330
18.	Date of Next Meeting: Tuesday 26th September 2017, Hastings Centre		Chair	

David Clayton-Smith

David Clayton-Smith

Chairman

27th June 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, 9th May 2017 at 09:30 in the St Mary's Boardroom, EDGH.

Present:
Mr David Clayton-Smith, 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
Dr David Walker, Medical Director
Mrs Alice Webster, Director of Nursing
Mrs Lynette Wells, Director of Corporate Affairs
Mr Ian Miller, Financial Improvement Director

In attendance:
Miss Jan Humber, Joint Staff Committee Chair
Dr Waleed Yousef, Consultant Gynaecologist (for item 045/2017 only)
Mr Pete Palmer, Assistant Company Secretary (minutes)

Welcome and Apologies for Absence

036/2017 Chair's Opening Remarks

Mr Clayton-Smith welcomed everyone to the meeting of the Trust Board held in public.

He noted that from midnight on Saturday 22nd April, the Trust had entered the formal pre-election period which meant that there were specific restrictions on the activity of civil servants. The NHS customarily followed these same restrictions and applied caution with external communications with the guidance preventing announcements and activities that could influence or be seen to influence the election. There were no significant announcements planned by the Trust that would be affected by pre-election period.

He welcomed Ian Miller to his first Board meeting in public with the Trust.

Apologies for Absence

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

Barry Nealon, Vice Chairman

Monthly Award Winners

Mr Clayton-Smith reported that the monthly award winner for March was Sharon Paine who worked as a Locality Manager. She was nominated for her work in providing support to the Health Visiting Teams and to Children's Centres .

April's winner was the EDGH Health Records Department Clinic Prep team who won for continuing to provide a full service to outpatient clinics while undergoing a major office move partway through a week.

037/2017 **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.

038/2017 **Minutes**
The minutes of the Trust Board meeting held on 21st March 2017 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.

039/2017 **Matters Arising**
The matters arising from March's meeting were noted.

040/2017 **Feedback from Quality Walks**
Mr Stevens reported that he had recently undertaken a number of quality walks and had been warmly welcomed during all his visits. He had found safety huddles to be used well in all areas. The environments on Pevensey ward and in pathology had been excellent but he had found issues with lack of space on the Cardiac Care Unit. Staff had reported improved nursing recruitment in all areas but consultant recruitment, particularly in pathology, was still a concern.

Dr Bull explained that recruiting histopathology consultants to the Trust was difficult as they often preferred to work within large departments that would allow them to specialise and to undertake research. The histopathology clinical lead was exploring how specialisation could be offered within the Trust

Mr Stevens reported that the pathology teams had raised concerns about point of care pathology testing. Tests that could more appropriately be undertaken within the pathology department were being

undertaken on wards which incurred additional expense for the Trust.

The Board noted the feedback on Quality Walks.

041/2017 **Board Committees Feedback**

Audit Committee
Mr Stevens reported that the Trust's new external auditors, Grant Thornton, would shortly begin working for the Trust.

Finance and Investment Committee
Mr Clayton-Smith reported that he had chaired April's Finance and Investment Committee meeting on behalf of Mr Nealon. The Trust expected to report a deficit of £46.5million for 2016/17. A control deficit of £36.5m had been agreed for 2017/18 and plans were being developed to meet this target.

People and Organisational Development Committee
Ms Kavanagh explained that following the GMC's visit to the Trust it had been agreed that a Trust junior doctors' strategy would be developed. The importance of ensuring that the Committee received appropriate assurances about workforce statistics and performance had been discussed.

Mr Clayton-Smith praised the work that was being undertaken by the Trust's Committees, and asked if the POD Committee was becoming more established. Ms Kavanagh replied that she was pleased to see the difference the Committee was starting to make within the organisation.

Mrs Churchward-Cardiff asked what role POD would take in ensuring that the Trust's medical rotas were compatible with junior doctors' working hours under their new contracts. Dr Bull reported that an oversight group for all medical rotas was being established, with Terms of Reference completed and membership being established. The Trust was committed to moving all medical rostering onto an electronic system which should improve both the visibility and management of rotas within the organisation.

Quality and Safety Committee
Mrs Bernhauser reported that she had recently attended Trust meetings that fed into the Quality and Safety Committee and was assured that the governance of those meetings was robust and that concerns and information were being appropriately raised to the Committee.

The Board noted the Committee Reports.

042/2017 **Board Assurance Framework**

Mrs Wells explained that the risk that had previously been on the register concerning A&E and patient flow had been separated into two different items for clarity, both rated as red. Assurance around patient transport services had increased as an improved service was being provided by South Central Ambulance Service. The service was being carefully monitored and she proposed that the risk be reduced to an amber rating.

She explained that no update on the assessment of young people with mental health issues was included within report, but that a significant amount of work had been undertaken with Sussex Partnership Trust on the issue and an update would be provided at the next meeting.

Mrs Wells proposed that two items were removed from the Board Assurance Framework (BAF). The first related to the tracking of health records and the formation of temporary notes. Health records tracking using iFIT was now embedded within the organisation and had become business as usual, although additional improvements were expected. The risk concerning reception and outpatients had now moved to business as usual.

She noted that the BAF contained two similar recruitment risks and proposed that these were amalgamated as the actions were the same for both.

Ms Kavanagh reported that she had recently visited the Health Records department where an issue with the electronic storage of community medical records had been mentioned. Dr Bull explained that the issue affected a small proportion of community notes, with many now available in fully electronic form using SystmOne. Some community areas still kept paper notes, and available storage for these was limited. An electronic solution to storing the records was being looked at, while the physical records were due to be moved to appropriate storage within a week. He explained that the risk relating to health records on the BAF concerned the state of long standing clinical notes, and the difficulties of tracking these through the system. The physical quality of the notes posed no risk to patient care.

Mrs Churchward-Cardiff asked for an update on item 2.1.5 concerning community paediatricians as the latest information on the BAF was from January 2017. Dr Bull reported that an associate specialist had been appointed to the team, but that no appointment had been made to a consultant post. The service was being covered by two locums, who had recently moved to the Trust bank, and Dr Bull was optimistic that permanent appointments would be made in the future.

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. They agreed to the removal of the risks associated with

health records and reception/outpatients and to the amalgamation of the two similar risks concerning recruitment.

043/2017 **Chief Executive's Report**

Dr Bull noted that this was the first Board meeting of the 2017/18 financial year. The previous year had seen the Trust receive an improved CQC rating of 'Requires Improvement' following inspection and other external reviews of the organisation confirmed continued improvement. A key challenge remained in meeting the four hour A&E standard, which had seen a comprehensive range of improvements introduced across the system resulting in improving performance.

The Trust continued to support junior doctors with the implementation of their new contract and Guardians of Safe Working Hours had been appointed within the Trust. A ward improvement programme had formed a consistent view of what good looks like for the Trust and this was being spread systematically across the organisation, including within community settings.

Dr Bull reported that the shadow form of the Accountable Care Organisation (ACO) had been established. Discussions about the commissioning functions of the Sustainability and Transformation Plan (STP) continued with an acute services review to take place to develop an acute services strategy for the STP.

In response to a question from Mr Clayton-Smith, Mrs Webster explained that the Trust had to report all incidents on a national reporting system, and were then benchmarked against peer organisations every six months. The Trust had generally been rated within the middle quartile but was now rated as seventh in the country.

Mr Clayton-Smith asked whether the Trust budgeted for fines that might be accrued due to breaches of the new junior doctors' contract. Mr Reid explained that the fines were redistributed through leadership processes and compensated individuals effected by overworking. Dr Walker noted that the level of fines had been lowered than anticipated. Reported breaches had been helpful in highlighting areas where rota pressures existed and these were being investigated.

QUALITY, SAFETY AND PERFORMANCE

044/2017 **Integrated Performance Report Month 12 (March)**

Performance

Mrs Webster reported that incidents rated at four and five were individually investigated by the Trust. Training was being offered to staff in best practices in investigating and learning from incidents. Response rates to Friends and Family surveys had recently been much improved in inpatient areas with work continuing to improve response rates in

outpatient departments.

The number of complaints received by the Trust in March had reduced from previous months and the number of overdue complaints was only 6-7, which marked significant progress. The average overdue period had reduced to 10 days and Divisions had made a huge effort to improve their responses to complaints.

Dr Bull said that he would like to see numbers of compliments and commendations included within performance reporting and Mrs Webster explained that a process was being developed to enable Divisions to report plaudits.

Dr Walker reported that the Trust had seen increased mortality rates during the winter months, but that this had reduced since February. This increase in winter mortality was recurrent and was associated with the Trust's elderly population. A mini flu epidemic in Hastings had led to additional flu related deaths.

Mr Miller noted that patient safety indicators leading to harm or death showed recent improvement and asked why the yearly rating had not changed. Mrs Webster explained that this related to any incident rated four or five where a patient may have come to harm, noting that all incidents were investigated individually.

Mr Miller noted that red rated areas on the safety thermometer had increased during February. Mrs Webster explained that one of the contributing factors to this was the way that pressure ulcers were reported, as these were counted against the Trust whether they were acquired by patients outside or within the Trust.

Access

Mrs Chadwick-Bell reported that the Trust had had improved performance to 80.7% against the four hour A&E target during March, with improvement sustained during April. Performance of 85% had been achieved the previous week. The average length of stay for patients had reduced as had the number of patients who had stayed in hospital for more than seven days, resulting in improved patient flow.

A mapping exercise would be taking place to ensure that patient flow data accurately reflected what was taking place within the Trust. Discharge improvements and the tracking of referrals into social care were being focussed on. Any delays to discharges were now being escalated to a hospital director to ensure high level management of incidents.

Mrs Chadwick-Bell reported that the Trust had been successful with a bid for capital to extend A&E at EDGH and to redesign the front of A&E at the Conquest which would allow for GPs to be present within the departments on both sites. It was hoped that GPs would be present in

the departments for 12 hours a day, seven days a week from October 2017 and would relieve pressure on the A&E departments. A visit from the Emergency Care Intensive Support Programme to the Trust's A&E departments the previous week had led to very positive initial feedback received.

The Trust's Referral to Treatment (RTT) performance continued to improve and had resulted in the Trust's best performance for almost a year. The Trust's backlog of patients who had waited for over 18 weeks for treatment had reduced to its lowest level since April 2016.

Diagnostic targets had not been achieved during March due to issues with radiology capacity and equipment, which would be targeted. The Trust had seen an increase in referrals of 12.4% from the previous year, an additional 2,500 patients, which was impacting on 18 week performance. Some specialities had seen a 50% increase in referrals and work was being undertaken with the CCGs about the increases.

Mrs Chadwick-Bell noted that data around cancelled outpatient clinics was incorrectly presented within the report and that this would be rectified.

Mr Clayton-Smith asked whether there were difference in A&E performance between EDGH and the Conquest. Mrs Chadwick-Bell explained that daily differences in attendance could be up to 10%, but that these had evened out to less than 1% difference over the course of each month. Dr Bull noted the daily fluctuations allowed the Trust to clearly identify the reasons for reduced performance on particular days.

Mr Stevens expressed concern that having a GP with the A&E departments might encourage patients to attend purely to see the GP. Mrs Chadwick-Bell explained that the CCG would be commissioning and paying for the GP service within A&E and that appropriate patient pathways would be developed to safely manage patients attending with primary care needs.

Mrs Churchward-Cardiff asked why the Trust's performance in carrying out an initial assessment within A&E had deteriorated since November. Mrs Chadwick -Bell explained that a lack of substantive staff and junior doctors had contributed to the drop in performance, but noted that she thought that the data may not be accurate and that this was being verified.

In response to a question from Mrs Churchward-Cardiff, Mrs Chadwick–Bell reported that the Trust aimed to cancel less than 20% of outpatient clinics at short notice. Dr Bull explained that a lot of the reported cancellations were as a result of departmental processes for approving leave or late cancellations by locums.

Mrs Churchward-Cardiff asked whether feedback had been received

following the trial of placing GPs in the A&E departments during the Easter bank holiday weekend. Mrs Chadwick-Bell explained the GPs had reported that they could have seen a greater number of patients and that criteria for patients who could be seen by the GPs would be reviewed as a result. The GP model being introduced was nationally mandated and patients would be triaged by a senior nurse before being seen by a GP, an Emergency Nurse Practitioner or treated as a major case.

Mrs Churchward-Cardiff asked about the figures for colorectal breaches, noting that patient numbers were very low, with a high rate of breaches. Dr Bull explained that every breach was reviewed with divisions at IPR meetings, and that the colorectal figures related to just two patients.

Mr Miller asked for information about the potential of Sustainability and Transformation Fund (STF) investment. Mr Reid reported that the STF regime had been simplified for 2017/18. 30% of funding, equal to about £3million a year, would be based on the delivery of the 95% A&E standards and discussions were being held to agree a trajectory for realising this funding.

Finance

Mr Reid reported that the Trust's final position for 2016/17 had been a £46.5 million deficit, a figure which excluded STF funding and that was £8million adrift from the control total agreed at the start of year. He noted that the total was significantly improved from the £57million risk that had been identified during month 6 and 7and was also an improvement on the £48million deficit recorded in 2015/16. He explained that the Trust's monthly run rate had reduced from £6million to £4.3million and agency spending had also reduced but remained above the NHSI cap.

Mr Reid reported that a significant difference remained between the positon of the Trust and the CCG around the timing of paying invoices at the end of the financial year and explained that this was being addressed in a professional manner. An audit of the end of year accounts was being undertaken.

2018/19 was expected to be a very challenging year financially and the Trust would continue to build upon the excellent foundations from 2017/18. The Trust was hoping to achieve £28.7milllion in efficiency savings during 2018/19. Lord Carter work indicated that there should be efficiency opportunities of over £40million for the organisation, but these would need to be managed carefully in order for the full benefit to be realised. Plans for realising the full £28.7million were being finalised and trajectories for the year would be produced once schemes had been fully identified.

Significant process had been made during the previous months in identifying processes that drove overspending within the organisation.

No vacancy freeze had been implemented but all requests to fill vacancies were being thoroughly tested to ensure they were necessary.

Mr Reid reported that £27million of savings would have to be realised across the local health economy by East Sussex Better Together (ESBT) and that these plans might have an additional impact on the Trust. ESBT's financial plans were being developed in partnership in order to manage the collective financial challenge in a co-ordinated fashion.

Mr Miller explained that a month to month plan had been agreed for meeting the £36.5million deficit which, if achieved, should lead to the Trust leaving Financial Special Measures. A reduction of spending from £4.3million to £3million a month was needed to meet the target and he noted the importance of continuing to question spending at all levels to ensure that the target was met as quickly as possible.

Workforce
Miss Green reported that a key issue for the organisation was the recruitment of staff. There had been recent improvements, and further initiatives were being developed including looking at recruitment from overseas and the redesign of some roles to make them more attractive. A successful rolling programme of nurse recruitment had been introduced and plans for identifying the recruitment needs of divisions and new roles that could support these were being developed.

An ongoing trend of staff recommending the Trust as a place to work and have treatment was being seen through staff Family and Friend testing. A downward trend in appraisal rates had been identified and was being discussed with each division during IPRs in order to understand and improve the position. A reduction in sickness had been reported.

Mr Stevens asked how effective the Trust's exit interview processes were. Miss Green reported that work was being undertaken with divisions about when and how the exit interviews occurred. Dr Bull reported that online exit interviews had been introduced, but that staff take up had not been as good as had been hoped. He explained that exit interviews represented a very important opportunity for learning for the Trust and that work would continue to improve them.

The Board noted the IPR Report for Month 12.

045/2017 **Guardian of Safe Working Hours Report**

Dr Youseff reported that the new junior doctors contract had been introduced in October 2016, with new terms and conditions for Trusts and that by October 2017 all junior doctors would be on the new contract. Two Guardians of Safe Working Hours (GOSWH) had been appointed by the Trust with a junior doctors' forum established.

Junior doctors reported any hours worked in excess of their rotas, which may occur due to emergencies or the volume of their workload. These were reported to educational supervisors with junior doctors receiving either time in lieu or payment for the additional work. Exceptions to junior doctors working for more than 48 hours a week were also reported with departments being fined if this took place.

Dr Youseff explained that exception reporting had increased greatly in February and had included backdated incidents. By April the number of reports had greatly reduced reflecting the introduction of improved rotas and processes. Meetings had been held with areas where issues had been consistently reported, and large improvements were being realised in many areas. Six additional A&E junior doctor posts had been approved which had further reduced exception reporting. Excellent support had been received from both the Medical Director and the Chief Executive in resolving identified issues.

Dr Walker thanked the GOSWH for their hard work, noting that the improvements that were being realised were already clear. He explained that orthogeriatrics had been identified as a problematic area and a meeting was being arranged in order to provide junior doctors with support. The changes made within the A&E departments represented a big success story for the new system.

Mrs Chadwick-Bell explained the while the A&E rota had improved, the changes had impacted on the availability of junior doctors within the department. This had led to the need for locums to cover overnight gaps in the rota. Dr Youseff noted that the new contract had led to a change in shift patterns which were no longer staggered. Junior doctors numbers on the rota had been increased in order to address the issue, but one or two additional junior doctors were still needed in A&E at the Conquest.

Dr Bull noted that the new contract placed an onus on the Trust to comply with contract requirements. The decision to change shift patterns within A&E in order to comply with contract requirements had not sufficiently considered the organisational impact and a medical rota oversight group had been established to ensure that any future changes were reviewed appropriately.

Mrs Churchward-Cardiff asked about the impact of rotaing junior doctors for 46-47 hours a week, close to the 48 hour limit. Dr Youseff explained that rotas shouldn't exceed 45-46 hours so that small amounts of

additional work could be undertaken without accruing fines.

The Board noted the Guardian of Safe Working Hours Report.

STRATEGY

046/2017 **ESBT Update**

Ms Ashton provided an update on ESBT progress, noting that the paper being presented had previously been seen by the Board at their seminar in April. An Accountable Care Group was looking at potential models to establish the appropriate form that the Accountable Care Organisation (ACO) should take for East Sussex. All of the Alliance's partner organisations would be involved in the decision making process, and the Trust's Board would be involved in ensuring the final decision was correct for ESHT. She expected a proposal to be presented to the Board in July.

Dr Bull explained that ESBT was developing joint working across social services, primary and secondary care and integrated locality teams. Relationships with local authorities and with social services were constructive and well developed. ESBT was also looking at the consequences of investing in social services within the entire system and was developing views about the most appropriate ways to invest, recognising that the right answer for the system was to develop care in the community and therefore reduce demand on hospitals.

Ms Kavanagh asked how plans were being communicated to the wider organisation to ensure that staff understood what was taking place, and that managers could articulate why the changes were important. Dr Bull explained that the Trust's initial communication had been through leadership conversations with information included within team briefs for staff. A program of events would take place, starting in June, to provide staff with more opportunities to become involved. Dr Bull noted that staff in integrated locality teams were very positive about the changes, while many hospital staff would see only a small impact from the changes.

The Board noted the update on ESBT.

047/2017 **Quality and Safety Strategy**

Mrs Webster reported that the paper being presented had previously been reviewed by the Quality and Safety Committee and the Patient Safety and Quality Group. The Quality and Safety Committee would review the strategy on an annual basis to ensure that was effective and in line with other Trust strategies.

The Board approved the Quality and Safety Strategy and that it would be monitored annually by the Quality and Safety Committee.

048/2017 **Organisational Development Strategy**

Miss Green noted that the Organisational Development strategy was an overarching Trust document, linked to the values and strategy of Trust. It comprised two parts: the Leadership and Talent Management Strategy and the Workforce Strategy which had previously been approved by the Board.

Mr Clayton-Smith asked how the strategy would act as an inspiration for staff that could make the Trust a more modern and attractive place to work, rather than becoming a management document. Miss Green explained that the delivery of the strategy would be key to inspiring staff.

Mrs Churchward-Cardiff noted the importance of ensuring that staff continued to be given the freedom to undertake their roles in an accountable manner, especially during difficult financial periods. Dr Bull agreed, emphasising that decisions within the Trust were not being made on a purely financial basis but that appropriate checks and controls were being introduced to ensure that staff with budgets knew what they were, could manage their budget and were held accountable.

Miss Humber welcomed the strategy and agreed that staff needed to be supported in progressing through the organisation.

The Board approved the Organisational Development Strategy.

049/2017 **Leadership and Talent Management Strategy**

Miss Green explained that the strategy set out how staff would be taught the skills they needed to undertake their jobs and how they would be supported in doing this. It would develop staff skills at all different levels across the organisation and set out options for career development.

Dr Walker said that he was pleased with the strategy and hoped that it would be embraced by the Trust's consultant body as it would lead to improvements across the organisation. He noted the importance of identifying junior doctors within the Trust who could benefit from leadership development. Mrs Bernhauser suggested that junior doctors could be invited to attend Board Committees as development opportunities.

The Board approved the Leadership and Talent Management Strategy.

050/2017 **Delegation of approval of Annual Report and Accounts 2016/17 and Draft Quality Account 2016/17**

Mrs Wells sought approval for the Audit Committee to approve the Annual Report and Accounts and the Quality Account, and for Dr Bull to be given delegated authority to sign off the documents which would be received by Board at the AGM in September.

Mr Reid sought approval for delegated authority for the Trust's auditors to issue a section 33 referral for Trusts in Financial Special Measures concerning the statutory duty to break even one year after another.

The Board delegated authority to the Audit Committee to approve, and to Dr Bull to sign, the Annual Accounts and Annual Report.

051/2017 **Board Sub-Committee Minutes**

i) Audit Committee

Mrs Churchward-Cardiff asked for an update on the purchase of software needed to undertake the National Diabetes Audit. Mr Reid explained that funding for the software had been identified, and discussions about which software package was most appropriate were taking place. He explained that a definitive decision should be presented at the next Audit Committee meeting. Mrs Bernhauser noted her concern about the reputational damage that the lack of resolution of the longstanding issue was causing. Dr Bull agreed to discuss the matter further with during the Medicine Division's IPR the following week.

The Audit Committee Minutes were noted

ii) Finance and Investment Committee

The Finance and Investment Committee Minutes were noted

iii) People and Organisational Development

The People and Organisational Development Committee Minutes were noted

iv) Quality and Safety

The Quality and Safety Committee Minutes were noted

ITEMS FOR INFORMATION

052/2017 **Annual Self Certification**

Mrs Wells explained that as part of their licence conditions, Foundation Trusts were required to self-certify on an annual basis. Acute Trusts were now subject to the same requirement to self-certify, with a submission deadline of 31st May. She explained that she was seeking confirmation that the Board was happy with statements of compliance, noting that a selection of Trusts would be selected for audit of their self-certification in July 2017.

Mr Clayton-Smith noted that the information had been presented very clearly and suggested that authority be delegated by the Board to himself and Dr Bull to sign off the final version of the document, allowing Board members an additional opportunity to submit comments to Mrs

Wells. Mrs Wells noted that the item would be brought before the Board at an earlier time during 2018.

The Board approved delegation to Mr Clayton-Smith and Dr Bull to sign the finalised Annual Self Certification.

053/2017 **Use of Trust Seal**
A single use of Trust seal on 5th April 2017 was noted.

054/2017 **Questions from Members of the Public**

Questions from Mr Campbell
Mr Clayton-Smith noted that Mr Campbell had submitted written questions to the Board prior to the meeting. He explained that a number of the questions would be answered outside of the meeting but three would be addressed.

Trust Executives and activities with ESBT
Dr Bull explained that the Trust's responsibility was to provide care to the people of East Sussex, and that not participating in ESBT would be of detriment to both ESHT and to patients. He acknowledged that the time spent in meetings was significant, explaining that there would continue to be some overlap between ESHT and system-wide meetings during the year.

Mr Cambell explained that he felt that ACO planning had not developed as much as he had hoped it would have done by this point in the test bed year. Dr Bull explained that he expected the shadow year to last for longer than a year, but hoped that this additional time would lead to the production of fully developed ACO plans.

Mr Cambell explained that he felt that Board members should work towards removing gaps in accountable care processes that effected patient care during their work with ESBT.

Public Accountability for Alliance
Mr Clayton-Smith explained that the first meeting of the Alliance Governing Board was due to take place the following day with alternate meetings to be held in public. The Alliance Governing Board had Non-Executive and Lay members who would provide independent scrutiny.

He asked whether Non-Executive colleagues felt that they were fully informed about Alliance activities. Mr Stevens replied that he felt that he was regularly briefed, including through Board meetings, and didn't feel that anything was not being disclosed.

ENT Consultants
Mrs Walke asked how many ENT consultants worked at EDGH. Dr Walker replied that the ENT a cross-site service and that the Trust employed two full time consultants. A further consultant had recently

retired and would be returning to work after a six week period and an advertisement for a fourth consultant had been unsuccessfully circulated. He explained that ENT staffing was very challenged.

A&E

Mrs Walke explained that she had recently visited A&E and had got the impression that the department wasn't busy, asking why patients were not seen more swiftly for routine treatment. Mrs Chadwick-Bell noted the difficulty of replying without knowing the details of the specific day. She explained that the A&E department comprised a number of different areas, and that A&E staff worked incredibly hard to look after the most sick patients first which could cause delays to treatment of less acute patients. Dr Bull noted that each A&E department treated around 5000 patients a month.

Shaping Health

Mrs Walke reported that she had recently attended an STP 'Shaping Health' group and had been surprised that there had been no discussion about access to services.

Medical Outliers

Mrs Walke asked why the Trust had so many medical outliers. Mrs Chadwick-Bell explained that medical outliers occurred when the Trust didn't have a bed available for a medical patient on a medical ward, and they would be given a bed on a surgical ward. The Trust had between 6-30 medical outliers on any given day.

Mrs Walke noted that one of the justifications given for single siting services was the elimination of medical outliers and asked whether single siting had helped. Mrs Chadwick-Bell replied that a piece of work was being undertaken to ensure that the bed base for each speciality was correct, but that was not related to siting of services.

Leadership and Talent Management Strategy

Mr Cambell noted that the word 'patient' did not appear anywhere within the core principles in the strategy. Miss Green said that she would review this.

055/2017 **Date of Next Meeting**

Tuesday, 25th July 2017, in the Uckfield Civic Centre

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 9th May 2017 Trust Board Meeting

Agenda item	Action	Lead	Progress
There were no matters arising from the Trust Board meeting on 9th May 2017			

Quality Walks March - June 2017

Meeting information:			
Date of Meeting:	25th July 2017	Agenda Item:	5
Meeting:	Trust Board	Reporting Officer:	Sharon Gardner-Blatch

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

31 services or departments have received visits as part of the Quality Walk programme by the Executive Team between 1st March and 30th June. 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

31 services or departments were visited as part of the Quality Walk programme by the Executive Team between 1st March and 30th June 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
2 3 17	2.30pm	Ophthalmology Day unit	Bexhill	Lynette Wells
9.3.17	10am	Mortuary	Conquest	David Walker
9.3.17	10am	EME	EDGH	Miranda Kavanagh
10.3.17	3pm	IV Team	EDGH	Joe Chadwick-Bell
16.3.17	2.30pm	Community Nurses	Station Plaza	Alice Webster
18.3.17	5pm	Gardner Ward	Conquest	Sue Bernhauser
18.3.17	6pm	SAU	Conquest	Sue Bernhauser
28.3.17	3pm	Mortuary	Conquest	Jonathan Reid
30.3.17	3pm	Mortuary	EDGH	Joe Chadwick-Bell
3.4.17	4.30pm	Seaford 2	EDGH	Sue Bernhauser
4.4.17	2.30pm	Podiatry	EDGH	Alice Webster
20.4.17	12.30pm	Joint Community Rehab Team	Lewes	Jonathan Reid
21.4.17	11am	James Ward	Conquest	Jackie Churchward Cardiff
24.4.17	10am	Theatres	Conquest	David Walker
25.4.17	3pm	Irvine unit	Bexhill	Catherine Ashton
26.4.17	12.30pm	Pevensey ward	EDGH	Mike Stevens
26.4.17	1.45pm	CCU	EDGH	Mike Stevens
26.4.17	3pm	Pathology	EDGH	Mike Stevens
3.5.17	10am	Tissue Viability Nurse	EDGH	Miranda Kavanagh
3.5.17	10am	Day Surgery	Uckfield	Alice Webster
3.5.17	11am	Physio	Uckfield	Alice Webster
10.5.17	9.00am	Amberstone MSK Physio	Hailsham	Sue Bernhauser
10.5.17	10am	Milton Grange	Eastbourne	Catherine Ashton
16.5.17	2pm	Health Visitors	Centenary House	Jackie Churchward Cardiff
19.5.17	11am	Outpatients (Medical Level 2)	Conquest	Monica Green
7.6.17	11am	Firwood House	Eastbourne	Catherine Ashton
8.6.17	1.30pm	Community Dietetics	Avenue House	Jackie Churchward Cardiff
8.6.17	3pm	Podiatry	Avenue House	Jackie Churchward Cardiff
26.6.17	12.30pm	Health Visitors Lewes and Newick Team	Orchard House Lewes	Miranda Kavanagh
29.6.17	1pm	Physiotherapy	Newhaven	Jackie Churchward Cardiff
29.6.17	2.30pm	Podiatry	Newhaven	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.
Where feedback has been received this has been passed on to the relevant managers for information.

Key Themes and Observations

Communication and Engagement

- In the outpatients departments visited all the staff spoken to were very positive and well engaged, they had regular team meetings and safety huddles.
- It was clear from conversations and observations that there was good communication between the individual surgical wards and the SAU.
- Many staff reported that they attended regular briefings and were aware and updated on issues facing the Trust.
- The Locality Health Visiting and Homelessness services which are provided by small teams reported feeling that they have a very heavy workload and don't feel the service is fully appreciated. There are also long running issues with IT connectivity to their tablets which does not appear to be getting resolved.
- Community Dietetics reported that they feel they are sometimes included as an afterthought for new initiatives such as Frailty.
- The EME team were described as innovative and anticipatory of technological change.

Incidents Risks and Safety Issues

- A lack of pathologists was reported and as a result some Post Mortem's are sent to Brighton.
- It was noted that the lack of permanent committed consultant staff on the cardiac wards could prolong patient stays and risk senior oversight of care.
- The dietetics department caseloads have continually increased across all the conditions with particular pressure for babies/children. The team felt the service was more intervention than prevention as caseloads increase.
- It was observed that the Community MSK service would significantly benefit from some new up to date equipment.

Other Issues

- District Nurses reported finding it difficult to manage workloads due to the numbers of vacancies in the GP practices locally as they spend a lot of time trying to manage the 'case communication' rather than managing the case . The GP issue has been raised with the CCG
- Issues continue with mobile devices (SystmOne).
- 'Noisy ears' were noted to be in use – these alert staff when they are making too much noise and have reduced ward noise, particularly at night.
- Improvements to the environment of James Ward that was highlighted a year ago have not yet been implemented and it was noted to the credit of the ward staff that high standards are being maintained despite these challenges.
- In Health Visiting it was reported that poor housing conditions and transient and non-English speaking families considerably added to the input and number of visits required by the teams and that health visiting was seen primarily as a health promoting proactive service but due to the complexity and limited staffing it has meant most interventions were now reactive to problems.

- Staff reported concerns about the time it takes to get minor improvements undertaken and also frustrations with the vacancy approval panel with posts being authorised and then withdrawn.
- In Podiatry there is now a centralised booking system but this can make it difficult for some patients to communicate with local clinic staff, and in addition the phone system installed last year is still problematic with patients complaining of poor telephone communication, with dropped calls, non-pick up and no message service.

Staffing

- Staff reported that having the Matrons Assistants now in post was a benefit and also that the new Ward Orderly roles have had a significantly positive impact on the wards, working to a very high standard to support ward operational tasks and clinical cleans.
- In one area it was reported that there is a need for a greater number of middle grade doctors to cover the shifts especially at night.
- Some Health Visitors reported that the current staffing levels did not provide sufficient flexibility for covering absences and training and in the Dietetics service there were challenges covering Children's services and delays for hospital patient's referrals.

Patient feedback

- James ward has a very high return rate for the Friends and Family Test feedback (100%) and achieves a 98% recommendation score.
- In a community podiatry clinic visited it was noted that patients looked well cared for and that privacy and dignity was well maintained.
- In the Outpatients department patients were very positive and said staff were very helpful and welcoming.

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 convened on 31st May 2017 to sign off the annual accounts and annual report. A summary of the items discussed is outlined below and the minutes of the meeting will be presented to the Board following approval at the next Audit Committee.

2. Annual Accounts and Report 2016/17

The Trust's external auditors presented their opinion on the annual accounts and report for 2016/17. The income that was anticipated from the CCG continued to be subject of negotiation between the Trust and the CCG due to the change of contract for 2016/17 to Payment by Results.

The Trust's final deficit showed a slightly improved position in the annual accounts from £43.9million to £43.792million.

The Committee approved the Annual Accounts and Annual Report 2016/17. These will be formally received at the Trust AGM on 26th September 2017.

3. Head of Internal Audit Opinion for 2016/17

The Trust's internal auditors, TIAA, provided their annual report and opinion. The report acknowledged the positive progress made by management in the second half of the year to improve the adequacy and effectiveness of controls in many areas however, the overall Head of Internal Audit Opinion given for the year as a whole was "Limited" assurance. This was the same opinion as given for 2015/16.

Mike Stevens
Chair of Audit Committee

11th July 2017

East Sussex Healthcare NHS Trust

People & Organisational Development (POD) Committee

1. Introduction

Since the Board last met a POD Committee meeting was held on 15 June 2017. A summary of the items discussed at the meeting is set out below.

2. Review of Action tracker

Updates for outstanding actions were provided to the Committee:

- The workforce resourcing group would provide an update on the Lord Carter work for the next Committee meeting.
- Further analysis of BME recruitment would be provided to the Committee at the next meeting.
- A number of initiatives would be introduced over the coming months to improve medical engagement, including mentorship for new consultants and an in-house leadership training package for trainee doctors.

3. Terms of Reference

The updated terms of reference were reviewed and agreed subject to the following amendment:

- Junior doctor representation to be added to the membership

The Committee proposed including junior doctor representation across all Board committees and MG agreed to speak to Committee chairs in this regard.

4. Annual workplan

The POD Committee annual workplan was reviewed and approved subject to the following amendments:

- Workforce risk register to be reviewed at every meeting
- Equality reports to be received annually
- BME network feedback to be received every six months
- Purpose of Committee in conjunction with CQC well-led domain to be reviewed at the September meeting.

5. Feedback from sub-groups

The Committee received a written update from each of the sub-groups; Engagement & OD Group, Education Steering Group, Workforce Resourcing Group and HR Quality & Standards Group.

6. Recruitment

The Committee received a report on recruitment which detailed vacancy rates for each staff group and actions being taken to address recruitment hotspots. MT agreed to look into discrepancies with budgets and WTE figures quoted within the report for urgent care.

7. Medical Revalidation annual report

The Assistant Director – Revalidation was welcomed to the meeting and presented the draft Medical Revalidation annual report for 2016-17. The Committee approved the report and commended the revalidation team for all their hard work to ensure 100% compliance for doctors.

8. Nursing Revalidation annual report

The Assistant Director – Revalidation presented the draft Nursing Revalidation annual report for 2016-17. This was the first complete year of revalidation undertaken for nursing staff with 99% compliance achieved. Lessons learned had been identified and would be

taken forward for future years. The Committee approved the report and thanked the Revalidation team for their work with this.

9. Leading Excellence Programme

An update was provided to the Committee regarding the roll-out of the Leading Excellence Programme. Two cohorts would be undertaking the programme; Cohort 1 would consist of Division senior leaders, Hospital Directors and other Associate Directors, and Cohort 2: An application process would be held for Heads of Nursing, Service Managers and Specialty leads.

10. HR Incident Report 2016-17

The Committee received the HR incident report for 2016-17, which detailed numbers of cases, investigations and hearings undertaken throughout the year. A downward trend had been identified for numbers of cases raised compared to previous years and it was felt this could be attributed to the work of the speak up guardian. JCC queried whether some of the improvements in response to the CQC recommendations had been started. MT clarified that many of the improvements had been completed and the report wording would be adjusted accordingly.

Approved minutes of the meeting held on 30 March 2017 are attached for the Board's information.

Miranda Kavanagh
Chair of POD Committee

11 July 2017

Quality and Safety Committee

1. **Introduction**
   Since the Board last met a Quality & Safety Committee meeting was held on 24 May 2017 and minutes are due to be approved at the next meeting on 19 July 2017. A summary of the items discussed at the meeting is set out below.

2. **Report from Chair and Chair's Actions**
   - CQC Action Plan would be tracked through the Quality and Safety Committee.
   - Low attendance at meetings had been raised as a concern – reminders to be sent out.
   - Chair of QSC assured following attendance at a recent Patient Safety and Quality Group meeting.

3. **Patient Story**
   This involved an example of holistic care for a young inpatient who had been able to take some important exams due to the efforts of staff on the ward and in Human Resources.

4. **Board Assurance Framework**
   Seen by Trust Board due to an anomaly over meeting dates.

5. **High Level Risk Register**
   Neuraxial Safety risk had been reviewed but in the absence of an alternative device remained open. Other Trusts to be asked how they were addressing this risk.

   Justin Harris, new Radiology clinical lead to be asked to update the next meeting on issues raised in CQC report and in particular, plain film reporting backlog.

6. **CQC Progress Report**
   Recent mock inspection had highlighted many positives - a number of issues identified that would need to be addressed.

7. **ESHT 2020 Improvement Programme**
   Urgent Care on red – issues around medical staffing.
   New medical model imminent.
   Challenge regarding sepsis screening compliance on wards being addressed.

8. **Complaints Annual Report**
   Process and compliance much improved.
   Aim to improve Datix reporting.

9. **Governance Quality Report**
   Key challenges:
   - Attendance at core meetings.
   - Friends and Family Test compliance/scores in both Emergency Departments.
   - Low incident reporting from doctors.
   - Ophthalmology/Radiology – being monitored through the Patient Safety and Quality Group.
   - Assurance being sought that actions being followed up in IPRs.

10. **Quality Account 2016/17**
    Approved.

11. **Healthwatch Reports**
    Noted.

12. **Deep Dive – EOLC**
    Not presented – held over to July meeting.

Sue Bernhauser, Chair, Quality and Safety Committee
12 July 2017

Finance and Investment Committee – Annual Review of Effectiveness

Meeting information:			
Date of Meeting:	25th July 2017	Agenda Item:	6
Meeting:	Trust Board	Reporting Officer:	Barry Nealon, Committee Chair

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

It is considered good practice for every Committee of the Trust to conduct an annual self-assessment review of its effectiveness. The attached annual Finance and Investment Committee report sets out the outcome of this review which was conducted via a questionnaire to all Committee members in June 2017. The report provides an overview of the activities of the Committee and confirms how it has complied with its Terms of Reference.

The Terms of Reference are attached and remain fit for purpose, no revisions are proposed.

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

Approved by Finance and Investment Committee on 28 June 2017

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

The Board is requested to review the attached Annual Report and confirm that it is assured the Finance and Investment Committee has discharged its duties in line the Terms of Reference.

East Sussex Healthcare NHS Trust

Finance and Investment Committee - Annual Review 2016/17

1. Introduction

The purpose of this paper is to provide assurance to the Trust Board that the Finance and Investment Committee (F&I) has carried out its objectives in accordance with its Terms of Reference set by the Trust Board.

2. Authority and Duties

The F&I Committee is a sub committee of the Board with responsibility for maintaining a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. Under delegated authority from the Trust Board, the Committee determines and reviews the:

- Financial strategy for the Trust
- Future financial challenges and opportunities for the Trust
- Future financial risks of the organisation
- Integrity of the Trust's financial structure
- Effectiveness and robustness of financial planning
- Effectiveness and robustness of investment management
- Robustness of the Trust's cash investment approach
- Investment and market environment the Trust is operating in,
- Financial and strategic risk appetite that is appropriate for the organisation
- Process for business case assessments and scrutiny and the process for agreeing or dismissing investment decisions depending on the above

3. Membership

The Committee is chaired by a Non Executive Director of the Trust and has 2 Non Executive Directors as members who are appointed by the Trust Chairman. The Chief Executive, Director of Finance, Chief Operating Officer and Director of Corporate Affairs and Associate Director of Strategy are also members.

Quoracy for the meeting is 3 members of which one must be a non-executive director. The Committee met 13 times during the financial year and all meetings were quorate.

4. Annual review of terms of reference and work plan

The Committee's Terms of Reference were considered as part of the self-effectiveness review and it was agreed they remain fit for purpose. Minor

revisions were proposed; specifically that under ‘duties’ a more explicit statement be added to highlight the Committee’s role in approving the annual financial plan, tracking progress against delivery, including oversight that risks to achieving the plan are identified and appropriately mitigated.

The Annual Work Programme was set at the start of the year as a standing agenda item was reviewed at every meeting of the Committee.

Matters considered in 2016/17 included:

- Oversight of Financial Special Measures Requirements
- Reviewing monthly operational and financial performance against the Trust’s Financial Recovery Plan
- Financial and business planning
- The annual capital programme and regular updates against plan
- Reviews of all Business Cases over £250k in value
- Approval of the annual reference cost collection process
- IMT project updates
- Quarterly reviews of EBITDA (Earnings before interest, taxes, depreciation, and amortization) and a programme of regular rolling reviews of specialties with negative EBITDA
- Estates and energy planning
- Regular review of aged debtors
- Tenders and Service developments
- Procurement strategy and quarterly procurement updates
- Budget Setting Update 2017/18
-
- Business Planning Update 2017-19
- Deep dive into specific services such as cardiology and endoscopy
- Progress on Sussex and East Surrey STP and East Sussex Better Together

5. Annual Self-Assessment of Effectiveness

In June 2017 the Committee undertook an annual self-assessment of its effectiveness. Members agreed that the number of Committee meetings held had been sufficient. It was agreed that matters considered and decisions made by the Committee were taken on an informed basis and that these decisions were understood, owned and properly recorded and would bear scrutiny; subsequent implementation of decisions and progress had been reported back to the Committee although it was recognised this could be improved.

A number of Committee members felt that agendas, whilst well-structured, were full and matters could therefore be rushed. In addition, there was too much focus on operational rather than strategic matters. Greater attention to the capital spending strategy and effective utilisation of the estate were areas suggested for further review. The work plan will be review to reflect this feedback.

An effective feedback mechanism from the F&I to the Board is in place, with the minutes being received and matters highlighted by the Committee Chair at each Board meeting.

6. F&I Chair's Overview

In October 2016 the Trust was placed in Financial Special Measure by NHS Improvement. This was as a result of a significant negative variance against the Trust's financial control total plan and because of the significant deficit forecast for 2016/17. A financial recovery plan was developed and the F&I Committee closely monitored progress in delivering this.

Whilst acknowledging the scale of the financial challenge faced by the Trust, the F&I Committee have been clear in its position that all cost improvement and efficiency plans should have no adverse impact on quality or safety. The Committee received assurance that an effective quality impact assessment process was in place.

In previous years budget targets have not always been met and throughout the year the Committee sought Executive assurance that effective grip and control existed and this will continue in 2017/18 to ensure the ownership and delivery of the demanding control total.

During 2016/17 the Trust increased its involvement in East Sussex Better Together Alliance and the STP and the Committee has taken an interest in these developments. In the coming year the Alliance moved into shadow form for East Sussex, with parties entering into a formal agreement. As the transition is made to this broader remit, the Committee will monitor

progress carefully and seek assurance that this progressive integration does not detract from the commitment to meet its fiscal objectives.

On behalf of the Committee, I would like to place on record our thanks to the PA to the Finance Director, who so ably provides administrative support.

The Committee is of the opinion that it has effectively discharged its responsibilities throughout the year and that there is nothing it is aware of at this time that have not been disclosed appropriately.

Barry Nealon
Finance & Investment Committee Chairman
28 June 2017

East Sussex Healthcare NHS Trust

Finance and Investment Committee - Terms of Reference

1. Constitution

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

2. Purpose

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

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

3. Membership and attendance

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

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

4. Quorum

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

5. Frequency

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

6. Duties

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

In particular its duties include:

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

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

- Do not compromise the Standing Orders and Standing Financial Instructions
- Do not adversely affect the strategic risk facing the Trust

- Do not adversely affect the organisation's ability to deliver its operational plans

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

7. Reporting arrangements

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

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

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

December 2016

Board Assurance Framework

Meeting information:			
Date of Meeting:	25 July 2017	Agenda Item:	7
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. Following agreement at the last Board meeting two items have been removed in respect of health records and clinical administration. The following revisions are proposed:

RAG rating:
2.1.4 Increased assurance in respect of mortality from amber to green as there are effective controls in place and mortality metrics are now within expected range.

Addition:
A new gap in control has been added from the high level risk register.
2.1.8 Effective controls are required to ensure the Trust has adequate clinical and support services to provide access to 7 day services including diagnostic and consultant led interventions.

Removal:
3.3.1 There is a proposal to remove one item from the BAF regarding patient transport. The new provider is now in place and the service is operating effectively.

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

Audit Committee – 26th July 2017 Quality and Safety Committee – 19th July 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 note the increased assurance around mortality and agree the addition of the gap in control regarding seven day services and the removal of the item related to patient transport.

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 may be unable to invest in delivering and improving quality of care and patient outcomes. It could also compromise 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. May-17 Good progress in implementing CQC actions. Mock inspections planned for May-17 Jul-17 Action tracker in place and monitored with divisions and at Q&S. New CQC regulatory guidance being reviewed and communication plan developed to ensure Trust can evidence compliance.	end Oct-17	◄►	DN	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. May-17 Performance of 62 days below trajectory at 69.9% (latest data Feb 17) Greater focus on patient tracking with Guys being set up to run weekly in order to replicate the scrutiny on 38 day transfers currently in place with MTW and BSUH. Refer to monthly IPR for details of ongonig programmes of work to improve cancer metrics. Jul-17 Continued focus on 62 day achieved 76% (latest data Apr 17) Trajectory for achievement of 85% October 2017.	end-Oct 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.	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. May-17 Trust allocated A&E capital funding from DH - £700k for Conquest and £985k for DGH. This will support streaming in the emergency departments. Funding bid also submitted for wider Urgent Care Programme eg development of ambulatory care. Jul-17 Project in place streaming redevelopment commencing to be in place by Oct 17	end Oct 17	◄►	COO	SLF
2.1.3	C	Focus required on patient flow and delayed discharges across Trust sites to minimise impact on emergency departments and support compliance with constitutional standards.	Nov-16 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. May-17 Achievement of key constitutional targets and trajectories remains challenging however, performance is improving . A number of actions completed and being embedded, refer to performance report. Continued focus and programmes of work around A&E management, medical model and improved discharge. July-17 4 week improvement challenge started June with a concerted effort across the Trust to meet the 4 hour clinical standard. Achieved significant improvement in meeting the A&E standard but increased A&E attendance made it difficult to sustain. A&E Improvement Plan is in place and monitored weekly against 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.	end Oct 17	◄►	COO	

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	Assurance is required that there are robust mechanisms in place to monitor trust mortality 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. May-17 SHMI remains 110 (in range). Increase in RAMI in December 2016 and January 2017, review being undertaken to establish reason for variance; national comparators awaited. July-17 SHMI 109 (in range). Annual RAMI at 98 has fallen significantly in spite of the rise in Dec 16 and Jan 17. Reduced in Feb and March back below peer level. Data suggests depth of coding had declined again, which is now being addressed	end Sep-17	▲ Jul-17 (Amber 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. 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. May-17 Continuing increase in referrals to community paeds, 3 locums supporting. New referrals first appointment continue at 6 months. Ad hoc clinics for follow up. Systm One data nearly completed upload – some consultants already live – Eastbourne site starting live first. Jul-17 50% increase in referrals to service over the last two years. Wait time for initial appt remains at 6 months. All consultants are live on system one. 2 locums in place and 1 locum has joined the Trust in a substantive post. No further ad hoc clinics as poorly attended. Commenced telephone follow up consultations	end Jul-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. Jul-17 Ward nurses having mental health training currently as part of away days. Special Observations Policy ratified and specials being requested ad hoc. Paediatric strategic work including mental health in reach plan	end Oct-17	◄►	COO	SLF Q&S
2.1.7	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. May-17 Position resolved with community paediatrics due to data transition to Sytm One. Ongoing discussion to find Trustwide solution. Jul-17 All doctors validating Follow Up waiting lists and telephone Follow Ups now taking place. Longest waiter 36 weeks.	end Sep-17	◄►	COO	SLF Q&S
2.1.8	C	Effective controls are required to ensure the Trust has adequate clinical and support services to provide access to 7 day services including diagnostic and consultant led interventions.	01/07/2017 7 Day Service Steering Group reporting into Clinical Effectiveness Group and Quality Improvement Steering Group. Project has support from Programme Management Office, with dedicated project lead assigned. Baseline audit being undertaken. Working closely with NHS England and NHS Improvement to gain best practice/lessons learnt from other Trusts	end Dec-17	**NEW Jul-17**	COO	SLF Q&S

Risk 2.2 There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.	
Key controls	Clinical Unit Structure and governance process provide ownership and accountability to Clinical Units Clinicians engaged with clinical strategy and lead on implementation Job planning aligned to Trust aims and objectives Membership of SLF involves Clinical Unit leads Appraisal and revalidation process Implementation of Organisational Development Strategy and Workforce Strategy National Leadership and First Line Managers Programmes Staff engagement programme Regular leadership meetings Succession Planning 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. May-17 Compliance improving slightly with Appraisal rate 78.89% and Mandatory Training 88.54% for March. Focussed work programme targeting areas and divisions where compliance requires improvement. Jul-17 Continued improvement in both Appraisal 81.73% and Mandatory Training 88.29% L&D continue to analysis and work with managers to achieve compliance.	end Sep-17	◄► Mar-16	HRD	POD SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
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” May-17 Developing with Health Education England bespoke leadership development programme for ESHT to support organisational leaders in transformation, systems leadership and improvement. Initial scoping meetings taking place. Jul-17 Cohort 1 of Leading excellence programme identified and invited to attend first programme commencing in August	end Dec-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 Trust fully engaged with SPT and ESBT programmes

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. 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 May-17 STP Programme Board is reviewing Carnall Farrar work to provide a broad strategic understanding of demand and capacity issues in our Acute Hospitals in the STP footprint and all partners are working closely together to consider how we can provide Acute services that will meet the future needs of our population sustainably. Jul-17 Our System wide placed based plans (ESBT) are the local delivery plan that aligns commissioners and providers in health and social care. We have undertaken significant work across the system to redesign care pathways and this is linked to our clinical strategy which is currently being consulted on. Work is ongoing with the wider STP work currently reviewing pathology provision along with other acute services.	end Dec 17	◄►	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. May-16 Full transition to new provider has taken place. Still being closely monitored as in early stages and still dependent on some private providers until full recruitment has taken place. Overall performance has been much better with incident reports remaining at a low level. Jul-17 New provider in place, service operating effectively. Propose removal from BAF.	end Jan-17	▲ July-17	COO	SLF

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	Ongoing requirement for assurance on the controls in place to deliver the financial plan for 2017/18, with an efficiency requirement of £28.7m, leading to a reduction in deficit for the Trust and exit from financial special measures.	July 2017 – the Trust has a detailed financial plan for 2017/18, initially approved by the Trust Board in January 2017 and which has been subject to an iterative development process. Both the Finance and Investment Committee, on behalf of the Trust Board, and NHSI Improvement – through the Financial Special Measures Team – have sought additional assurance and specification of the plan to ensure delivery. As at 3rd July, the Trust has approved CIP schemes of £32.3, against a CIP requirement of £28.7m, and is continuing to develop a pipeline of savings. As at the same date, the Trust has also recognised that additional resource is required to ensure delivery of key schemes. Internal and specialist resource has been deployed to directly support the workforce and CSR workstreams, as well as operational delivery teams around the patient flow and elective care workstreams, and the Trust has a process in train to secure further resource for procurement and commercial workstreams. A final presentation to both the Finance and Investment Committee and NHSI in July should allow the Trust to move more fully from 'planning' to 'delivery.' The Trust has delivered on plan to Month 2, and early indicators suggest delivery at Month 3. From Month 4, the level of risk increases, and the level of both delivery support and scrutiny/challenge will continue to increase to ensure adverse variance or emerging risk is identified and escalated at the right pace. Key risks to the financial position are articulated in the Board report, and discussed in more detail at the Finance and Investment Committee. The Trust has appointed a new Head of Contracts, to ensure early escalation of contentious contract issues, and has bolstered the Financial Management Team to ensure appropriate support for budget-holders. A detailed activity and bed management plan has been agreed with the operational teams and clinical units, and the Performance and Information team are providing regular updates on performance against the plan to ensure early identification and action of performance below expectations.	Commenced and on-going review and monitoring to end Mar-18	◄►	DF	F&I

Risk 4.2: In running a significant deficit budget we may be unable to invest in delivering and improving quality of care and patient outcomes. It could also compromise 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 Capital plans operational review on a monthly basis by the Capital Review Group, and detailed review by the Finance and Investment Committee, on behalf of the Board, on a monthly basis. 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	The Trust has a five year plan, which makes a number of assumptions around external as well as internal funding. 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-17 – The Trust has set an initial capital plan for 2017/18, which reflects key organisational priorities and the funding available. The Trust continues to seek additional funding opportunities, including capital bids for specific investment schemes and dialogue with both the financial special measures team and NHS Improvement about alternative opportunities. The five year capital plan is being redeveloped and refreshed to reflect the challenges and opportunities facing the Trust. The Trust is in discussions with a range of third parties around alternative non-capital means of financing key programmes of change. Jul-17 – the Trust has an approved capital plan for the year, following a detailed prioritisation process, and this is reviewed by the Capital Review Group on a monthly basis, with interim checkpoints to refresh the forecast. The demand for capital is greater than that available, and the Trust has a number of applications for capital in with NHSI for loan capital (primary care streaming, and ambulatory care). The Trust is also working with a number of potential strategic partners and with the Friends to establish alternative sources of capital funding to ensure that the clinical infrastructure is maintained. It will be important to review the capital programme – both the spend and the demand for capital – on a regular basis through the CRG and FIC to maintain sight of risks to clinical quality.	On-going review and monitoring to end Mar-18	◄►	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 Clear process for handling tenders/gathering business intelligence and mobilisation or demobilisation of resources Participating in system wide development through STP and ESBT Alliance Strategy team monitoring and responding to relevant tender exercises
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
	No GAPS identified

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	Jan-17 Following increases in the establishment and sustained recruitment, substantive workforce numbers have continued to increase, from 5684 ftes to 5949 ftes (Apr-Nov). 80 offers made to overseas nurse. 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 business case developed to roll out across the Trust. In discussions with Brighton University to establish Expect to work placements for Physicians Associates 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. Mar-17 6 Doctors assistants started, positive impact on workload of Junior Drs, consideration will be given to roll-out to other specialties in the Trust. GP Fellowship role advertised, anticipated start date of Sept-17. 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 Nov-17). EU nurses c30 offers. Targeted UK nurse campaign commenced Feb-17. Joined NHS Employers Retention programme, 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. May-17 Recruitment hotspots identified. Regular Department meetings to review vacancies established and action plans discussed.to address priority vacancies. Recruitment and Retention Policies examined as a method of addressing turnover and attraction issues.7 Head hunters engaged to assist with Hard to fill positions for Medical posts. Continued focus on overseas recruitment for registered nursing; 76 Philippine nurses offered (start date /Nov/Dec 2017.15 Italian nurses recruited in March/April. Additional visits to EU/Italy proposed to address future requirements and turnover. AHP- Workforce planning to be carried out to identify and address future requirements ((MSK contract).Recruitment campaign to support. Trial of Refer a Friend and Golden Handshake for Theatre nurses, with subsequent roll out across Trust. Workforce planning process developed to identify skill mix and new roles. Jul-17 Recruitment Incentives developed to assist with attracting suitable candidates for difficult to recruit areas. Utilising agencies on the preferred list of suppliers as Expressions of Interest. International Nurse recruitment continues-Skype interviews conducted with both Italian and South African nurses-8 offers made, also planned with Philippine nurses . Regular monthly events planned and recruitment booklet to be finalised by 14th July Continued development of new roles eg GP Fellowship posts and Trust Associate posts in A and E. Workforce reviews and planning sessions are programed for the autumn, linked to the business planning cycle. These will review workforce needs, including the introduction of new roles.	end Dec-17	◄►	HRD	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.	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. May-17 Increasingly positive staff feedback. Quarterly Staff Family and Friends Test - significant year on year increase in two questions asked If a friend or relative needed treatment would you be happy with the standard of care provided by the organisation? increased from 61% Q4 2015 to 77% Q4 2016 . Would you recommend your organisation as a place to work? Increased from 38% Q4 2015 to 66% Q4 2016 Jul-17 – Work continues following staff feedback in the National Staff survey – working on the three corporate priorities agreed and each division has their own action plan. All areas encouraged to regularly feedback about actions taken .The latest Staff Family and Friends test has identified an increase in the number of staff who would recommend the trust for care and treatment to 80% but there has been a reduction in the number of staff who would recommend us as a place to work. We will be engaging with teams to find out more about this responses and what they feel will make a difference.	end Sep-17	◄►	HRD	POD SLF

Chief Executive's Report

Meeting information:			
Date of Meeting:	25th July 2017	Agenda Item:	8
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

Alice Webster has left the organisation to take up her new role at NHSI. She will be much missed. Appropriate tributes have been paid to her work for the Trust and her leadership of the nursing profession and of quality and safety over a number of years. Hazel Tonge will be acting as Director of Nursing pending the arrival of Vikki Carruth as substantive Director of Nursing.

2. Quality and Safety

2.1 Mortality

The latest SHMI (for the period Jan 16-Dec 16) has just been released and is within the expected range at 1.09, which is an improvement on the previous period (Oct 15-Sept 16 = 1.10) and a considerable improvement on the same period for the previous year (Jan 15-Dec 15 = 1.14). In addition the latest validated RAMI (March 16-Feb 17) is 100, compared with 112 for the same period last year – again a significant improvement. Although SHMI is most often used by NHSI as a comparator it is not designed for integrated Trusts and RAMI is a better measure of our position. Good note taking and clinical coding remain key to giving an accurate picture of our performance.

We have been advised that our next CQC inspection will be on a revised basis and may be deferred to early 2018. We will be raising this with the CQC since this delays our opportunity of exiting special measures. In the meantime we continue to prosecute the quality improvement programme arising from the CQC reports and our recent mock inspections. A new QSM Improvement Director has been appointed by NHSI. Philippa Slinger will be joining the team on a part time basis in the near future.

3. People, Leadership and Culture

3.1 Recruitment and Retention

Recruitment – A number of incentives have been produced to assist in attracting candidates for difficult to recruit posts. The process will be monitored to demonstrate both improvement in overall attraction and cost savings to the Trust (Agency vs Bank). International recruitment continuing in the Philippines, India, Italy and Spain for Nursing, medical and AHP staff groups.

Temporary Workforce – Continued progress on conversion of agency staff to bank and bank to permanent. To date 21 Medics (net saving £237k) and 30 HCAs have joined the Bank.

Workforce Planning – We are working to develop a long term workforce plan to address recruitment issues within key departments. Initial proposals are being produced for ED, with subsequent phased roll out across the Trust.

3.2 New doctors contract

Exception reports continue to show a decline in the numbers being submitted by junior doctors. The have reduced from 173 in January 2017 to 37 in May 2017. Work rota reviews have also taken place to make rotas more robust which should see a further decrease in the number of exception reports being raised. A new overarching roster review group has been established which has met for the first time.

We will be arranging exception reporting refresher sessions for Clinical/Educational supervisors and also familiarisation sessions for new junior doctors as part of the August rotations.

A junior doctors' Guardian of Safe Working Forum has been held, junior doctors noted the reduction in exception reports due to working hours. Concerns were expressed regarding the pressure on the medical rotas when additional bed capacity is opened within the hospitals. The Guardians will be monitoring this position.

There are 6 FY1, 7 FY2 and 5 Core Trainee vacancies in the allocations for August 2017. We have advertised these posts and currently have 19 applicants with interview dates in July to fill these gaps. These posts are subject to a rolling advert.

Once the August intake is complete this will mean that 156 doctors will be on the new Junior Doctor contract (2016) and the further 47 higher speciality trainees will join the Trust in October 2017, when all 218 doctors in training will be on the new contract.

3.3 Staff engagement

The first cohort of the Leading Excellence Programme will commence in August 2017
Business skills training for Divisional teams has commenced from the end of June

4. Finance and Capital

4.1 We have now completed the development of our Financial Recovery Plan which will enable us to deliver the 17/18 control total target and budget of £36.5m deficit (prior to Sustainability and Transformation Fund allocations). Given the projections of in year cost pressures and inflation, this requires us to achieve cost improvements of £28.5m. Having agreed the plan, the additional resource requirements for delivery have been identified and are now being appointed. Good progress continues to be made with embedding the existing improvements and the Trust has delivered its plan over the first two months of the year.

4.2 There have been some significant payroll issues during the month for bank staff, following changes to government tax code algorithms and guidance. This has meant that for those members of staff working bank shifts on top of their salaried job, the weekly payments have carried additional tax levies, which are then rebalanced in their monthly wage packet. The payroll team have worked hard to address this issue and have held a series of pay workshops to resolve the problem. Members of staff who have a salaried job and also work bank shifts have the option of reverting to monthly pay or accepting the variation of tax in their weekly pay.

4.3 Cash flow remains a critical issue with a number of suppliers threatening to withdraw services in the absence of payments. We have been seeking to hold the cash position pending the reduction of interest on loans from 6% to 3.5%, but this has put added pressure on payments to creditors. An early solution to this is being sought with NHSI.

5. Access and Delivery

5.1 4 hour clinical standard

The Trust delivered 81.4% in May, which was a 1% improvement on the previous month. Activity continues to increase on the previous year, with 5.1% increase in attendances. Ambulance conveyances have increased by 6.9%.

In order to consolidate and crystallise the work done to establish improved systems and processes over the past year, the Executive Team agreed to set a 4 week challenge to reach 95% delivery, starting in mid-June. This is being managed as an accelerated improvement approach rather than a new plan, building on the existing actions, rapid review of issues and implementation of solutions and wider promulgation and ownership of the four hour standard.

We have achieved a step change in performance, which has been delivered despite a significant increase in activity in weeks 2 and 3, which was reflected nationally and we believe to be linked to the hot weather. By way of a comparison over Christmas and New Year we saw an average of 2100 attendances a week.

- week 1 – 92.5% (2320 attendances)
- week 2 – 90.6% (2478 attendances)
- week 3 – 87.1% (2410 attendances)

The unvalidated overall performance for June is 88%

With the greater focus on the detail where patients have breaches, or near breaches we have identified the following key elements:

- Ownership of the standard across the entire workforce, everyone has a part to play
- Focus the standard on improved clinical outcomes for patients who reach the right speciality teams and ward within 4 hours. We have these pathways in place, but need to further embed these.
- Timely escalation to divisions if likely delay to patients either within ED or to support discharges on the wards
- That success breeds success and information being clearly visible in the EDs and performance reporting elsewhere supports ownership of the challenge

The two key fundamental factors and continuing challenge to our performance are:

- sufficient ED staff on any one shift to meet demand and assess patients within an hour of arrival
- good flow to the wards and discharges to the community.

5.2 Cancer Targets

The teams continue to do well in delivering the cancer standards, and do so with increasing demand to the 2 week pathways. However we continue to be challenged in delivering the 62 day standard and as such, this has now become an increasing priority to achieve compliance by September. New processes for monitoring have been established and NHSI have increased their level of oversight. We are awaiting details on how we can bid for additional funds via NHSI to establish additional clinics and surgical capacity.

5.3 18 weeks referral to Treatment

The Trust delivered 92.3% performance in May, which exceeds the 92% constitutional standard, this is the first time this has been achieved since February 16. This reflects the hard work of the divisional teams and corporate teams and reflects some validation and training activities, and focus on the non-admitted pathways and waiting times. However the non-admitted pathway remains a challenge and the total waiting list has increased. This is in part due to lower activity levels during April and the reduction in outsourced activity. This is being reviewed as a capacity gap remains in some specialities and although it is hoped this will reduce through our theatre efficiency programme, there will remain a need to outsource.

5.4 Diagnostics

Performance in May (2.3%) improved on the previous month, but this has been an ongoing challenge, due in part to the non-obstetric ultrasound staffing capacity, cardiac diagnostics and reduced availability through breakdown of CT and MRI scanners.

5.6 Trauma Peer Review

The Trust had a peer review of the Trauma Service on 28th June, from which we received good feedback. The draft report will come to us in mid-July for accuracy checks and publication by end July and the final report will go to the Trauma Network Board in September.

In summary, no significant concerns raised and generally positive feedback;

The Peer Review Team expressed their sincere thanks to everyone and it was noted the level of engagement at the morning presentation and in forward preparation was to be commended

The Trust's trauma rehabilitation services were highlighted as a shining star and evidence of exemplary practice

Although our TARN data completeness has been an issue, they are pleased at how well this has now been resolved and the recognition of the importance of the TARN co-ordinator and impact on reputation (with lack of data)

National standards well evidenced but less so with the local standards, some recognition that the standards may not be clear on the level of evidence required

6. Strategy, Innovation and Planning

6.1 Strategy and Planning

The strategic plans for the divisions along with the nursing, estates and workforce strategies were presented to the Board at a recent seminar. We recognise that there is still further work needed to ensure that we are consistently delivering safe and sustainable services but we can see the huge strides that we have made in recognising the challenges and opportunities that we need to prioritise in the coming year.

6.2 ACO

The Alliance is now in its 2017/18 test-bed year and we continue to work closely with our colleagues in ESCC, CCGs and SPFT to take our collaboration to new levels to further

improve and deliver services, test the new approach and understand the impacts. The ACO Development Group are currently developing the appraisal process of the options for organisational form for the future ESBT accountable care model after the 2017/18 test year, and the outcomes of this options appraisal will come to our Board in July 2017 for discussion and approval

6.3 STP

The STP Programme Board is now reviewing the work that Carnall Farrar undertook to provide a broad strategic understanding of demand and capacity issues in our Acute Hospitals in the STP footprint and all partners are working closely together to consider how we can provide acute services that will meet the future needs of our population sustainably.

7. Corporate Affairs

7.1 Quality Account

Our 2016/17 Quality Account has now been published on NHS Choice and can be accessed here:

http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=1492

The Quality Account will be formally received at our AGM on Tuesday 26th September.

NHS Choices also allows users to rate and comment on NHS health and social care services. We review and respond to all feedback and ensure learning is shared where appropriate. I am pleased to advise that Conquest Hospital is currently rated 4 ½ out of 5 stars and Eastbourne DGH 4 out of 5 stars. Our community hospitals are not currently rated on the site.

7.2 Care Quality Commission

As outlined at the last Board Seminar, the CQC have recently released the results of their first consultation on the 'next phase of regulation'. The 5 key questions (are services safe, effective, responsive and well led) will remain unchanged. However, there are a number of revisions to the wording and scope of many of the prompts that underpin the CQC's Key Lines of Enquiry (KLOEs) and there is an increased focus on systems, leadership, processes, security of records, sharing of information, learning from mistakes and improvements, use of best practice, communication and the Equality Act, use of technology, end of life care, governance, engagement and how services evidence improvement.

There is also a new monitoring, inspection and ratings regime for NHS Trusts, meaning that all Trusts can expect each year to have a well-led assessment and at least one core service inspection. Frequency will depend on how services were rated at their last inspection and as a special measures Trust we are expecting our services to be inspected again in early 2018. We are in the process of reviewing the changes and will communicate these across the Trust.

7.3 Fire Readiness

In the wake of the tragedy at Grenfell Tower, all trusts were asked to urgently review fire readiness and this has been undertaken. We have regular East Sussex Fire and Rescue Service inspections of our facilities, comprehensive risk assessments are carried out by our internal fire advisors (ex-Fire Service personnel), and fire wardens are in place. We have an ongoing programme of work to address fire compartmentation at the DGH site and this is agreed and monitored by the fire service. Post the Grenfell Tower tragedy we will be reviewing our program of works at DGH with fire services colleagues.

We do not have any building over 6 storeys high with refurbishment carried out in the last 10 years. We do have some buildings with cladding and the majority use the original materials and construction methodology. The main exception is a recent Endoscopy building with rain screen cladding installed in 2012/2013 at Eastbourne (no inpatient facilities). None of the cladding that is installed is of Aluminium Composite Material construction and we have not been designated as Category One by NHS Estates and Facilities, which would warrant further investigation of our estate at this time.

Our Annual Fire Safety Report will be considered at the next Audit Committee and will then be presented to the Trust Board in September.

Quality Special Measures

Meeting information:			
Date of Meeting:	25th July 2017	Agenda Item:	9
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

The Board considered recent changes to the CQC regulatory regime at the June Seminar. This paper provides an overview of the changes highlighted which relate to the assessment framework and monitoring, inspection and ratings regime.

We will communicate the revisions to the CQC regulatory regime across the organisation and are planning our next mock inspection in September 2017. Good progress is being made in addressing the 'must' and 'should' do areas highlighted at the October CQC inspection and this is monitored at Divisional IPR meetings and through the Trust's Quality and Safety Committee

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

Board Seminar June 2017

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

The Board is asked to review and note the contents of this paper.

CQC Regulatory Regime Revisions

1. Introduction

The CQC has just published the outcome of the consultation it ran recently on forthcoming changes to its regulatory regime.

Key revisions are as follows:

- There will now be two CQC assessment frameworks (instead of the current multiple provider handbooks) - one for healthcare and one for adult social care. In terms of timing, NHS Trusts are expected to implement the new assessment frameworks from this month, whilst adult social care providers and GPs will have until November 2017 and independent sector providers until 2018/19 to implement the new frameworks.

- There will be a new monitoring, inspection and ratings regime for NHS Trusts, also coming into effect from this month, meaning that all Trusts can expect each year to have a well-led assessment and at least one core service inspection.

2. New assessment frameworks

The CQC will be going ahead with its plan to introduce two assessment frameworks for all providers, to replace the existing provider handbooks. The 5 Key Questions (Are services safe, effective, caring, responsive and well-led) will remain unchanged, but there are various revisions and additions to the existing Key Lines of Enquiry and Prompts. For example, there are new KLOEs/Prompts in relation to medicines management, end-of-life care, use of technology, response to external alerts/reviews and involvement of families and carers.

In order to assist us with updating systems/processes the CQC has published versions of the frameworks with the changes clearly marked (copy available at: http://www.cqc.org.uk/sites/default/files/20170609_Healthcare-services-KLOEs-prompts-and-characteristics-showing-changes-FINAL.pdf) We will review and communicate across the Trust the updated key lines of enquiry .

3. New CQC regime for NHS Trusts

The consultation proposals in relation to how NHS Trusts should be monitored, inspected and rated will be implemented broadly as originally proposed, with smaller more focussed inspections. The key points in the new CQC regime for NHS Trusts are as follows:

3.1 Monitoring

The CQC will be using a new 'Insight' system to determine which core services to inspect (until this is launched they will focus on existing data collections available nationally). A new annual Provider Information

Requests (PIRs) will also be implemented. We regularly meet with the CQC but there will also be formal quarterly relationship management meetings which will help inform the CQC's regulatory planning.

3.2 Inspection

The CQC is proceeding with its plan for NHS Trusts to have a well-led assessment and assessment of at least one core service each year (with frequency of core service inspections subject to how services were rated at the last inspection).

Trust level well-led assessments will take place approximately once a year. Trusts will be informed of the timing of these following the CQC's internal regulatory planning meetings. The CQC has indicated that the scope/depth of these well-led inspections may vary according to the nature of the individual Trust.

In relation to core services, each year the CQC will inspect all core services rated 'inadequate', half of those rated 'requires improvement', a third of those rated 'good' and a fifth of those rated 'outstanding'. In order to address concerns expressed in the consultation that long gaps between inspections for some core services could prevent Trusts being able to demonstrate improvements, some core service inspections will be triggered by information suggesting that the quality of care has improved.

3.3 Ratings

The new assessment frameworks contain revised guidance about what 'outstanding', 'good', 'requires improvement' and 'inadequate' look like for each of the 5 Key Questions.

The CQC has committed to setting out clearly in each report how it reached the rating for each question, including factors considered and how these impacted on the CQC's decision-making. Inspection reports will be shorter but they will also publish data which has supported them in reaching their rating. At the last Board seminar we reviewed our ratings and what individual rating changes would be required to move from Requires Improvement to Good.

4. Next Steps

As outlined in the CEO's report we do not have a date for our next inspection yet but expect this to be comprehensive as we are a Trust in Quality Special Measures. We are making good progress in addressing the 'must' and 'should' do areas highlighted at the October inspection and this is monitored at Divisional IPR meetings and through the Trust's Quality and Safety Committee. Deep dives are undertaken into specific areas for assurance, for example End of Life Care. We will communicate the revisions to the CQC regulatory regime across the organisation and are planning our next mock inspection in September 2017.

Integrated Performance Report – Month 2 (May)

Meeting information:			
Date of Meeting:	25th July 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

The trust achieved the RTT standard but remains challenged against the key constitutional targets and trajectories

- RTT incompletes was 92.27% against the 92% standard.
- A&E performance was 81.4% against the 95% standard. This was a marginal decrease from March.
- Diagnostics failed the standard – 2.3% against the 1% target
- Cancer 62 Days achieved 76.% against the 85% standard (for April, one month in arrears).

- 2016/17 reported a deficit of £43.9m (£46.5m excluding STF), as per the forecast position.
- 2017/18 plan is for a deficit of £26.5m (£36.4m excluding STF).
- Final accounts to be submitted 1st June 2017.
- At M1 the Trust delivered its financial plan
- Although activity levels were below that forecast for RTT and activity growth, expenditure was also lower than expected.

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

Finance and Investment Committee, 28th June 2017
Executive Directors – 4 July 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 2 – May 2017

TRUST INTEGRATED PERFORMANCE REPORT

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East Sussex Healthcare NHS
NHS Trust

Contents

East Sussex Healthcare NHS
NHS Trust

May 2017

Key Issues

•The Trust met the RTT standard for May. The three key performance indicators (A&E, Diagnostics and Cancer 62 Days) did not meet the standards. There were however some improvements seen in diagnostics and A&E. These are reviewed in the relevant sections of the report which shows performance, trajectories and actions.

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

East Sussex Healthcare NHS
NHS Trust

Indicators

Indicator Description	Target	Previous Months				Current Month			YTD			Trend
		May-16	Feb-17	Mar-17	Apr-17	May-17	May-16	Var	This Yr	Last Yr	Var	
Total patients safety incidents reported	M	1078	1235	1247	1066	1150	1078	6.7%	2216	2132	3.8%	
% Patient safety incidents with no harm or near miss	70.0%	67.2%	80.1%	83.1%	84.7%	81.7%	67.2%	14.6%	83.2%	65.9%	17.3%	
% Patient safety incidents causing severe harm or death	0	0.1%	0.5%	0.2%	0.2%	0.3%	0.1%	0.2%	0.2%	0.1%	0.1%	
Total Non-ESHT patients safety incidents reported	M	244	151	151	139	179	244	-26.6%	318	564	-77.4%	
No of never events reported	0	0	0	0	0	0	0	0	0	1	-1	
No of serious incidents reported	M	0	7	5	3	5	0	5	8	7	1	
No of moderate incidents reported	M	5	11	5	10	11	5	6	21	11	47.6%	
Total Falls per 1000 beddays	7	6.0	6.4	6.3	5.7	6.2	6.0	0.1	5.9	6.0	-0.1	
Total falls reported	M	149	155	160	136	153	149	2.7%	289	301	-4.2%	
No of falls no harm	M	101	107	122	105	117	101	15.8%	222	198	10.8%	
No of falls minor/moderate	M	48	46	37	31	36	48	-25.0%	67	103	-53.7%	
No of falls major/catastrophic	M	0	2	1	0	0	0	0	0	0	0	
Falls Assessment Compliance	M	93.9%	88.9%	91.8%	90.1%	90.4%	93.9%	-3.5%	90.2%	93.0%	-2.8%	
No of pressure ulcers grade 3 & 4 (trust acquired)	R	5	6	4	4	4	5	-1	8	11	-3	
No of pressure ulcers grade 2 (trust acquired)	R	42	65	56	57	57	42	15	114	103	0	
Pressure Ulcer Assessment Compliance	M	86.0%	93.2%	92.1%	89.4%	85.9%	86.0%	-0.2%	87.6%	89.9%	-2.4%	
No of medication administration incidents	M	25	36	16	22	35	25	0	57	54	0	
Medication errors causing severe harm	0	0	0	0	0	0	0	0	0	0	0	
Observations completed on time (per protocol)	M	80.7%	83.3%	84.3%	85.4%	85.2%	80.7%	4.5%	85.3%	80.2%	5.1%	
No of Cardiac Arrest calls		8	4	9	8	0	8	0	8	14	-6	
No of MRSA cases	0	0	0	0	0	0	0	0	0	0	0	
No of CDI cases	4	7	2	2	1	5	7	-2	6	9	-3	
No of MSSA cases	M	0	0	0	0	0	0	0	0	2	-2	

East Sussex Healthcare NHS
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Indicators

Indicator Description	Target	Previous Months				Current Month			YTD			Trend
		May-16	Feb-17	Mar-17	Apr-17	May-17	May-16	Var	This Yr	Last Yr	Var	
Safety thermometer overall score	92.0%	93.6%	92.5%	91.7%	93.2%	92.6%	93.6%	-1.0%	7.1%	6.7%	0.4%	
% of VTE risk assessments completed	95.0%	97.9%	97.0%	97.1%	96.5%	97.3%	97.9%	-0.6%	96.9%	96.6%	0.3%	
Emergency C-Section rate	9.0%	13.4%	13.1%	12.4%	17.2%	12.8%	13.4%	-0.6%	15.0%	14.4%	0.6%	
Mixed sex accomodation breaches	0	7	0	0	0	6	7	-1	6	7	-1	
Inpatient FFT Response rate	45.0%	13.94%	31.77%	32.94%	30.92%	34.81%	13.9%	20.9%	30.92%	14.01%	16.9%	
Inpatient FFT Score (% positive)	96.0%	97.29%	97.27%	96.52%	97.04%	97.00%	97.3%	-0.3%	97.04%	98.26%	-1.2%	
A&E FFT Response rate	22.0%	9.91%	7.52%	6.72%	8.29%	9.38%	9.9%	-0.5%	8.29%	8.96%	-0.7%	
A&E FFT Score (% positive)	88.0%	83.69%	82.51%	95.94%	90.02%	90.00%	83.7%	6.3%	90.02%	87.97%	2.1%	
Outpatients FFT Score (% positive)	M	96.08%	95.57%	95.43%	95.29%	95.80%	96.1%	-0.3%	95.29%	96.02%	-0.7%	
Maternity FFT Response rate	45.0%	11.59%	43.08%	43.18%	46.81%	45.93%	11.6%	34.3%	46.81%	29.19%	17.6%	
Maternity FFT Score (% positive)	96.0%	92.45%	97.00%	96.62%	98.11%	97.90%	92.5%	5.5%	98.11%	90.21%	7.9%	
No of complaints reported	R	55	41	55	41	52	55	-5.5%	93	130	-39.8%	
All ward moves	M	2344	2110	2307	2109	2247	2344	-4.1%	4356	4647	-6.7%	
Night ward moves	M	434	406	385	368	370	434	-14.7%	738	904	-22.5%	
Crude Mortality Rate	M	1.7%	2.1%	1.7%	1.8%	1.7%	1.7%	0.0%	1.7%	1.9%	-0.2%	
HSMR (CHKS)	100	111	105	107								
SHMI (CHKS)	100	1.10										
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	10.0%	7.7%	7.2%	8.0%	0.2%	0.0%	7.7%	-7.7%	0.1%	7.9%	-7.8%	

Note: SHMI shown is month by month index score and not rolling 12 months.
Mixed sex accommodation breaches refer to overnight, sleeping breaches.

East Sussex Healthcare NHS
NHS Trust

Quality Overview

There were 5 serious incidents reported as occurring in May. The incidents related to : 1 incorrect removal of the wrong tooth (Never Event), 1 slip/trip/fall, 1 treatment delay, 1 intrapartum still birth and 1 sub-optimal care.

One Never Event was reported in May. This related to the incorrect removal of a tooth.

Infection control reported no incidents of MRSA or MSSA. There were 5 cases of CDIFF recorded.

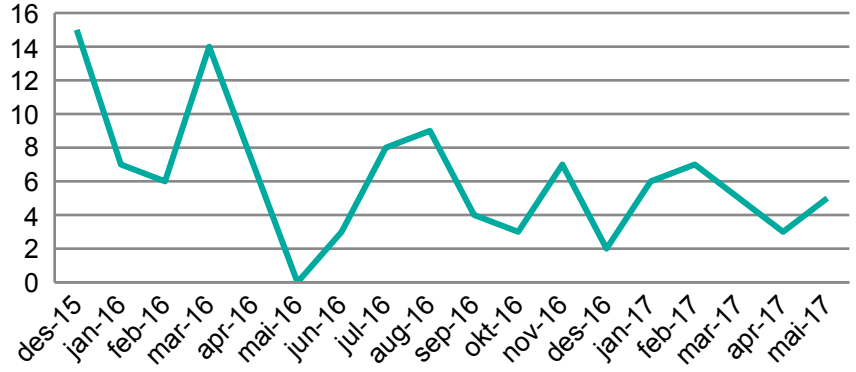
There was one breach incident of overnight mixed sex accommodation breaches reported. This affected six patients

There were 4 grade 3 and 4 Pressure Ulcers reported this month, these are outlined below:

- 2 community acquired and acute hospital acquired

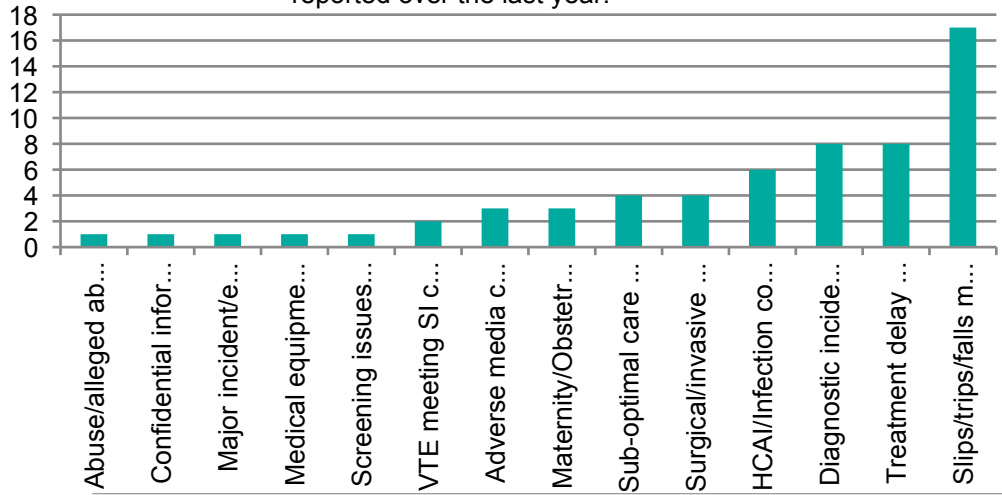
2. Serious Incidents, Never Events and Patient Safety Incidents

Serious Incidents Reported



Patient Safety Incidents

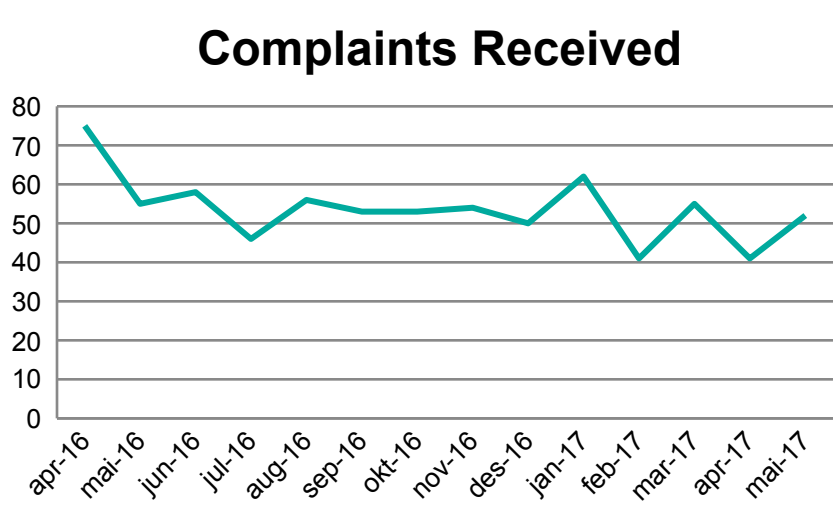
The graph below shows the STEIS categories of the Serious incident reported over the last year.

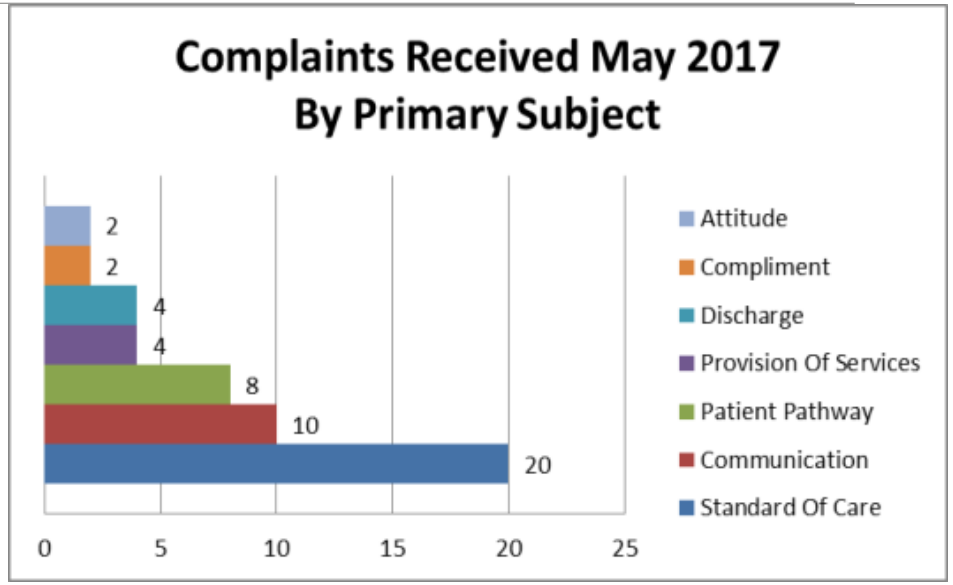


The number of serious incidents reported in May increased to 5.

East Sussex Healthcare NHS
NHS Trust

3. Complaints





Complaints and PALs

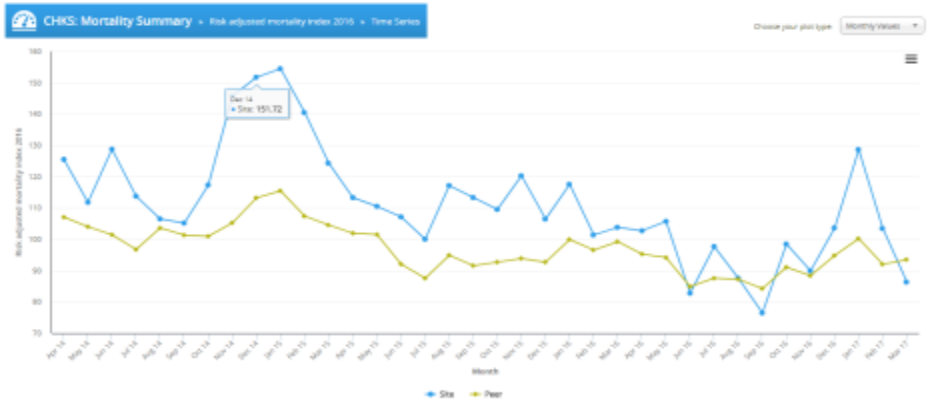
- 52 new complaints received
- 60 complaints were closed
- 9 complaints were re-opened
- 93 complaints were open at the end of the month
- 5 open complaints were overdue
- 316 open complaint actions
- 619 PALS contacts were recorded across both sites

Friends and Family Test (FFT) and NHS Choices

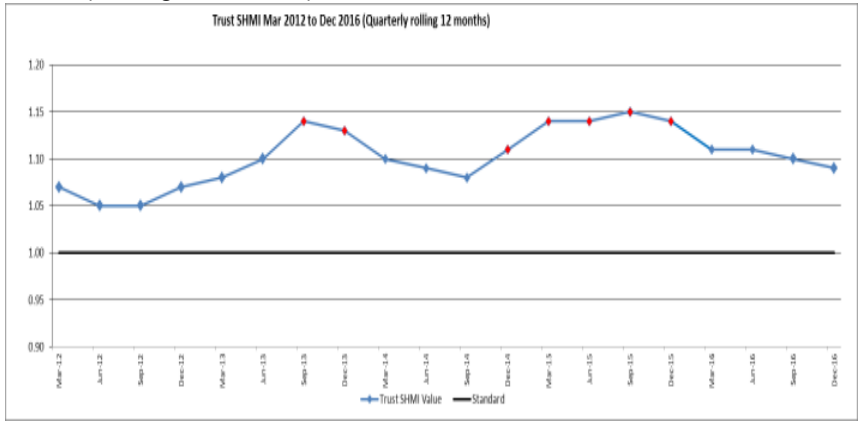
- FFT Inpatient responses rates have increased by 4%
- FFT response rates for A&E have slightly increased from 8% (April) to 9% (May).
- Community FFT and Outpatient FFT response rates remain low.
- 22 postings on NHS Choices during May with 5 giving a poor star rating.

4. Mortality

RAMI 2016



SHMI (Rolling 12 months)



SHMI for the period January 2016 to December 2016 is the latest published and is 1.09. The Trust is currently within the EXPECTED range.

RAMI April 2016 to March 2017 (rolling 12 months) is 98 compared to 110 for the same period last year (April 2015 to March 2016). March 2016 to February 2017 was 100

RAMI shows a March position of 86 compared to a peer value of 93. The February position was 103 against a peer value of 92

Crude mortality shows April 2016 to March 2017 at 1.85% compared to April 2015 to March 2016 at 1.86%

The percentage of deaths reviewed within 3 months was 59% in February 2017 compared to 56% in January 2017

Main causes of death – May 2017

Pneumonia	15
Bronchopneumonia	12
Sepsis	8
Congestive cardiac failure	7
Senile corporeal degeneration	7
Community acquired pneumonia	6
Myocardial infarction	4

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
		May-16	Feb-17	Mar-17	Apr-17	May-17	May-16	Var	Yr	Last Yr	Var	
A&E Performance (4 hour wait)	95.0%	85.0%	76.0%	80.7%	80.1%	81.4%	85.0%	-3.7%	80.8%	84.5%	-3.8%	
A&E 12 Hour trolley waits	0	0	0	0	0	0	0	0	0	0	0	
A&E Unplanned re-attendance	5.0%	3.3%	2.7%	3.1%	3.0%	3.2%	3.3%	-0.1%	3.1%	3.3%	-0.2%	
A&E Time to Initial Assessment (% Ambulance conveyan	M	93.1%	81.7%	79.7%	80.9%	80.8%	93.1%	-12.3%	80.9%	93.7%	-12.8%	
A&E Time to Treatment (% within 60 Minutes)	M	40.1%	48.5%	43.0%	41.1%	40.4%	40.1%	0.3%	40.7%	43.4%	-2.7%	
A&E Left before seen	M	2.2%	1.0%	1.2%	1.5%	1.4%	2.2%	-0.8%	1.4%	2.1%	-0.7%	
Non Elective Conversion Rate	M	24.6%	27.8%	27.5%	26.4%	26.0%	24.6%	1.5%	26.2%	25.5%	0.7%	
A&E Cubicle Waiters (average number per day)	M	51	56	50	51	48	52	-4	8	8	0	
Number of zero LOS NEL Ambulatory admissions	R	610	451	584	621	683	610	12.0%	1304	1266	2.9%	
% Zero LOS NEL Ambulatory admissions	M	40.5%	35.8%	38.5%	42.4%	41.5%	40.5%	2.4%	41.9%	42.0%	0.0%	
Total Non Elective Beddays	M	22694	22397	23194	22164	23011	22694	1.4%	45175	46368	-2.6%	
RTT Incomplete (%achievement)	92.0%	90.7%	89.3%	90.8%	90.8%	92.3%	90.7%	1.6%	91.5%	90.4%	1.1%	
RTT Backlog (number of patients waiting over 18 weeks)	M	2931	3131	2680	2794	2401	2931	-18.1%	56277	55376	1.6%	
RTT 52 Week waiters	0	0	0	0	0	0	0	0	0	0	0	
RTT 35 week waiters	0	140	326	302	331	277	140	137	608	252	356	

East Sussex Healthcare NHS
NHS Trust

Indicators

Indicator Description	Target	Previous Months				Current Month			YTD			Trend
		May-16	Feb-17	Mar-17	Apr-17	May-17	May-16	Var	This Yr	Last Yr	Var	
Diagnostic performance (% patients waiting over 6 weeks	1.0%	2.7%	1.2%	1.4%	5.0%	2.3%	2.7%	-0.4%	96.4%	97.2%	-0.8%	
Cancer 2WW standard	93.0%	95.6%	98.4%	98.1%	96.8%		95.6%		96.8%	95.8%	1.0%	
Cancer 2WW standard (Breast Symptoms)	93.0%	98.5%	98.8%	98.7%	96.7%		98.5%		96.7%	95.9%	0.8%	
Cancer 31 Day standard	96.0%	99.4%	98.8%	97.1%	98.1%		99.4%		98.1%	99.0%	-0.9%	
Cancer 31 Day subsequent drug treatment	98.0%	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%	94.1%	94.1%	100.0%		100.0%		100.0%	100.0%	0.0%	
Cancer 62 day urgent referral standard	85.0%	68.3%	69.9%	76.3%	76.0%		68.3%		76.0%	68.0%	8.0%	
Cancer 62 day screening standard	90.0%	66.7%	66.7%	85.7%	80.0%		66.7%		80.0%	80.0%	0.0%	
Urgent operations cancelled for a 2nd time	0	0	0	0	0	0	0	0	0	0	0	
Proportion of patients not re-booked within 28 days of las	0.0%	0.0%	2.7%	#DIV/0!	0.0%		5.7%		0.0%	0.0%	0.0%	
Delayed Transfer of Care	3.5%	5.7%	7.6%	7.3%	8.6%	6.3%	5.7%	0.6%	7.4%	5.5%	1.9%	
Outpatient appointment cancellations < 6 weeks	R	29	44	46	51	37	29	27.6%	88	43	51.1%	
Outpatient appointment cancellations > 6 weeks	R	1033	1124	1378	1247	1387	1033	34.3%	2634	2154	18.2%	

East Sussex Healthcare NHS
NHS Trust

Access and Delivery overview

The trust has made positive improvements in both RTT and A&E. Although diagnostics failed the standard it has reduced substantially from April. Continued work is underway to improve Cancer 62 Days which remains challenged.

A&E performance was 81.4% against the 95% standard. This was a marginal improvement on April. Activity has continued to increase. A&E attendances increased further showing a 10% increase on May 16 and up 8.3% year to date.

RTT incompletes was 92.3% against the 92% standard. This represents achievement of the standard. The waiting list has continued to increase and this represents a risk for future delivery

Diagnostics failed the standard – 2.3% against the 1% target. This was an improvement on the previous month. This is predominantly due to vacancies and equipment failure in radiology.

Cancer 62 Days achieved 76.0% against the 85% standard (for April, one month in arrears). This is in line with the March figure.

There were no patients waiting more than 52 weeks

2. ELECTIVE CARE

East Sussex Healthcare NHS
NHS Trust

Outpatients

Item	Measure	Target	23.04.17	30.04.17	07.05.17	14.05.17	21.05.17	30.05.17
Registration of referrals (referral received & logged on Oasis)								
0-2 days	Percentage	80%	78%	89%	84%	87%	80%	78%
3-13 days	Percentage	18%	15%	8%	13%	11%	17%	20%
14 days +	Percentage	2%	7%	2%	3%	2%	3%	2%
Total number of referrals received	Total number		**1789**	**2042**	**1739**	**2040**	**2137**	**2100**
ERS (Referrals Received & Waiting for triage)								
Number of ERS Referrals Received (Current Month - May 2017)	Total number		738	1046	255	558	877	1198
Number of ERS Referrals not triaged within 4 weeks	Total number						109	90
Number of e-referrals waiting for Triage (Current Month - May 2017)	Total number	225	302	334	186	310	443	560
Number of e-referrals still waiting for triage from previous months (Mar/Apr 2017)	Total number	0	76	64	318	199	109	90
Cashing up (incomplete)								
Current Month - May 2017 (Deadlines: RTT Submission 19/6/17)	Total number	1750	2613	2999	1380	2223	2861	4019
April 2017 (Deadlines: RTT Submission 17/5/17 & Trust 15/6/17)	Total number	175	1	2	1584	535	21	14
March 2017 (Deadlines: RTT Submission 15/04/17 & Trust 17/5/17)	Total number		0	0	1	0	2	3
YTD outcome forms not submitted within required deadline			143	123	123	122	0	0
Clinical letters								
Total number of letters submitted to BigHand	Total number		5959	7417	7749	6913	8530	7418
Total number of letters awaiting signature	Total number						3927	3244
Total number of letters signed	Total number						522	1224
Total number of letters completed and sent in less than 7 days	Total number		3011	4065	4022	4166	5032	4736
Percentage of letters completed within 7 days	Percentage	80%	51%	55%	52%	60%	59%	64%
DNAs								
New appointments	Total number	-	155	159	161	171	164	144
Follow up appointments	Total number	-	339	463	369	472	389	350
New appointments % (KPI changed w/ending 30.4.17 from 7.91%)	Median Target	7.6%	8.67%	6.48%	9.38%	7.96%	8.18%	6.61%
Follow Up appointments % (KPI changed w/ending 30.4.17 from 7.91%)	Median Target	8.1%	7.74%	7.65%	7.79%	8.07%	7.31%	6.72%
Health Records								
Number of temporary file notes created			102	176	160	154	155	168
Total Number of outpatient appointments			7884	10186	7871	9775	9253	9919
Percentage of temporary notes created based on number of outpatient appointments		1.00%	1.29%	1.73%	2.03%	1.58%	1.68%	1.69%
Cancer - 2ww booking by tumour site								
Brain	Percentage of referrals booked within 7 days		N/A	0%	0%	0%	100%	67%
Breast			26%	52%	33%	64%	30%	49%
Colorectal			25%	40%	25%	38%	16%	18%
Gynaecology			4%	27%	25%	37%	35%	26%
Head & Neck			3%	6%	16%	9%	30%	3%
Lung			18%	13%	5%	20%	29%	11%
Max Fax			17%	67%	14%	13%	44%	50%
Other			0%	50%	0%	0%	67%	0%
Paediatrics			N/A	50%	N/A	0%	100%	N/A
Skin			1%	45%	53%	3%	24%	32%
Upper GI			15%	14%	27%	27%	61%	29%
Urology			24%	48%	33%	67%	54%	62%
Total Number of 2ww Referrals Received (processed within timescales - see below for details)	Total Number		**353**	**327**	**407**	**334**	**415**	**421**
Number of 2ww referrals booked within 7 days			53	121	123	106	142	139
Number of 2ww referrals booked within 8 - 14 days			299	205	280	226	256	271
Number of 2ww referrals booked outside 14 days		0	1	1	4	2	17	11
Theatre Cancellations due to Notes not being Present								
Number of patients who had their TCI cancelled	Total number	0	0	0	0	0	1	0

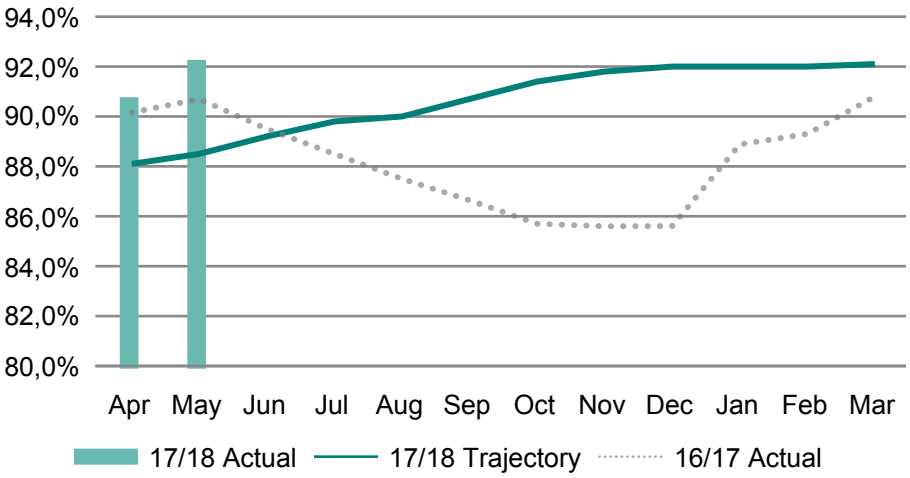
Complaints								
Total number received re clinical administration via PALS contacts	Total number		9	13	7	10	10	14
Total number formal written complaints re clinical administration being the Lead Investigator (data supplied by PALS/Complaints team)	Total number		0	0	0	0	0	0
Datix incidents raised relating to Patient Experience during OPA (reported per week)	Total number		0	1	5	1	1	0
Number of PALs contacts relating to Patient Experience during OPA	Total number		0	0	0	0	0	0
Number of formal complaints relating to Patient Experience during OPA	Total number		0	0	0	0	0	0
Outpatient Clinic Cancellations / Changes								
Total clinic cancellations / changes received	Total number	-	104	204	130	151	154	133
Clinic cancellations / changes requests received less than 6 weeks notice (excluding CQ Cardiology and CQ T&O)	Total number		45	66	55	59	51	64
Total number of appointment slots cancelled / changed with less than 6 weeks notice								1743
Clinic cancellations / changes received less than 4 weeks notice to patients (excluding CQ Cardiology and CQ T&O)	Total Number		24	45	34	41	35	44
Total number of appointment slots cancelled / changed with less than 4 weeks notice								1173
Outpatient Appointments Cancelled by Hospital								
Number of New patients affected	Total number		282	388	312	481	485	398
Number of Follow-Up patients affected	Total number		1700	2006	1672	1978	2109	2074
Number of New and Follow Up patients Cancelled / rescheduled as overall % of average outpatients	Percentage	15%	25%	24%	25%	25%	28%	25%
Outpatient Appointments Cancelled by Patient								
Number of New Appointments Cancelled	Total number		335	456	331	431	406	474
Number of Follow-Up Appointments Cancelled	Total number		893	1135	905	1096	1079	1150
Outpatient Clinic Utilisation								
Cardiovascular			N/A	N/A	N/A	N/A	N/A	N/A
Medicine			57.6%	59.3%	57.5%	56.7%	51.5%	52.3%
Surgery			67.0%	72.0%	74.3%	68.4%	65.2%	61.3%
Women and Children (excludes Paed Epilepsy and Paed Surgery)			58.9%	61.6%	61.1%	66.4%	63.2%	58.4%
Inpatient Theatre Utilisation								
Theatre Utilisation		85.00%	86.74%	88.18%	88.83%	87.61%	87.76%	86.02%
Theatre hours available			439	557	427.5	545.5	518.5	528.5
Theatre hours utilised			380.78	491.18	379.77	477.90	455.02	454.62
Unused theatre sessions (figure quoted in hours)			163.5	153	154.5	149.5	156	136.5
OP Booking (Conquest) - Telephone Call Handling								
Number of calls presented / received			2496	2510	2108	2472	2589	2426
Number of calls incorrectly presented to OP booking office			142	159	111	112	102	82
Number of calls answered			1838	2110	1679	2021	2166	1992
Number of calls not answered after automated welcome message			658	400	429	451	423	434
Average waiting time (minutes)		TBC	04:40	04:33	05:32	04:51	04:27	04:40

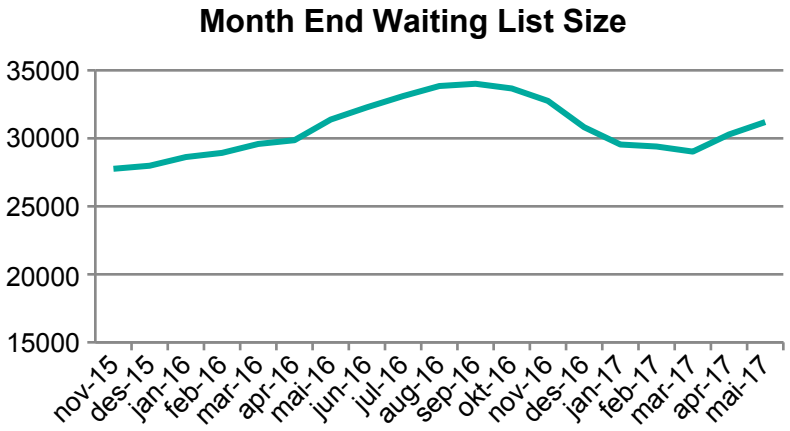
Outpatients

Weekly Exception Reporting:
Registering of Referrals: KPIs achieved for - 3-13 Days and 14+ days.
eRS: Longest wait for triage is currently 14/3/17. This KPI is monitored on the Clinical Admin daily operational call and information is sent daily to the Service Managers for escalation.
Cashing up: March cashing up stands at three. The team are working on April and May outcome forms with additional resources.
Clinical Letters: Slight increase in performance compared to the previous week. The team continue to target those specialties that have a delay in the signing and validating of letters. Work ongoing to improve further with reporting data available every 24hours for Service Managers to access.
DNA Performance: Excellent achievement on both New and Follow-up appointments last week. A change to the call reminder service has been made which would have taken effect from last week is that we now include Locum clinics for this service (with a few exceptions).
Health Records: Overall percentage of temporary sets created was 1.69%, which is similar to the previous weeks. A significant number of the temp sets created, relate to late add-on's to OP clinics. Monitored daily and detailed analysis being undertaken to establish reason for temporary wallets being created.
Cancer 2ww booking performance: 33% of referrals received were booked within seven days a decrease on previous weeks . With 11 booked over 14 days 1 due to patient being on holiday the rest due to capacity.
Theatre Cancellations due to Notes not being Present: Zero cancellations due to no notes last week.
Complaints: No Formal complaints and 14 PALs contacts received last week.
Outpatient Clinic Utilisation: The Productive Outpatient Group screening and clearing all dormant clinics to improve accuracy of data
Outpatient Clinic Cancellations/Changes: New data added to show the number of appointment slots cancelled/changed. Short notice clinic cancellations increased last week, compared to the previous week for both KPIs - "less than six weeks notice" and "less than four weeks notice".
OP Booking (Conquest) Telephone Call Handling: Waiting times have stayed at a steady level for our patients calling in when compared to the previous week. Work ongoing to look at ways to reduce the number of calls our patients are required to make to the Trust by increasing patient choice initially.

RTT

May performance was 92.27% against the trajectory of 88.5%. This meets the required target and represents a further improvement in performance. The waiting list has seen a further incremental increase, in part due to lower admissions in April and a reduction in out-scourcing. An outsourcing plan is being discussed to supplement additional throughput in theatres and outpatient efficiencies to mitigate the impact of additional cost to the reduce the backlog.





East Sussex Healthcare NHS
NHS Trust

All Incomplete Pathways Main Specialty Report

[Back]

Specialty		Breaches	NonBreaches	Total Cases	Performance	
General Surgery	Report	557	4078	4635	87.98%	✗
Urology	Report	101	1963	2064	95.11%	✓
Trauma & Orthopaedics	Report	327	2245	2572	87.29%	✗
Ear, Nose & Throat (ENT)	Report	535	3650	4185	87.22%	✗
Ophthalmology	Report	211	3796	4007	94.73%	✓
Oral Surgery	Report	57	1784	1841	96.90%	✓
Neurosurgery	-					
Plastic Surgery	-					
Cardiothoracic Surgery	-					
General Medicine	Report	3	107	110	97.27%	✓
Gastroenterology	Report	83	2092	2175	96.18%	✓
Cardiology	Report	45	1883	1928	97.67%	✓
Dermatology	Report	2	714	716	99.72%	✓
Thoracic Medicine	Report	6	717	723	99.17%	✓
Neurology	Report	57	1014	1071	94.68%	✓
Rheumatology	Report	11	337	348	96.84%	✓
Geriatric Medicine	Report	10	286	296	96.62%	✓
Gynaecology	Report	289	1870	2159	86.61%	✗
Other	Report	116	2251	2367	95.10%	✓
	Totals	2410	28787	31197		

Non-Admitted Incomplete Main Specialty Report

[Back]

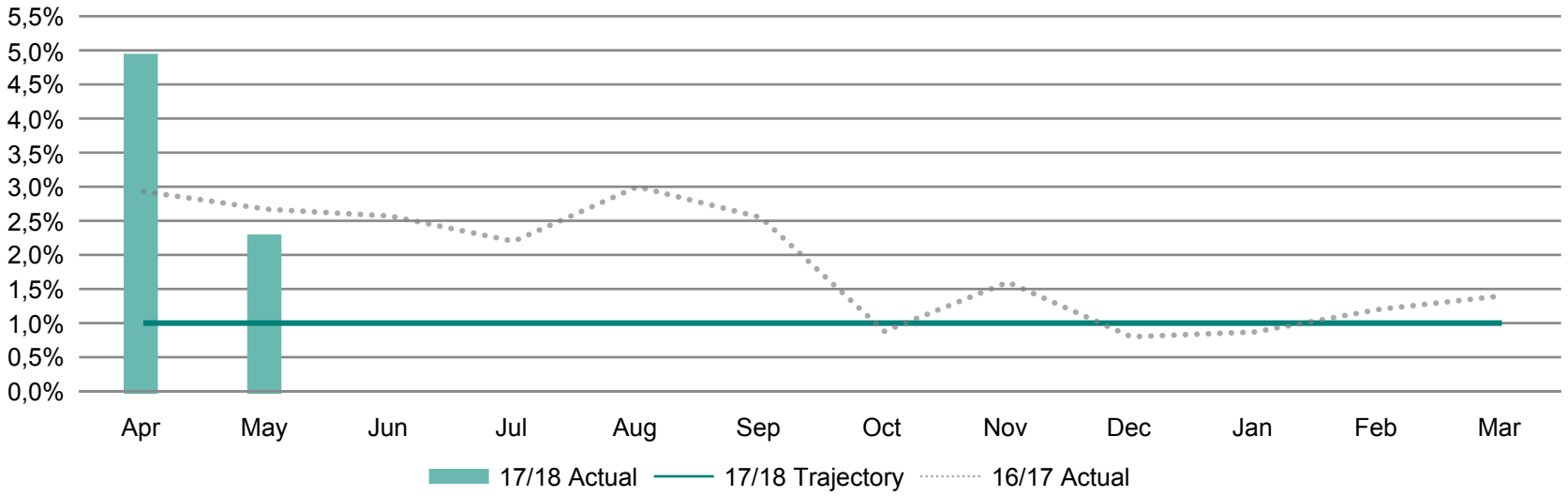
Specialty		Breaches	NonBreaches	Total Cases	Performance	
General Surgery	Report	375	3722	4097	90.85%	✗
Urology	Report	44	1537	1581	97.22%	✓
Trauma & Orthopaedics	Report	95	1742	1837	94.83%	✓
Ear, Nose & Throat (ENT)	Report	214	3326	3540	93.95%	✓
Ophthalmology	Report	49	2723	2772	98.23%	✓
Oral Surgery	Report	22	1392	1414	98.44%	✓
Neurosurgery	-					
Plastic Surgery	-					
Cardiothoracic Surgery	-					
General Medicine	Report	3	106	109	97.25%	✓
Gastroenterology	Report	83	2083	2166	96.17%	✓
Cardiology	Report	41	1804	1845	97.78%	✓
Dermatology	Report	1	656	657	99.85%	✓
Thoracic Medicine	Report	6	715	721	99.17%	✓
Neurology	Report	57	1014	1071	94.68%	✓
Rheumatology	Report	11	336	347	96.83%	✓
Geriatric Medicine	Report	10	286	296	96.62%	✓
Gynaecology	Report	23	1513	1536	98.50%	✓
Other	Report	116	2248	2364	95.09%	✓
	Totals	1150	25203	26353		

Admitted Incomplete Main Specialty Report

[Back]

Specialty		Breaches	NonBreaches	Total Cases	Performance	
General Surgery	Report	182	356	538	66.17%	✗
Urology	Report	57	426	483	88.20%	✗
Trauma & Orthopaedics	Report	232	503	735	68.44%	✗
Ear, Nose & Throat (ENT)	Report	321	324	645	50.23%	✗
Ophthalmology	Report	162	1073	1235	86.88%	✗
Oral Surgery	Report	35	392	427	91.80%	✗
Neurosurgery	-					
Plastic Surgery	-					
Cardiothoracic Surgery	-					
General Medicine	Report	0	1	1	100.00%	✓
Gastroenterology	Report	0	9	9	100.00%	✓
Cardiology	Report	4	79	83	95.18%	✓
Dermatology	Report	1	58	59	98.31%	✓
Thoracic Medicine	Report	0	2	2	100.00%	✓
Neurology	-					
Rheumatology	Report	0	1	1	100.00%	✓
Geriatric Medicine	-					
Gynaecology	Report	266	357	623	57.30%	✗
Other	Report	0	3	3	100.00%	✓
	Totals	1260	3584	4844		

Diagnostics



Diagnostics failed to meet the 1% standard with a performance of 2.3%, this is an improvement on the 4.97% in April. Plans are in place from Radiology in order to minimise the risk of further breaches however this may take some time to impact fully. This includes the procurement of new equipment and recruitment plans. Discussions have also been held with the local CCG's regarding support from AQPs.

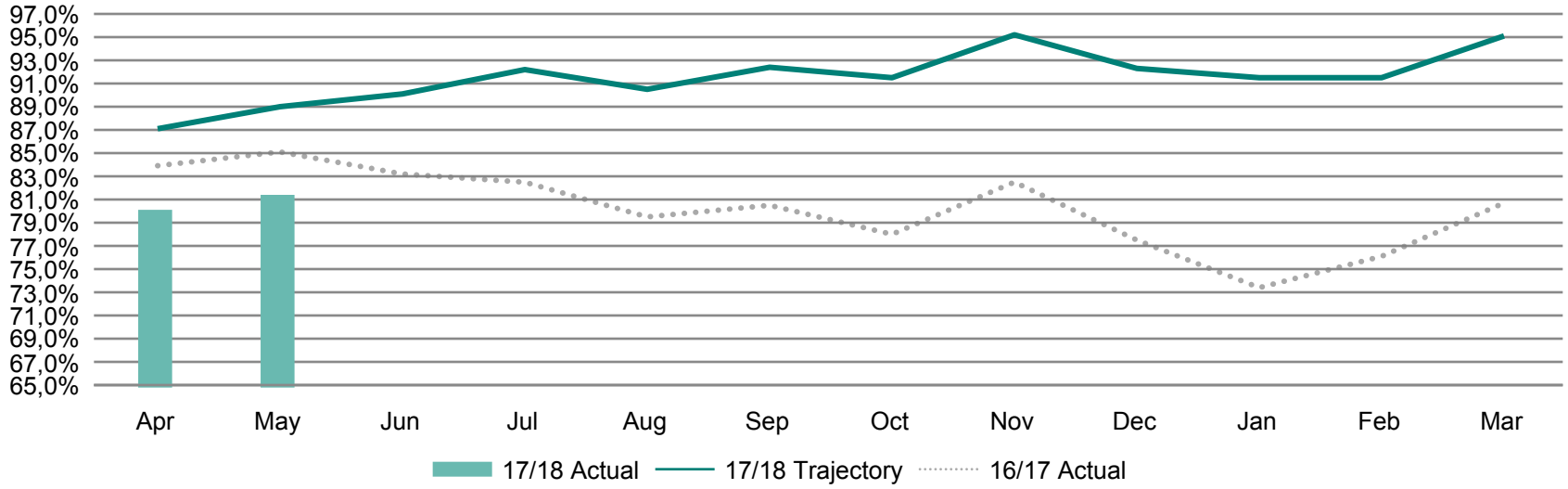
The breaches were:

	Breaches
Cyst/Urology	4
Endoscopy	9
TOE	2
Sleep Studies	3
Radiology	119
Total	137

3. EMERGENCY CARE

East Sussex Healthcare NHS
NHS Trust

A&E Trajectory



A&E performance improved marginally in May with a Trust wide figure of 81.4%

Attendances remain on the increase across both sites and were up 5.1% on May 2016, and 6.9% year on year

The Trust is undertaking a 4 week improvement challenge starting in mid June with a concerted effort across the Trust to meet the 4 hour clinical standard.

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

Overarching Plan

East Sussex Healthcare NHS
NHS Trust

Preventing Admission
- Crisis response
- Extended HIT
- Frailty Teams
- DOS review
- Increase primary care access

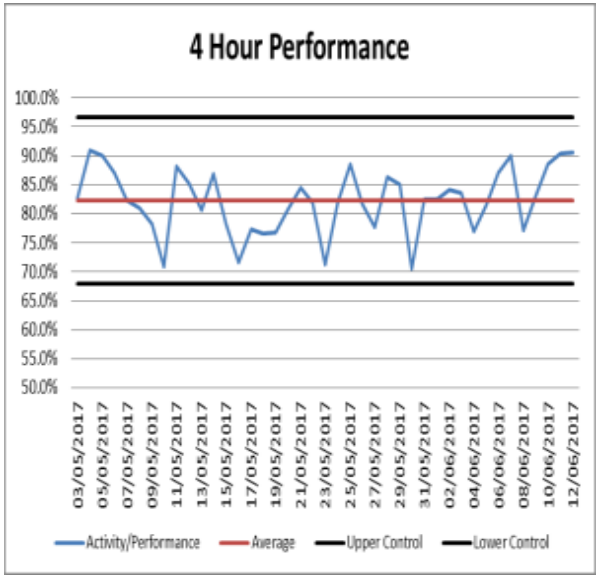
ED Processes
- Staffing profiles to meet demand
- Co-located primary care
- Streaming to speciality
- Appropriate use of CDU
- Separate minors stream and ENP capacity

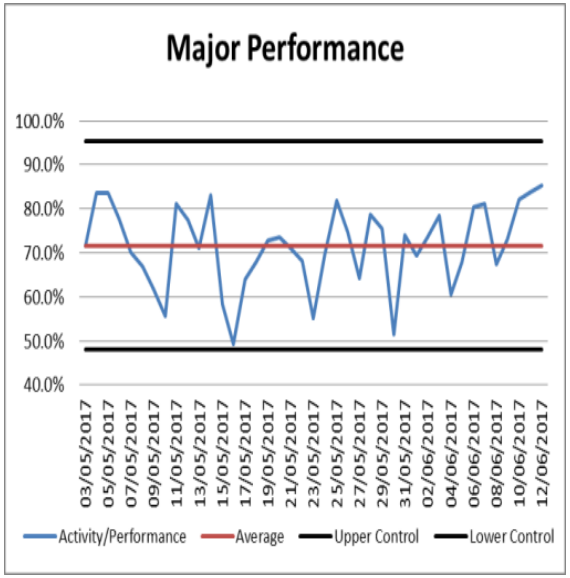
Medical Model
- Enhanced AEC and AMUs
- Frailty at front door
- Hot clinic access
- Speciality in reach to AMU
- Extended AEC opening hours

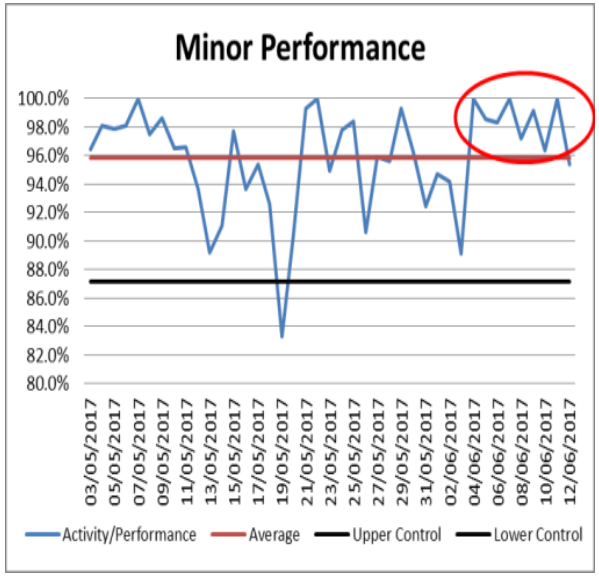
Patient Flow
- Red to Green
- Integrated Discharge Team
- Stranded patient review
- Daily discharge tracking
- Use of choice policy

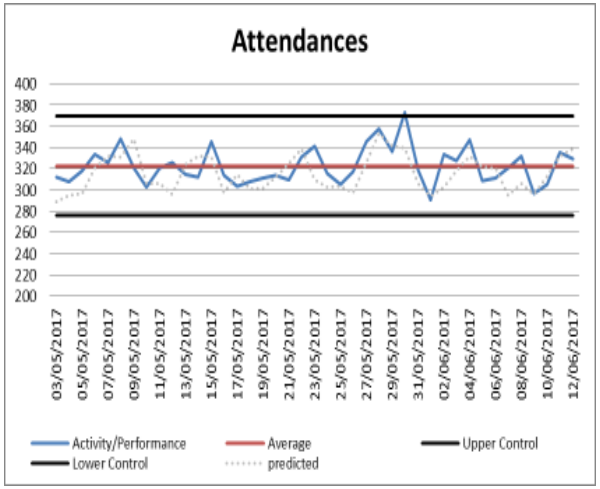
Community
- Integrated Support Workers
- Care Home Plus
- Increased rates for NH
- Discharge to assess
- Trusted assessor

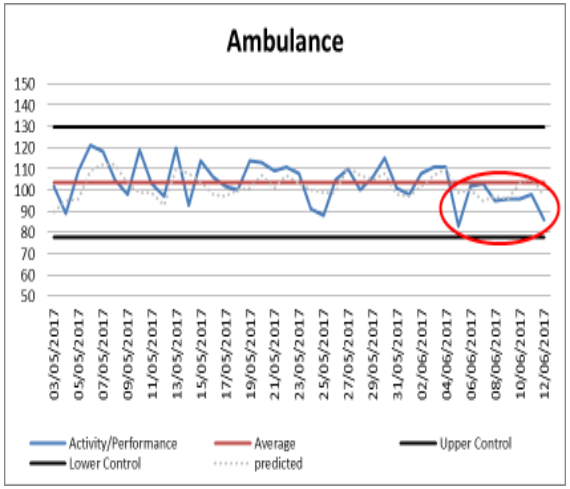
Operational Processes
- Capacity modelling
- Escalation and full capacity policy
- Extended clinical site management
- Improvement Director

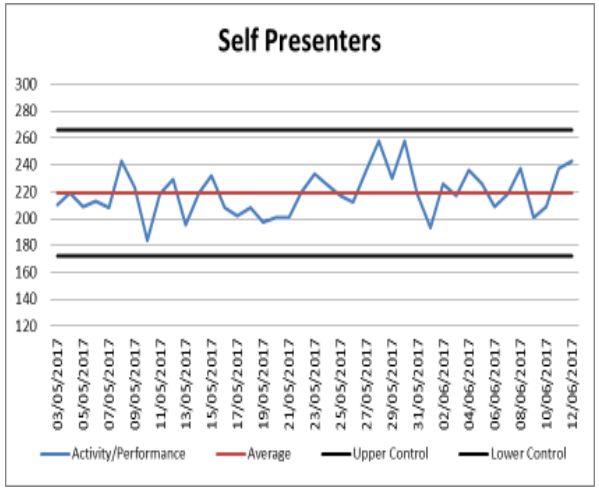

4 Hour Performance
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
03/05/2017
05/05/2017
07/05/2017
09/05/2017
11/05/2017
13/05/2017
15/05/2017
17/05/2017
19/05/2017
21/05/2017
23/05/2017
25/05/2017
27/05/2017
29/05/2017
31/05/2017
02/06/2017
04/06/2017
06/06/2017
08/06/2017
10/06/2017
12/06/2017
Activity/Performance
Average
Upper Control
Lower Control


Major Performance
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
03/05/2017
05/05/2017
07/05/2017
09/05/2017
11/05/2017
13/05/2017
15/05/2017
17/05/2017
19/05/2017
21/05/2017
23/05/2017
25/05/2017
27/05/2017
29/05/2017
31/05/2017
02/06/2017
04/06/2017
06/06/2017
08/06/2017
10/06/2017
12/06/2017
Activity/Performance
Average
Upper Control
Lower Control

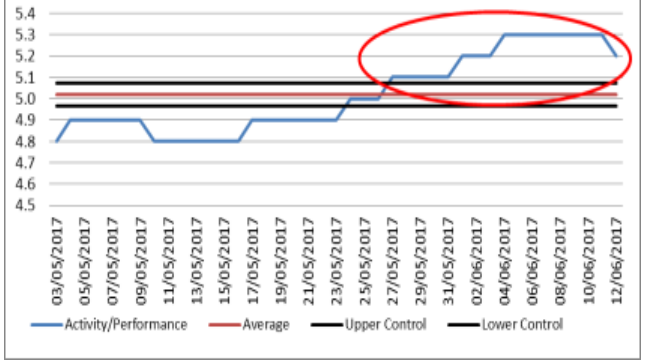

Minor Performance
100.0%
98.0%
96.0%
94.0%
92.0%
90.0%
88.0%
86.0%
84.0%
82.0%
80.0%
03/05/2017
05/05/2017
07/05/2017
09/05/2017
11/05/2017
13/05/2017
15/05/2017
17/05/2017
19/05/2017
21/05/2017
23/05/2017
25/05/2017
27/05/2017
29/05/2017
31/05/2017
02/06/2017
04/06/2017
06/06/2017
08/06/2017
10/06/2017
12/06/2017
Activity/Performance
Average
Upper Control
Lower Control


Attendances
400
380
360
340
320
300
280
260
240
220
200
03/05/2017
05/05/2017
07/05/2017
09/05/2017
11/05/2017
13/05/2017
15/05/2017
17/05/2017
19/05/2017
21/05/2017
23/05/2017
25/05/2017
27/05/2017
29/05/2017
31/05/2017
02/06/2017
04/06/2017
06/06/2017
08/06/2017
10/06/2017
12/06/2017
Activity/Performance
Average
Upper Control
Lower Control
predicted

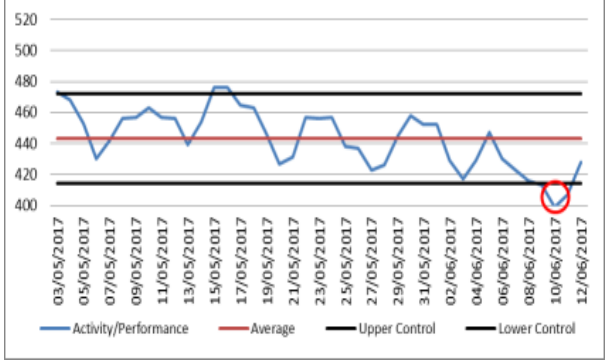

Ambulance
150
140
130
120
110
100
90
80
70
60
50
03/05/2017
05/05/2017
07/05/2017
09/05/2017
11/05/2017
13/05/2017
15/05/2017
17/05/2017
19/05/2017
21/05/2017
23/05/2017
25/05/2017
27/05/2017
29/05/2017
31/05/2017
02/06/2017
04/06/2017
06/06/2017
08/06/2017
10/06/2017
12/06/2017
Activity/Performance
Average
Upper Control
Lower Control
predicted


Self Presenters
300
280
260
240
220
200
180
160
140
120
03/05/2017
05/05/2017
07/05/2017
09/05/2017
11/05/2017
13/05/2017
15/05/2017
17/05/2017
19/05/2017
21/05/2017
23/05/2017
25/05/2017
27/05/2017
29/05/2017
31/05/2017
02/06/2017
04/06/2017
06/06/2017
08/06/2017
10/06/2017
12/06/2017
Activity/Performance
Average
Upper Control
Lower Control

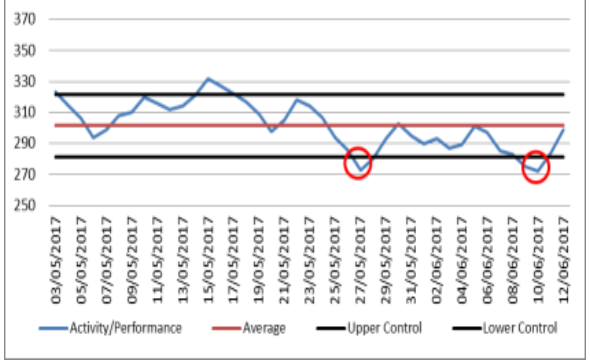
NEL Average Length of Stay (rolling 42 Days)



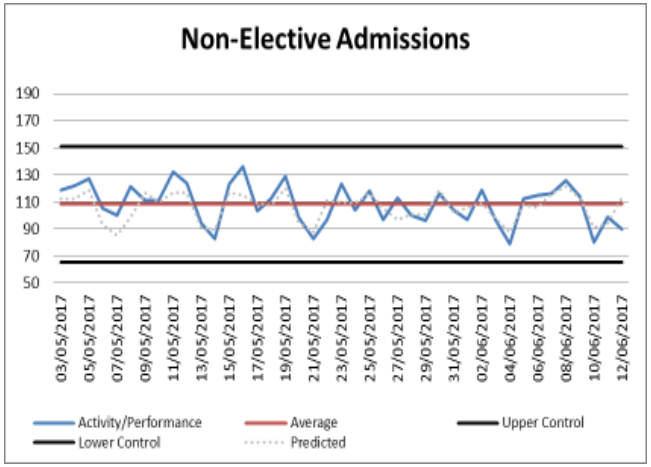
Stranded Patients >=7 Days LOS



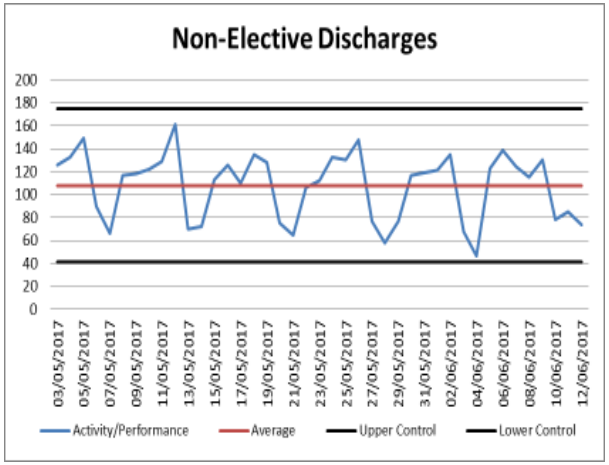
Long Stay Patients >=14 Days LOS



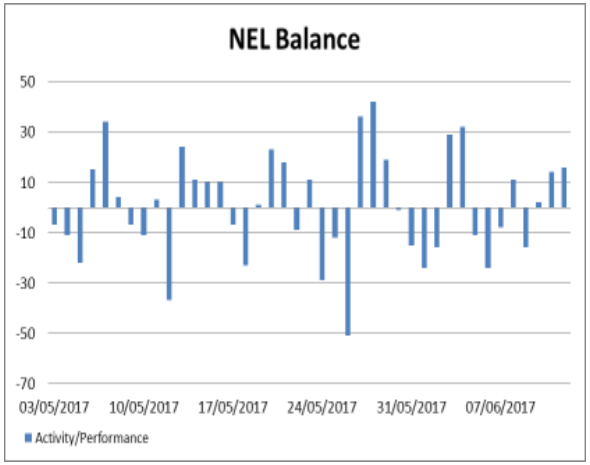
Non-Elective Admissions



Non-Elective Discharges



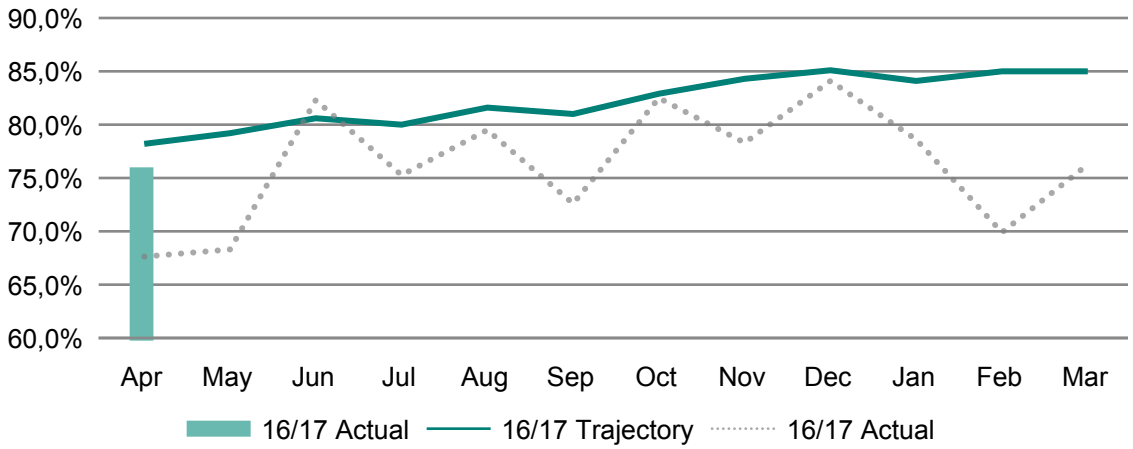
NEL Balance



4. CANCER

East Sussex Healthcare NHS
NHS Trust

CANCER 62 Days



Achieved: 2 week wait

Achieved: 31 Day Standard

Did not achieve trajectory (78.2%) or the Standard (85%) for 62 Days with a performance of 76%

April 2017 2WW Ref to First Treatment 62 Days

Site	Seen/Treated			On Target			Breaches			Compliance			Target
	Conq.	EDGH	All	Conq.	EDGH	All	Conq.	EDGH	All	Conq.	EDGH	All	
Breast Cancer	5.0	9.0	14.0	5.0	9.0	14.0	0.0	0.0	0.0	100 %	100 %	100 %	85 %
Colorectal	6.5	5.0	11.5	4.5	4.0	8.5	2.0	1.0	3.0	69.2 %	80.0 %	73.9 %	85 %
Gynaecology	1.0	1.0	2.0	1.0	1.0	2.0	0.0	0.0	0.0	100 %	100 %	100 %	85 %
Haematology	1.0	1.0	2.0	0.0	1.0	1.0	1.0	0.0	1.0	0.0 %	100 %	50.0 %	85 %
Head & Neck	2.5	1.0	3.5	0.0	1.0	1.0	2.5	0.0	2.5	0.0 %	100 %	28.6 %	85 %
Lung	5.5	2.0	7.5	4.0	2.0	6.0	1.5	0.0	1.5	72.7 %	100 %	80.0 %	85 %
Other	0.5	0.0	0.5	0.5	0.0	0.5	0.0	0.0	0.0	100 %		100 %	85 %
Sarcoma	0.5	0.0	0.5	0.5	0.0	0.5	0.0	0.0	0.0	100 %		100 %	85 %
Skin	11.5	15.0	26.5	10.0	14.0	24.0	1.5	1.0	2.5	87.0 %	93.3 %	90.6 %	85 %
Upper GI	5.0	2.0	7.0	4.0	2.0	6.0	1.0	0.0	1.0	80.0 %	100 %	85.7 %	85 %
Urology	2.0	21.0	23.0	1.0	10.0	11.0	1.0	11.0	12.0	50.0 %	47.6 %	47.8 %	85 %
Total	41.0	57.0	98.0	30.5	44.0	74.5	10.5	13.0	23.5	74.4 %	77.2 %	76.0 %	85 %

The 62 Day Target is a key national priority. Achievement has been set for September 2017. The NHSI is providing a package of support to assist in the delivery of the target. This includes improvement managers and tertiary pathway trackers

Completed Actions

- New prostate pathway implemented, dedicated MP MRI scan slots for prostate patients are now available . Data collection of the pathway in progress to support analysis and comparison with previous pathway. Joint PTL with Guys & St Thomas's is now in place to run weekly in order to replicate the scrutiny on 38 day transfers currently in place with MTW and BSUH.
- 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.
- Shared 62 Day PTL meeting with BSUH commenced on 10th February 17 and supports the transfer of Day 38 patients and the 62 Day target.
- 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.
- Head & Neck intensive pathway review took place on Monday 6th March 2017, pathway reviewed and improvements agreed in order to streamline the admin/diagnostic phase of the pathway. Re-review meeting to be arranged in 3 months.
- Colorectal Intensive pathway review took place on 7th April 17, pathway reviewed and improvements agreed in order to improve access to OPD capacity and position paper to be completed with regards to straight to colonoscopy.

Planned Actions

- Collaborative working on NG12 continues with CCG partners. Additional scoping work underway for the straight to diagnostics element of the NG12. The forms went live from 1st April 2017.
- Review of Oncology SLAs to ensure adequate capacity for ongoing increased demand. Review is underway and an initial introduction meeting has taken place with further review meetings scheduled for 16th June 2017.
- Following funding agreement from NHSE, Fusion biopsy software for prostate patients has been purchased and training has commenced.
- Local EBUS service to commenced 8th June 2017.
- Lung Intensive pathway review meeting to be arranged to take place at the beginning of June (date to be confirmed at Lung AGM 27/04/17).
- Upper GI have been identified as the next tumour site to undergo an intensive pathway review.
- Respiratory team investigating the introduction of electronic booking for Bronchoscopy.
- Deep dive analysis of Oncology backlogs in all tumour sites underway to establish case for additional ad hoc clinics to bring waits back into line with compliance.

Finance

FINANCE

Financial Summary – May 2017

Key metrics	Plan YTD	Actual YTD	Plan Out-turn	Forecast Out-turn
Agreed control total (inc STF) (£'m)	(7.6)	(7.6)	(26.5)	(26.5)
Efficiency requirement (£'m)	1.4	1.4	28.7	28.7
Cash balance(£'m)	2.1	2.7	2.1	2.1

Better Payments practice code	Month Volume	Month Value	YTD Volume	YTD Value
Trade invoices	12.2%	28.5%	11.1%	24.8%
NHS invoices	23.5%	95.6%	21.2%	95.9%

Target: 95% on all categories

NHSI Finance and use of resources metrics	Plan YTD	Actual YTD	Plan Out-turn	Forecast Out-turn
Capital service cover rating	4	4	4	4
Liquidity rating	2	3	3	4
I&E margin rating	4	4	4	4
Distance from financial plan	1	2	1	1
Agency rating	1	1	1	1
Overall		3		3
Risk ratings after overrides		4		4

FSM override generates score of 4

Key Issue	Summary
Financial Summary	The Trust delivered to plan for May however the month was not without it's challenges. Contract income was £2.4m higher than April giving support to the hypothesis that April was impacted by consultant leave. However, collectively the five operational divisions are in total £0.7m adrift from plan YTD. Improved grip and control measures ensured delivery of the financial position. Some of the escalation capacity has been closed recently.
Efficiencies	The Trust has a £28.7m CIP target for 2017/18 which is heavily phased towards the latter part of the year and at Month 2 some of these savings remain unallocated. In May the CIP number was delivered but this was reliant on over performance of grip and control measures.
Balance Sheet	The Trust continues to draw down loan funding to support operational deficits.
Cash Flow	Cashflow remains challenging resulting in increased creditor values and poor performance against the Better Payment Practice Code. The Trust has drawn cash equivalent to the income and expenditure deficit to date.
Capital Programme	The overall capital programme is over-committed by £2.1m, it is anticipated that that some schemes will slip and mitigate the risk of overspending. Capital Review Group (CRG) is monitoring capital spend.

Variance Highlights – May 2017

Division	Variance against budget YTD (£'m) Other Income	Contract Income	Pay	Non pay	Total
Medicine	0.0	(0.0)	(0.2)	(0.1)	(0.3)
Surgery	(0.2)	(0.4)	(0.2)	(0.0)	(0.8)
Emergency Care	0.0	0.3	(0.0)	(0.0)	0.2
Womens & Childrens	0.0	0.3	(0.1)	(0.0)	0.2
Out of Hospital	(0.1)	(0.3)	0.4	(0.0)	(0.1)
Operational sub total	**(0.2)**	**(0.2)**	**(0.1)**	**(0.1)**	**(0.7)**
Estates & Facilities	(0.1)	-	0.1	(0.1)	(0.1)
Central and Corporate	0.2	0.5	0.3	(0.2)	0.8
Capital Charges	-	-	-	0.1	0.1
Total trading deficit	**(0.2)**	**0.2**	**0.2**	**(0.3)**	**0.1**
Donated assets adj	-	-	-	(0.1)	(0.1)
TEDDs	-	(0.5)	-	0.5	0.0
STF	-	0.0	-	-	0.0
Total deficit	(0.2)	(0.2)	0.2	0.1	0.0

Adverse variances less than £50k (£0.05m) are shown as green.
More detailed tables of variances are shown on pages 5 and 6.

Operational highlights

During April three of the five operational divisions are behind plan and collectively these total £0.7m. This represents an improvement of £1m against April. DAS remains the largest variance and the broadly the other four divisions net out to zero. Although contact income is the biggest element of the DAS underperformance they are only area that is below plan on all cost groups.

Corporate highlights

Estates and Facilities are slightly behind plan on both income and non pay although this is partly offset by pay underspends.

Central and corporate are ahead of plan on contract income relating to last year. Corporate vacancies and over delivery on other income off set overspends in non pay

TEDDs (Tariff Excluded Drugs and Devices) are pass through income and costs and therefore the variances net out.

Income & Expenditure – May 2017

I&E Summary (£'m)	In Month			YTD			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
NHS Patient Income	25.6	27.0	1.4	51.6	51.8	0.2	318.4	318.4	-
Tariff-Excluded Drugs & Devices	2.8	2.7	(0.1)	5.6	5.1	(0.5)	33.5	33.5	-
Private Patient / ICR	0.3	0.2	(0.1)	0.6	0.5	(0.1)	3.7	3.7	-
Other Non Clinical Income	2.8	2.9	0.1	5.9	5.9	-	34.5	34.5	-
Total Income	**31.5**	**32.8**	**1.3**	**63.7**	**63.3**	**(0.4)**	**390.1**	**390.1**	**-**
Pay - Substantive	(22.9)	(20.0)	2.9	(45.3)	(39.9)	5.4	(268.9)	(244.2)	24.7
Pay - Bank	(0.4)	(1.8)	(1.4)	(0.9)	(3.5)	(2.6)	(4.5)	(18.5)	(14.0)
Pay - Agency	(0.2)	(1.4)	(1.2)	(0.4)	(2.9)	(2.5)	(1.4)	(12.1)	(10.7)
Total Pay	**(23.5)**	**(23.2)**	**0.3**	**(46.6)**	**(46.3)**	**0.3**	**(274.8)**	**(274.8)**	**-**
Drugs	(3.3)	(3.6)	(0.3)	(6.6)	(6.7)	(0.1)	(39.7)	(39.7)	-
Supplies and services - Clinical	(2.0)	(3.1)	(1.1)	(5.5)	(5.6)	(0.1)	(33.2)	(33.2)	-
Supplies and services - General	(0.4)	(0.4)	-	(0.7)	(0.8)	(0.1)	(4.1)	(4.1)	-
Purchase of healthcare from non NHS bod	0.2	(0.4)	(0.6)	(0.7)	(0.8)	(0.1)	(3.9)	(3.9)	-
Consultancy costs	-	(0.1)	(0.1)	(0.1)	(0.1)	-	(0.4)	(0.4)	-
Clinical Negligence	(1.2)	(1.2)	-	(2.4)	(2.4)	-	(14.6)	(14.6)	-
Premises	(1.3)	(1.1)	0.2	(2.2)	(2.2)	-	(13.5)	(13.5)	-
Depreciation	(1.0)	(1.0)	-	(2.1)	(2.1)	-	(12.8)	(12.8)	-
Other	(2.0)	(1.9)	0.1	(4.1)	(3.6)	0.5	(21.3)	(21.3)	-
Total Non Pay	**(11.0)**	**(12.8)**	**(1.8)**	**(24.4)**	**(24.3)**	**0.1**	**(143.5)**	**(143.5)**	**-**
Total Operating Costs	**(34.5)**	**(36.0)**	**(1.5)**	**(71.0)**	**(70.6)**	**0.4**	**(418.3)**	**(418.3)**	**-**
Surplus/-Deficit from Operations	**(3.0)**	**(3.2)**	**(0.2)**	**(7.3)**	**(7.3)**	**-**	**(28.2)**	**(28.2)**	**(0.0)**
Financing Costs: Interest, PDC, Etc	(1.0)	(0.8)	0.2	(1.3)	(1.3)	-	(8.2)	(8.2)	-
Total Non Operating Costs	**(1.0)**	**(0.8)**	**0.2**	**(1.3)**	**(1.3)**	**-**	**(8.2)**	**(8.2)**	**-**
Total Costs	**(35.5)**	**(36.8)**	**(1.3)**	**(72.3)**	**(71.9)**	**0.4**	**(426.5)**	**(426.5)**	**-**
Net Surplus/-Deficit	**(4.0)**	**(4.0)**	**-**	**(8.6)**	**(8.6)**	**-**	**(36.4)**	**(36.4)**	**(0.0)**
Donated Asset/Impairment Adjustment	-	-	-	-	-	-	-	-	-
Operational Surplus/-Deficit	**(4.0)**	**(4.0)**	**-**	**(8.6)**	**(8.6)**	**-**	**(36.4)**	**(36.4)**	**(0.0)**
Sustainability & Transformation Fund	0.5	0.5	-	1.0	1.0	-	9.9	9.9	-
Net Surplus/-Deficit	**(3.5)**	**(3.5)**	**(0.0)**	**(7.6)**	**(7.6)**	**-**	**(26.5)**	**(26.5)**	**(0.0)**

Divisional Performance (1) – May 2017

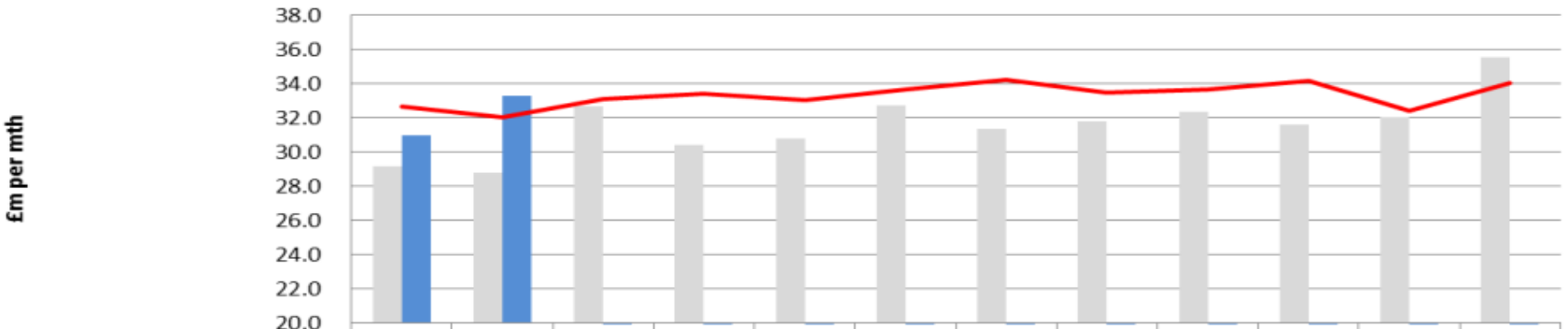
Divisional Summary (£'m)	In Month			YTD			Forecast			Notes
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	
Urgent Care:										A&E income (£0.2m YTD) and NEL (£0.1m YTD) both ahead of plan. Pay and non pay both broadly on plan. Annexe costs now shown in medicine.
Contract Income	1.8	1.9	0.1	3.4	3.6	0.2	19.8	19.8	0.0	
Other Income	(0.1)	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	
Pay	(0.9)	(0.9)	0.0	(1.9)	(1.9)	0.0	(10.4)	(10.4)	0.0	
Non Pay	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0	(0.6)	(0.6)	0.0	
Total	**0.7**	**0.9**	**0.2**	**1.4**	**1.6**	**0.2**	**8.8**	**8.8**	**0.0**	
Medicine:										YTD Contract income; over performance in geriatric (£1.0m) & respiratory (£0.6m) offsets underperformance in general medicine (£0.9m), cardiology (£0.4m) and gastro (£0.3m). YTD Pay overspends predominately driven by medical agency usage in gastro. Non pay endoscopy costs YTD continue to exceed budget.
Contract Income	7.0	7.2	0.2	13.9	13.9	0.0	85.8	85.8	0.0	
Other Income	0.2	0.2	0.0	0.6	0.5	(0.1)	2.3	2.3	0.0	
Pay	(4.9)	(5.1)	(0.2)	(9.7)	(9.9)	(0.2)	(55.5)	(55.5)	0.0	
Non Pay	(0.7)	(0.7)	0.0	(1.4)	(1.5)	(0.1)	(8.2)	(8.2)	0.0	
Total	**1.6**	**1.6**	**0.0**	**3.4**	**3.0**	**(0.4)**	**24.4**	**24.4**	**0.0**	
DAS:										YTD contract income Under performance in 13 out of 19 specialties (including T&O £0.4m, Max facs £0.2m) are partially offset by over performance in general surgery (£0.6m). Overspends on theatre agency nursing, medical locums and WLIs across the division drive YTD pay overspends
Contract Income	8.7	9.3	0.6	17.7	17.3	(0.4)	112.1	112.1	0.0	
Other Income	0.4	0.3	(0.1)	0.9	0.7	(0.2)	5.8	5.8	0.0	
Pay	(7.3)	(7.4)	(0.1)	(14.5)	(14.7)	(0.2)	(87.0)	(87.0)	0.0	
Non Pay	(2.7)	(2.8)	(0.1)	(5.2)	(5.2)	0.0	(30.4)	(30.4)	0.0	
Total	**(0.9)**	**(0.6)**	**0.3**	**(1.1)**	**(1.9)**	**(0.8)**	**0.5**	**0.5**	**0.0**	
WAC										May contract income significantly (14% - £0.5m) higher than April. YTD underperformance against the community block £0.1m is surpassed by over performance in paeds (£0.2m), midwifery service (£0.2m) & obstetrics (£0.1m) giving rise to being £0.3m ahead of plan. Medical agency and WLI payments drive the YTD pay variance
Contract Income	3.5	4.0	0.5	7.2	7.5	0.3	44.2	44.2	0.0	
Other Income	0.1	0.0	(0.1)	0.1	0.1	0.0	0.3	0.3	0.0	
Pay	(2.5)	(2.6)	(0.1)	(5.0)	(5.1)	(0.1)	(29.5)	(29.5)	0.0	
Non Pay	(0.3)	(0.3)	0.0	(0.6)	(0.6)	0.0	(3.5)	(3.5)	0.0	
Total	**0.8**	**1.1**	**0.3**	**1.7**	**1.9**	**0.2**	**11.5**	**11.5**	**0.0**	

Divisional Performance (2) – May 2017

Divisional Summary (£'m)	In Month			YTD			Forecast			Notes
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	
Out of Hospital:										PMU exceeded it's income plan for M2 but remains (£0.1m) below plan YTD. Community therapies block (£0.2m YTD) contract higher than plan. YTD ESBT variances; contract income (0.5m) offset by pay (£0.4m) & non pay (0.1m). Drugs overspends (£0.3m YTD) are hidden by underspends elsewhere including ESBT.
Contract Income	3.2	3.0	(0.2)	6.5	6.1	(0.4)	39.4	39.4	0.0	
Other Income	0.4	0.5	0.1	0.9	0.8	(0.1)	5.6	5.6	0.0	
Pay	(2.9)	(2.8)	0.1	(6.1)	(5.7)	0.4	(36.3)	(36.3)	0.0	
Non Pay	(1.1)	(1.2)	(0.1)	(2.3)	(2.3)	0.0	(13.6)	(13.6)	0.0	
Total	**(0.4)**	**(0.5)**	**(0.1)**	**(1.0)**	**(1.1)**	**(0.1)**	**(4.9)**	**(4.9)**	**0.0**	
Estates & Facilities:										Laundry (£0.1m) and car parking income (£20k) drive the YTD income variance. Small overspends on pay and non pay largely net off.
Contract Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Other Income	0.6	0.5	(0.1)	1.1	1.0	(0.1)	6.9	6.9	0.0	
Pay	(1.4)	(1.4)	0.0	(2.8)	(2.7)	0.1	(16.7)	(16.7)	0.0	
Non Pay	(1.2)	(1.3)	(0.1)	(2.5)	(2.6)	(0.1)	(14.6)	(14.6)	0.0	
Total	**(2.0)**	**(2.2)**	**(0.2)**	**(4.2)**	**(4.3)**	**(0.1)**	**(24.4)**	**(24.4)**	**0.0**	
Corporate Services:										YTD income variance driven by additional NHSI funding. Pay underspends in finance and IT (£0.2m YTD) are the main drivers of pay variance. Overspends in hosted services and finance drive the non pay overspends.
Contract Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Other Income	1.2	1.2	0.0	2.5	2.7	0.2	14.5	14.5	0.0	
Pay	(3.3)	(3.2)	0.1	(6.6)	(6.4)	0.2	(38.4)	(38.4)	0.0	
Non Pay	(2.3)	(2.5)	(0.2)	(4.6)	(5.0)	(0.4)	(25.3)	(25.3)	0.0	
Total	**(4.4)**	**(4.5)**	**(0.1)**	**(8.7)**	**(8.7)**	**0.0**	**(49.2)**	**(49.2)**	**0.0**	
Other:										TEDDs income and non pay both below (£0.5m YTD) plan. Income related to prior year is a big component of the contract income variance.
Contract Income (TEDDs)	2.8	2.7	(0.1)	5.6	5.1	(0.5)	33.5	33.5	0.0	
Contract Income (Other)	2.2	2.1	(0.1)	3.9	4.4	0.5	26.9	26.9	0.0	
Other Income	0.0	0.2	0.2	0.4	0.5	0.1	2.7	2.7	0.0	
Pay	(0.3)	0.1	0.4	(0.1)	0.1	0.2	(0.8)	(0.8)	0.0	
Non Pay TEDDs)	(2.8)	(2.7)	0.1	(5.6)	(5.1)	0.5	(33.5)	(33.5)	0.0	
Non Pay (Other)	(0.9)	(1.9)	(1.0)	(3.5)	(3.2)	0.3	(21.8)	(21.8)	0.0	
Total	**1.0**	**0.5**	**(0.5)**	**0.7**	**1.8**	**1.1**	**7.0**	**7.0**	**0.0**	

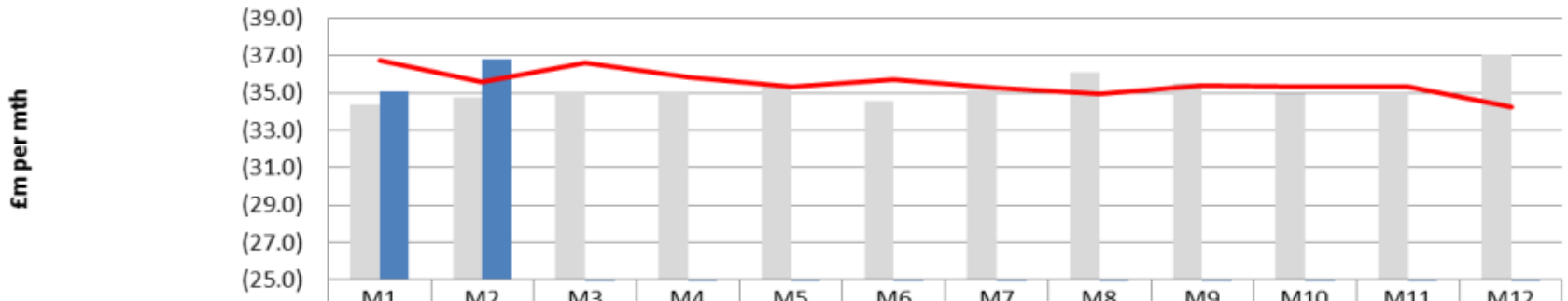
Trends – May 2017

Income run rate



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income 16/17	29.2	28.8	32.7	30.4	30.8	32.7	31.4	31.8	32.3	31.6	32.0	35.5
Run rate 2017/18 income	31.0	33.3	-	-	-	-	-	-	-	-	-	-
Budget 2017/18 income	32.7	32.0	33.1	33.4	33.1	33.7	34.2	33.5	33.7	34.2	32.4	34.0

Pay and non pay run rate



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
2016/17 run rate	(34.3)	(34.8)	(35.1)	(35.1)	(35.5)	(34.5)	(35.1)	(36.1)	(35.5)	(35.0)	(35.1)	(37.1)
Run rate 201718 spend	(35.1)	(36.8)	-	-	-	-	-	-	-	-	-	-
Budget 2017/18	(36.7)	(35.6)	(36.6)	(35.9)	(35.3)	(35.7)	(35.3)	(35.0)	(35.4)	(35.3)	(35.3)	(34.2)

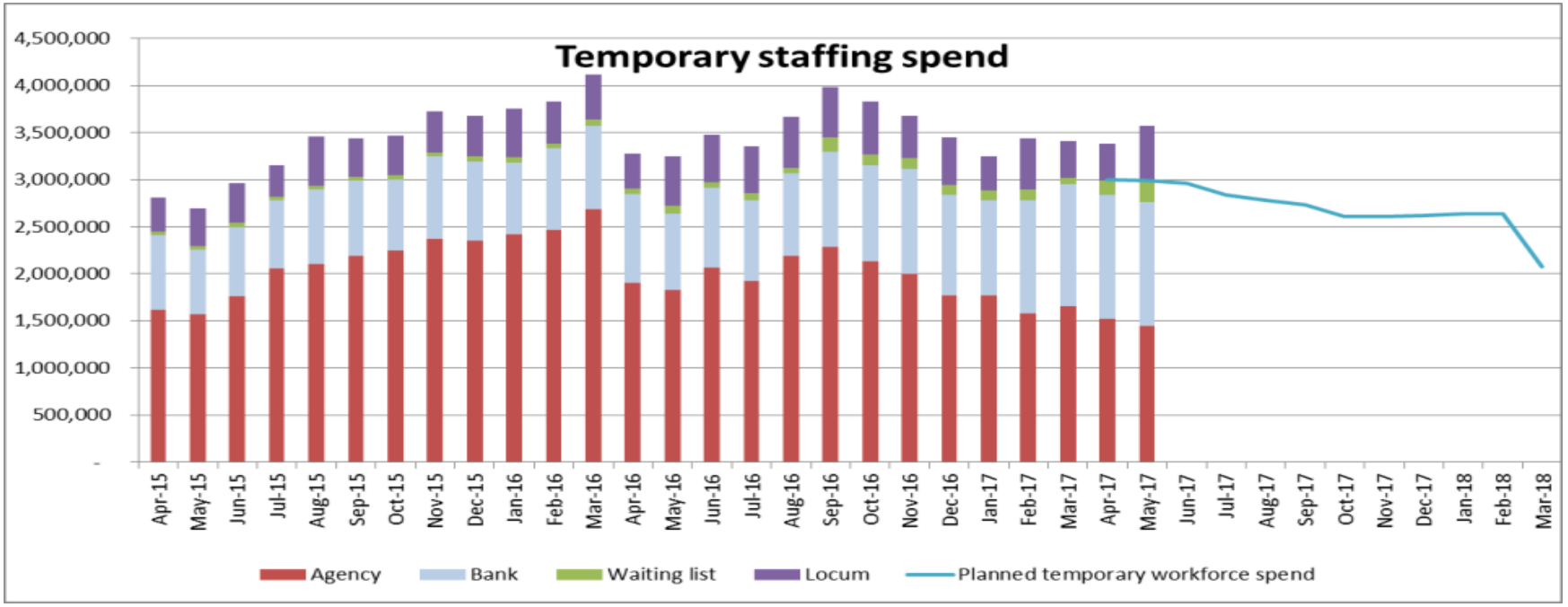
Workforce Pay Costs – May 2017

Staff Category £'m	FTE Plan	FTE Actual	In Month			YTD		
			Plan	Actual	Variance	Plan	Actual	Variance
Nursing	3,132	3,042	9.6	9.6	(0.0)	19.2	19.0	0.2
Medical	658	653	5.4	5.7	(0.3)	10.8	11.3	(0.5)
Administrative & Clerical	1,202	1,187	2.8	2.8	(0.0)	5.5	5.6	(0.0)
Prof & Tech	524	518	1.6	1.7	(0.0)	3.2	3.5	(0.2)
Professions Allied to Medicine	523	418	1.6	1.4	0.1	3.3	2.9	0.4
Ancillary	721	677	1.4	1.4	(0.0)	2.9	2.9	0.0
Senior Manager (Other)	125	104	0.7	0.6	0.1	1.5	1.2	0.2
Executive	8	8	0.1	0.1	0.0	0.2	0.2	0.0
Other Employees	0	0	0.3	0.0	0.3	0.1	0.0	0.0
Grand Total	**6,892**	**6,608**	**23.6**	**23.4**	**0.2**	**46.7**	**46.5**	**0.2**

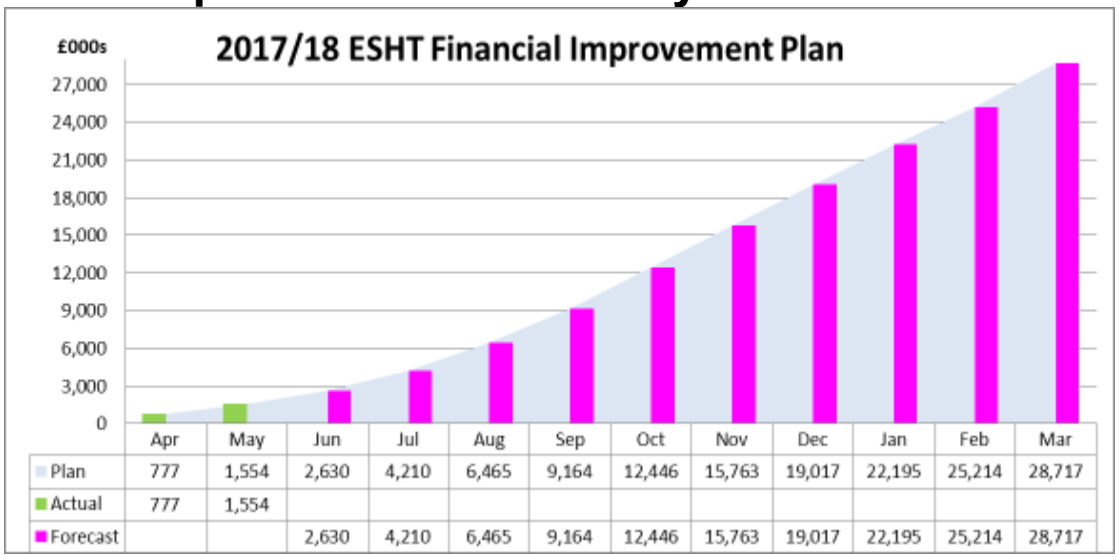
Highlights

- Nursing underspends in OOH (£0.3m) and WaCH (£0.1m) partially offset by medicine overspends (£0.2m).
- Medical overspends in WaCH, DAS & Medicine (£0.2m, £0.15m & £0.1m respectively).
- Prof & Tech overspends in OOH & Surgery.
- PAMS under spends in OOH (£0.5m) and DAS (£0.1m)

Note – variances in OOH often have income impact



Cost Improvement Plan – May 2017



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	777	1,554	2,630	4,210	6,465	9,164	12,446	15,763	19,017	22,195	25,214	28,717
Actual	777	1,554										
Forecast			2,630	4,210	6,465	9,164	12,446	15,763	19,017	22,195	25,214	28,717

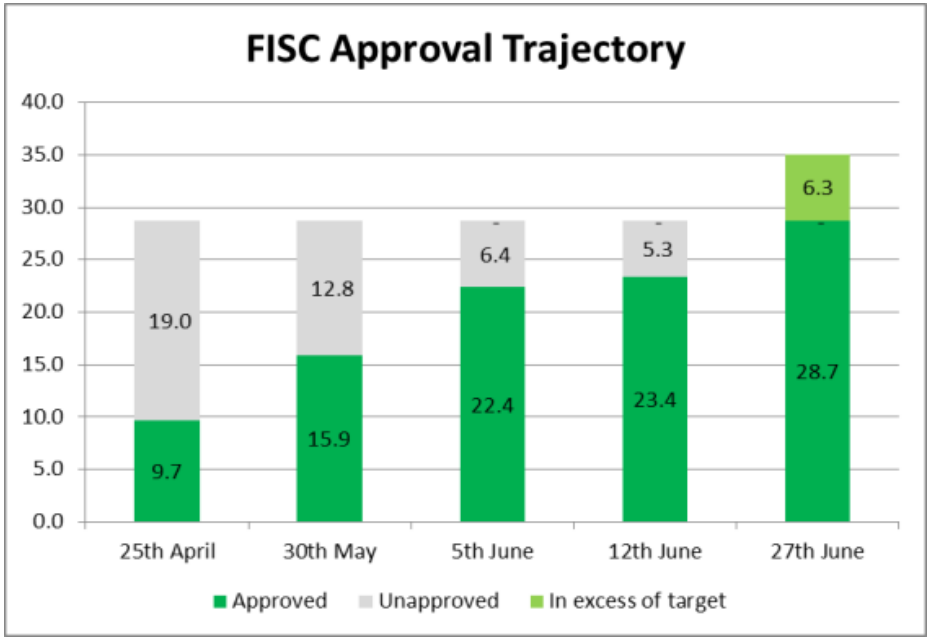
Headlines

- FISC has approved £23.4 of Projects to 12th June 2017, it is anticipated that a further £11.7m will be approved before the end of June. The trajectory graph below demonstrates this and shows that the Trust has identified £35m of plans, a risk adjustment has been applied to bring the value down to the £28.7m target.
- The Trust has delivered the CIPs for May and the YTD.
- Progress has been made on theatre 4 hour sessions at EDGH, with 3 specialties moving to this from 12th June and the remainder are to be scheduled before the end of June.
- Some additional resource is now supporting the ramp up of T&O escalations.

	YTD		
Workstream	Plan £000	Actual £000	Variance £000
Clinical Services Review	0	0	0
Data Quality and Clinical Networks	358	270	(88)
Elective Pathways	599	396	(203)
Grip & Control	283	560	277
Income	148	128	(20)
Non Pay	123	158	35
Patient Flow	42	42	0
Workforce	0	0	0
Total	**1,554**	**1,554**	**(0)**

	YTD		
Division	Plan £000	Actual £000	Variance £000
Corporate	13	2	(11)
Estates & Facilities	35	34	(1)
DAS	855	339	(516)
Medicine	216	95	(120)
Urgent Care	188	268	80
WAC	80	38	(43)
Out of Hospital	150	218	68
Trustwide	17	560	543
Total	**1,554**	**1,554**	**0**

N.B. Trustwide to be allocated across Division



Activity & Contract Income – May 2017

Income (£'m)	In Month			YTD			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Inpatients - Electives	4.1	4.7	0.6	9.1	8.5	(0.6)	57.2	57.2	0.0
Inpatients - Emergency	6.8	7.9	1.1	13.3	14.5	1.2	79.5	79.5	0.0
Excess Bed Days	0.6	0.5	(0.1)	1.0	1.3	0.3	5.9	5.9	0.0
Outpatients	4.3	4.1	(0.2)	8.6	7.7	(0.9)	54.6	54.6	0.0
Other Acute based Activity	2.9	2.8	(0.1)	5.6	5.6	0.0	33.1	33.1	0.0
Direct Access	0.8	0.8	0.0	1.6	1.6	0.0	9.9	9.9	0.0
Block Contract	6.8	5.9	(0.9)	12.6	12.2	(0.4)	79.6	79.6	0.0
Fines & Penalties	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	(0.7)	0.2	0.9	(0.4)	0.4	0.8	1.9	1.9	0.0
CQUIN	0.6	0.6	0.0	1.1	1.0	(0.1)	6.6	6.6	0.0
Subtotal	26.2	27.5	1.3	52.5	52.8	0.3	328.3	328.3	0.0
Exclusions	2.8	2.7	(0.1)	5.6	5.1	(0.5)	33.5	33.5	0.0
TOTAL	**29.0**	**30.2**	**1.2**	**58.1**	**57.9**	**(0.2)**	**361.8**	**361.8**	**0.0**

Activity	In Month			YTD			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Inpatients - Electives	5,007	4,078	-929	9,318	7,705	-1,613	58,989	58,989	0
Inpatients - Emergency	3,583	3,784	201	7,051	7,213	162	42,160	42,160	0
Excess Bed Days	2,282	1,842	-440	4,490	5,327	837	26,866	26,866	0
Outpatients	41,087	38,508	-2,579	76,563	75,129	-1,434	490,914	490,914	0
Other Acute based Activity	12,593	12,209	-384	24,577	24,355	-222	148,430	148,430	0
Direct Access	294,264	307,069	12,805	546,490	568,435	21,945	3,489,131	3,489,131	0
Other	681	591	-90	1,803	1,681	-122	8,075	8,075	0

Headlines (continued)

- May outpatients shows a significant improvement (14%) April. YTD outpatients remains under plan (£0.9m).
- Tariff exclusions £0.5m below plan (offset by reduction in spend).

Headlines

Overall the May position was £0.2m below plan. This is a significant improvement on April performance (9% increase before exclusions)

-YTD elective inpatients and day case (£0.6m) below plan. Predominately this is a medicine issue with gastro and cardiology being the two biggest underperformers.

-YTD Emergency Inpatients £1.2m over plan, geriatric medicine (£0.8m), respiratory Medicine (£0.6m), with small over performance across multiple specialties, partially offset by an under performance in General Medicine (£0.7m).

-YTD Elective Inpatients £0.6m under plan; Cardiology, Gastroenterology Trauma & Orthopaedics are the main drivers.

Balance Sheet – May 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.

• A prior year adjustment on the revaluation reserve of £6m (adjustment relating to PPE additions identified as part of the year-end audit) is yet to be reflected in the ledger

•Both payable and receivable balances remain high

BALANCE SHEET £000s	Actual 31/03/2017	YTD Actual	Forecast 31/03/2018
Non Current Assets			
Property plant and equipment	237,135	242,729	247,473
Intangible Assets	1,860	1,868	1,963
Trade and other Receivables	1,308	1,308	1,308
	240,303	**245,906**	**250,744**
Current Assets			
Inventories	6,195	6,214	7,743
Trade receivables	29,734	28,873	21,526
Other receivables	11,072	14,609	8,015
Other current assets	0	0	0
Cash and cash equivalents	2,100	2,695	2,100
	49,101	**52,391**	**39,384**
Current Liabilities			
Trade payables	(23,586)	(38,241)	(21,041)
Other payables	(29,448)	(19,472)	(26,271)
DH Capital investment Loan	(427)	(427)	(427)
Other Financial Liabilities	0	0	0
Provisions	(502)	(341)	(341)
	(53,963)	**(58,482)**	**(48,080)**
Non Current Liabilities			
DH Capital Investment Loan	(3,126)	(3,126)	(3,126)
Borrowings - Revenue Support Facility	(89,662)	(95,434)	(115,757)
Other Financial Liabilities	0	0	0
Provisions	(2,488)	(2,522)	(2,522)
	(95,276)	**(101,082)**	**(121,405)**
Total Assets Employed	**140,165**	**138,733**	**120,643**
Financed by			
Public Dividend Capital (PDC)	153,562	153,562	153,562
Revaluation Reserve	104,708	110,875	111,708
Income & Expenditure Reserve	(118,105)	(125,704)	(144,627)
Total Tax Payers Equity	**140,165**	**138,733**	**120,643**

Cash Flow – May 2017

13 month rolling cash flow statement (£'m)	May'17	Jun'17	Jul'17	Aug'17	Sep'17	Oct'17	Nov'17	Dec'17	Jan'18	Feb'18	Mar'18	Apr'18	May'18
	Actual	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
Cash flows from operations	(2.8)	(2.9)	(1.8)	(1.6)	(1.4)	(0.4)	(0.8)	(1.0)	(0.5)	(2.3)	0.5	(0.9)	(0.9)
Depreciation and amortisation	1.0	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.2	1.2
Capital donations	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)
Trade and other receivables	0.2	3.2	2.0	4.0	2.0	3.0	-	(1.0)	1.0	(1.0)	0.7	0.1	0.5
Inventories	0.0	-	-	-	-	-	-	-	(0.3)	(0.3)	(1.0)	(0.0)	(0.0)
Trade and other payables	(0.9)	(5.1)	(2.7)	(3.7)	0.6	(1.1)	(2.7)	3.1	(1.5)	(0.4)	1.7	(0.2)	(0.2)
Provisions	0.1	-	-	-	-	-	-	-	-	-	-	-	-
Cash from operations	**(2.4)**	**(3.7)**	**(1.5)**	**(0.3)**	**2.2**	**2.5**	**(2.5)**	**2.1**	**(0.2)**	**(2.9)**	**2.9**	**0.1**	**0.5**
Interest received	-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Intangible assets	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Property, plant and equip.	(0.9)	(0.8)	(0.9)	(0.8)	(1.2)	(1.5)	(1.7)	(1.0)	(1.0)	(0.9)	(2.0)	(2.2)	(1.0)
Cash from investing activities	**(1.0)**	**(0.9)**	**(0.9)**	**(0.9)**	**(1.2)**	**(1.5)**	**(1.7)**	**(1.0)**	**(1.1)**	**(0.9)**	**(2.0)**	**(2.2)**	**(1.0)**
Loans - received	2.6	5.5	2.5	3.1	2.8	1.2	1.5	1.2	1.1	1.9	-	2.6	2.6
Loans - repaid	-	-	-	-	(0.2)	-	-	-	-	-	(0.2)	(0.1)	-
Other capital receipts	-	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Interest paid	(0.0)	(0.1)	(0.3)	(0.5)	(0.8)	(0.1)	(0.1)	(0.0)	(0.3)	(0.5)	(0.7)	(2.1)	(0.4)
PDC dividend paid	-	-	-	-	(2.5)	-	-	-	-	-	(2.1)	-	-
Cash from financing activities	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6
Increase/(decrease) in cash	(0.8)	0.9	(0.1)	1.5	0.3	2.1	(2.8)	2.3	(0.4)	(2.4)	(2.1)	(1.6)	1.7
Opening cash	3.5	2.7	3.6	3.5	5.1	5.4	7.6	4.7	7.1	6.7	4.2	2.1	0.5
Closing cash	**2.7**	**3.6**	**3.5**	**5.1**	**5.4**	**7.6**	**4.7**	**7.1**	**6.7**	**4.2**	**2.1**	**0.5**	**2.2**

Headlines

- The cash position of the Trust remains extremely challenging and maintaining liquidity and supply of goods and services requires constant management intervention.
- There is a plan to secure additional loans to relieve creditor pressure but this is contingent on the Trust hitting Q1 I&E numbers.
- The cashflow has been discussed with NHSI in June and the Trust continues to work closely with them to mitigate potential risk.

Capital Programme – May 2017

Headlines

• The planned capital programme is over-committed by £1.8m, it is anticipated that that some schemes will slip and mitigate the risk of overspending.

• The forecast over planning margin has increased to £2.1m and will be managed by the Capital Review Group.

Capital Programme £000s	Annual Plan	In Month	YTD	Forecast
Capital Resource Limit (CRL)	**11,694**			**11,694**
Brought Forward	10	100	127	127
Estates - Brought Forward	4,300	96	196	4,299
Estates - Backlog Maintenance	1,924	24	36	1,853
Estates - Clinical	366	3	2	366
Estates - Statutory	380	27	45	380
IT - Brought Forward		80	89	89
IT - Core	2,220	20	95	2,298
IT - EDM	437	63	68	508
IT - Other	192	0	192	192
Medical Equipment	2,000	0	216	2,000
Minor Capital	1,200	125	290	1,200
Unplanned Urgents	500	0	0	500
Sub Total	**13,529**	**538**	**1,357**	**13,814**
Donated Assets Purchased	1,000	63	147	1,000
Donated Assets Funding	(1,000)	(63)	(147)	(1,000)
Net Donated Assets	**0**	**0**	**0**	**0**
Over PlanningMargin	(1,835)			(2,120)
Net Capital Charge against CRL	**11,694**	**538**	**1,357**	**11,694**

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

Headlines

- The target achievement of BPPC is 95%, the Trust remains significantly below this target.
- Receivables have reduced but remain at a high value.
- Payables have increased and continue to increase in age.

Finance and Use of Resources Metrics	YTD Actual	YTD Plan
Liquidity Ratio Rating	3	2
Capital Servicing Capacity Rating	4	4
I&E margin rating	4	4
Distance from Financial Plan Rating	2	1
Agency Spend Rating	1	1
Overall Use of Resources Rating	4	4

Local Measures	YTD Actual	YTD Plan
BPPC – Trade invoices by value (%)	25	95
BPPC – NHS Invoices by value (%)	96	95

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	2,230	18,019	1,694	2,691
31 - 60 Days	809	1,838	1,293	1,847
61 -90 Days	13,479	1,498	1,656	1,469
91 - 120 Days	1,259	134	254	92
> 120 Days	928	873	457	412
Total	18,705	22,362	5,354	6,511

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	7,301	6,282	9,521	9,135
31 - 60 Days	6,763	9,107	9,349	10,447
61 -90 Days	5,462	6,044	8,346	7,947
91 - 120 Days	3,550	2,786	4,536	4,562
> 120 Days	3,652	3,281	7,493	6,150
Total	26,728	27,500	39,245	38,241

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	12.18%	28.45%	11.10%	24.78%
NHS invoices paid within contract or 30 days of receipt	23.51%	95.60%	21.23%	95.92%

Sustainability and Strategy

SUSTAINABILITY

Sustainability

Strategy and Planning

The draft 17/18 IBP and ESHT 2020 Clinical Strategy are now complete . The outputs from these have been collated into key themes and action plans for delivery of year one schemes as part of the Clinical Services Review programme.

ACO

The ESBT Outcomes framework has been agreed at the newly formed Strategic Commissioning Board which is jointly chaired by CCG and ESCC representatives. This framework has been shared with our Trust Board at a recent seminar.

Four models will be appraised for the future delivery model for the ESBT Alliance. Outcomes of the option appraisal will form part of a suite of information that our Governing Body will consider in July.

We continue to work with our Alliance partners on streamlining key areas that will enable us to have a shared view of finances and performance data alongside our enhanced integrated teams. The Integrated Management Team and Alliance Group have been brought together to ensure that key Alliance business is not duplicated or not followed through.

STP

The STP has a clear focus on ensuring robust place based plans and we are progressing our ESBT plans at pace. Work continues on exploring the options for rapid access diagnostic within the STP area to support delivery of the cancer pathway, a pathology alliance, and rationalisation of Acute services where demand and capacity issues have been identified .

Leadership & Culture

LEADERSHIP & CULTURE

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

Safer Staffing

Site Name	Day		Night	
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
BEXHILL HOSPITAL	95.2%	105.0%	97.4%	110.6%
CONQUEST HOSPITAL	96.6%	107.3%	92.9%	103.9%
EASTBOURNE DISTRICT GENERAL HOSPITAL	94.5%	105.5%	89.5%	111.0%

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.

East Sussex Healthcare NHS
NHS Trust

1. WORKFORCE EXECUTIVE SUMMARY – KEY POINTS

Actual workforce usage of staff in May was 6607.65 full time equivalents (ftes), 280.16 ftes below the budgeted establishment.

Temporary staff expenditure was £3,285K in May (14.10% of total pay expenditure). This comprised £1,815K bank expenditure, £1,444K agency expenditure and £25K overtime. This is a slight increase of £9K overall compared to April.

There were 784.99 fte vacancies (a vacancy factor of 11.65%).

Annual turnover was 11.05% which represents 614.95 fte leavers in the last year. This was an increase of 0.05% compared to last month.

Monthly sickness was 3.50%, an increase of 0.07% from April. The annual sickness rate was 4.18%, a reduction of 0.05%.

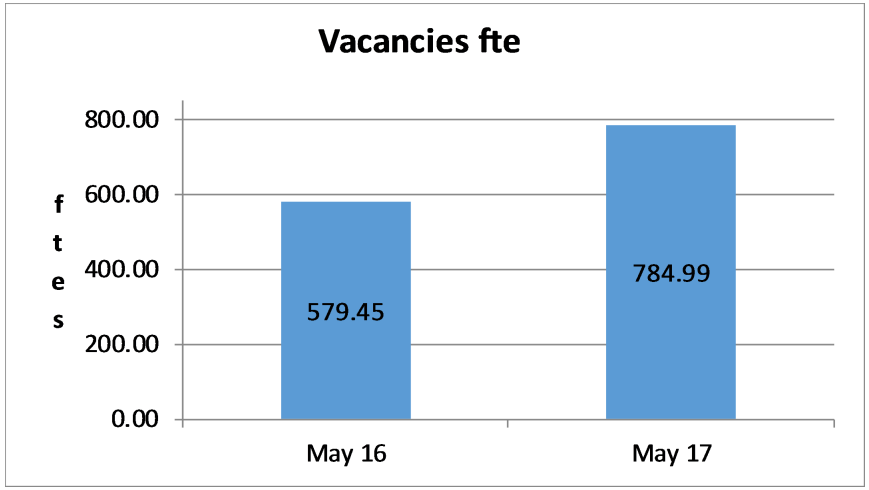
The overall mandatory training rate increased by 0.49% to 88.29%. Compliance has increased in all subjects, with the exception of Trust Induction and Deprivation of Liberties training.

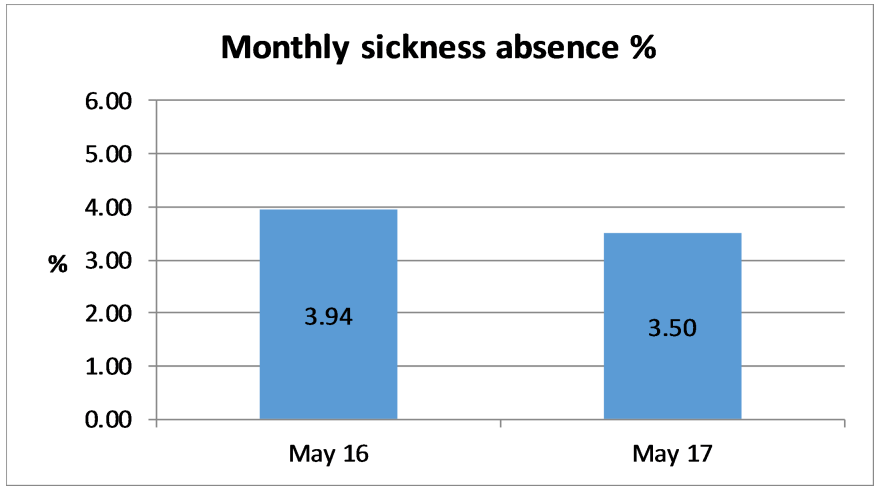
Appraisal compliance increased by 2.46% to 81.73%

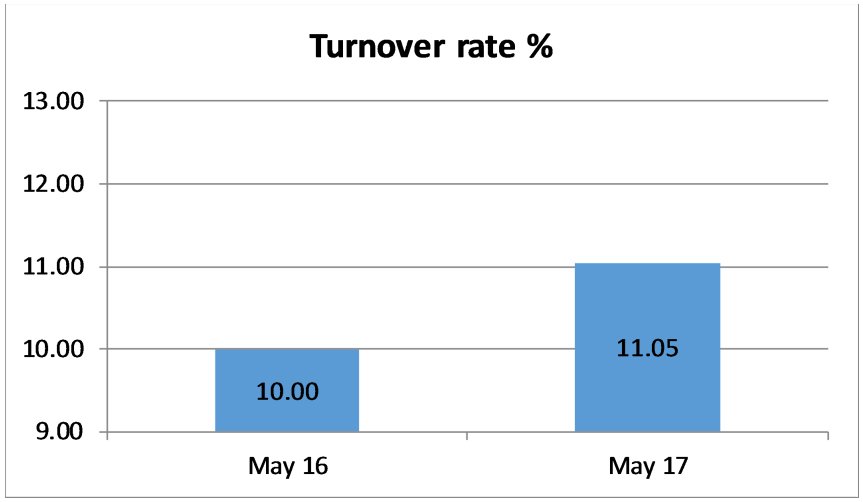
2. Overview

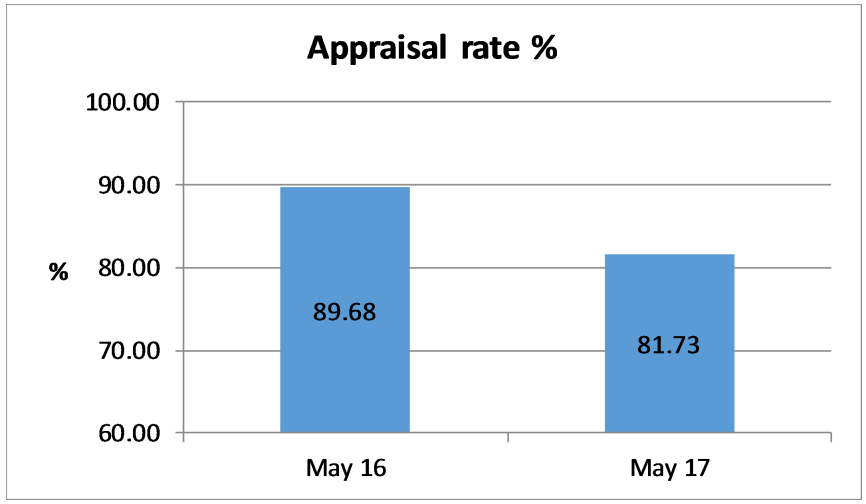
TRUST	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Trend line
WORKFORCE CAPACITY													
Budgeted fte	6437.07	6328.78	6394.73	6416.78	6477.44	6521.75	6458.23	6470.02	6470.09	6470.07	6966.14	6887.81	
Total fte usage	6370.72	6380.32	6465.06	6516.26	6542.43	6596.92	6526.36	6539.29	6572.22	6702.16	6674.22	6607.65	
Variance	66.35	-51.54	-70.33	-99.48	-64.99	-75.17	-68.13	-69.27	-102.13	-232.09	291.92	280.16	
Permanent vacancies	611.23	564.18	496.62	517.21	504.71	507.66	472.25	476.68	435.16	389.16	810.72	784.99	
Fill rate	90.23%	90.94%	92.01%	91.71%	91.99%	92.00%	92.49%	92.44%	93.10%	93.83%	88.35%	88.35%	
Bank fte usage (as % total fte usage)	6.26%	6.40%	6.31%	7.42%	6.98%	7.23%	7.22%	7.29%	7.29%	8.33%	8.85%	8.04%	
Agency fte usage (as % total fte usage)	5.49%	5.32%	5.71%	5.33%	5.14%	4.98%	4.37%	4.09%	3.88%	3.93%	3.20%	2.86%	
WORKFORCE EFFICIENCY													
Annual sickness rate	4.42%	4.40%	4.39%	4.37%	4.38%	4.37%	4.38%	4.41%	4.36%	4.30%	4.23%	4.18%	
Monthly sickness rate (%)	3.77%	4.08%	4.10%	4.01%	4.68%	4.47%	4.59%	4.78%	4.40%	3.96%	3.43%	3.50%	
Turnover rate	10.03%	10.02%	9.76%	9.66%	9.87%	9.53%	9.72%	9.77%	9.96%	10.31%	11.00%	11.05%	
TRAINING & APPRAISALS													
Appraisal rate	88.07%	85.77%	87.01%	83.14%	81.61%	79.21%	78.35%	78.42%	79.06%	78.89%	79.27%	81.73%	
Fire	87.62%	86.91%	85.51%	86.28%	86.16%	86.27%	84.46%	85.31%	84.35%	84.53%	83.32%	84.35%	
Moving & Handling	89.91%	90.58%	90.09%	90.99%	90.12%	89.75%	87.98%	89.06%	89.02%	89.45%	88.71%	89.23%	
Induction	94.38%	94.50%	93.73%	94.09%	92.54%	92.05%	93.70%	93.15%	95.43%	95.99%	95.76%	95.11%	
Infec Control	89.24%	88.97%	87.95%	89.01%	88.92%	88.63%	86.98%	86.84%	87.25%	87.65%	86.89%	87.55%	
Info Gov	84.51%	83.86%	83.64%	84.79%	84.32%	84.96%	84.21%	85.70%	84.24%	87.25%	83.74%	84.26%	
Health & Safety	87.95%	88.05%	87.75%	88.42%	88.83%	88.96%	88.59%	89.09%	88.51%	87.55%	87.63%	88.09%	
MCA	94.13%	94.09%	93.83%	94.45%	94.68%	95.27%	95.02%	95.43%	95.48%	95.68%	95.96%	96.04%	
DoLs	95.04%	95.68%	95.64%	95.64%	95.97%	96.61%	96.89%	97.42%	97.67%	97.88%	98.07%	98.04%	
Safeguarding Vulnerable Adults	83.10%	83.82%	83.06%	83.90%	84.71%	85.86%	85.87%	86.76%	87.22%	87.49%	88.24%	88.62%	
Safeguarding Children Level 2	82.93%	82.35%	82.43%	83.32%	83.40%	83.43%	83.16%	84.44%	86.35%	86.42%	86.78%	87.13%	

East Sussex Healthcare NHS
NHS Trust









3. Recruitment

The Trust vacancy rate has reduced by 0.37% to 11.65% this month (a reduction of 25.73 ftes).

The medical vacancy rate has reduced by 0.54% to 13.79% (85.31 fte vacancies), for registered nursing & midwives it has increased by 1.71% to 11.74% (247.40 fte vacancies), though this increase was largely due to increases in budgeted establishment this month, whilst for unqualified nurses, it has reduced by 0.77% to 14.56% (144.80 fte vacancies).

A weekly communication is sent to senior management highlighting medical recruitment activities to address vacancies as well as identifying any potential delays in processes such as shortlisting delays. A list of difficult to recruit to vacancies, has been sent to external recruitment agencies for expressions of interest. An external recruitment agency specialising in ex service personnel has also been contacted to advertise key medical posts.

Recruitment of Italian nurses is taking place at the end of June, with around 24 candidates scheduled for interview. The Trust has agreed guidelines with the recruitment agency to ensure suitable arrangements for arrival and orientation, including minimum language requirements.

A meeting has been held with the MSI recruitment agency to monitor the progress of the Filipino nurses due to arrive at the end of this year. Additional Skype interview dates are being arranged for June/July to meet the original target of 76 nurses.

A nurse recruitment agency has been engaged for a 4 week campaign to address Theatres and Community Nurse recruitment whilst rolling nurse recruitment also continues. Specific targeted adverts are being created for areas such as Theatres.

The programme to attract agency staff onto the Trust bank continues. Currently 26 medical staff and 23 healthcare assistants have moved across to the bank. There is a planned rollout programme with registered nurses the next target.

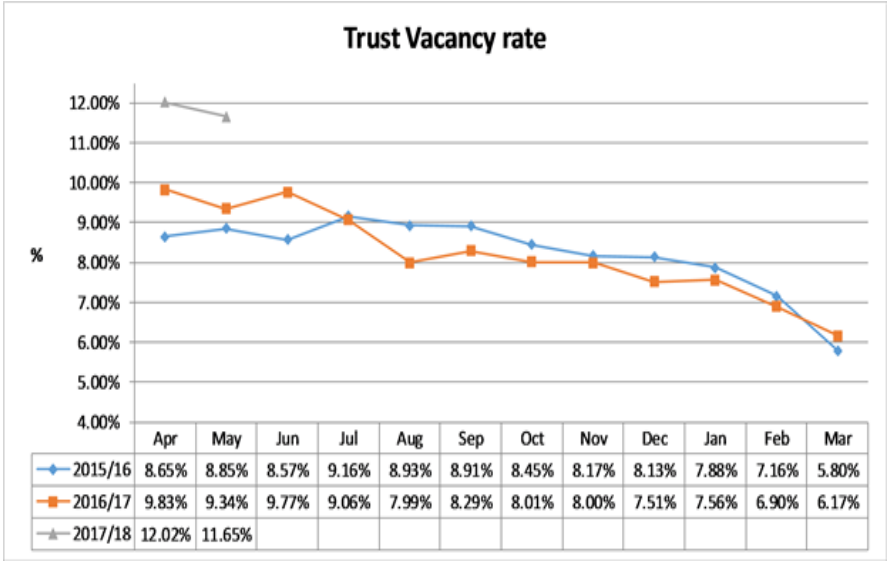
The Trust Executive has agreed to the use of a number of recruitment incentives for specific difficult to recruit to posts. Where agreed, this gives senior managers the options of recruitment and retention supplements, “golden handshakes” or refer a friend payments, for example.

Social media campaigns are being used to highlight the attractions of living and working in East Sussex, as well as specific areas such as working in A&E or in the Community.

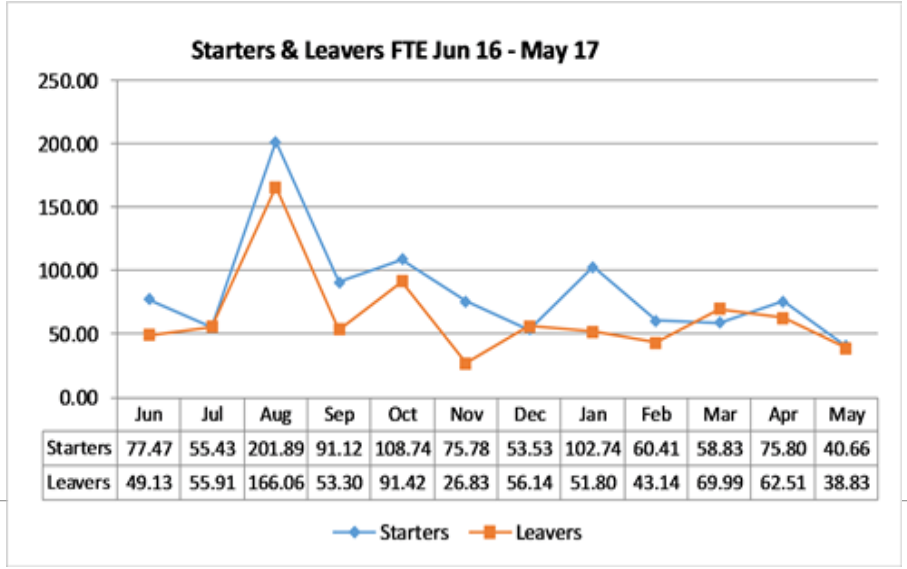
Turnover has slightly increased by 0.05% to 11.05% this month, an increase of 5.03 fte leavers. Exit interviews are being examined and meetings are being held with leavers to analyse the reasons for the increase in staff leaving the Trust.

4. Turnover

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Turnover	10.03	10.02	9.76	9.66	9.87	9.53	9.72	9.77	9.96	10.31	11.00	11.05

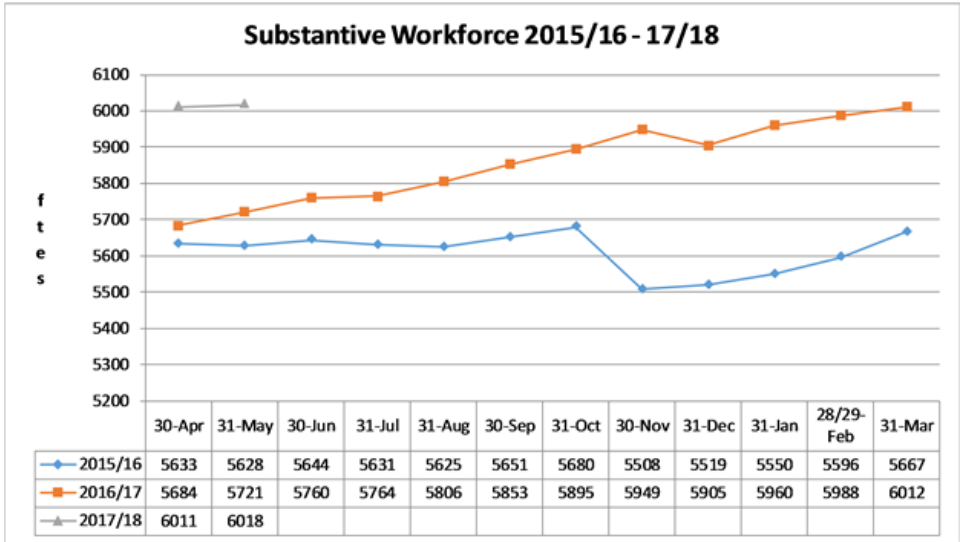


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	8.65%	8.85%	8.57%	9.16%	8.93%	8.91%	8.45%	8.17%	8.13%	7.88%	7.16%	5.80%
2016/17	9.83%	9.34%	9.77%	9.06%	7.99%	8.29%	8.01%	8.00%	7.51%	7.56%	6.90%	6.17%
2017/18	12.02%	11.65%										

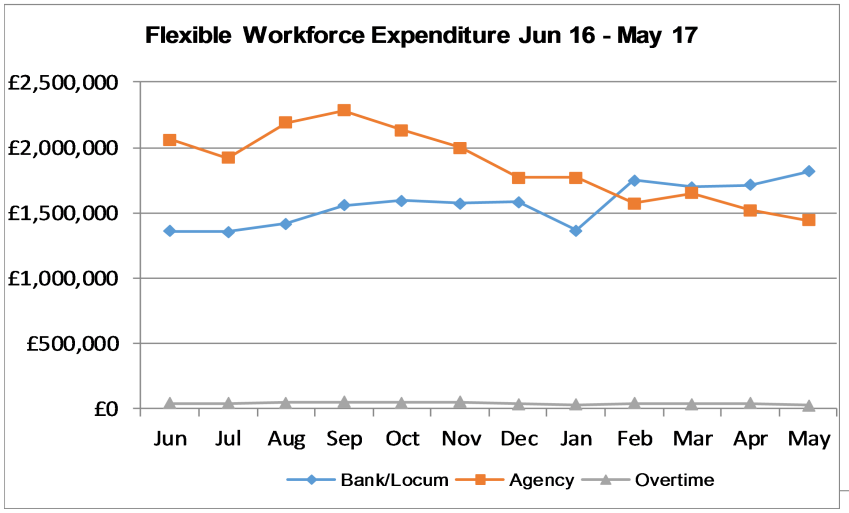


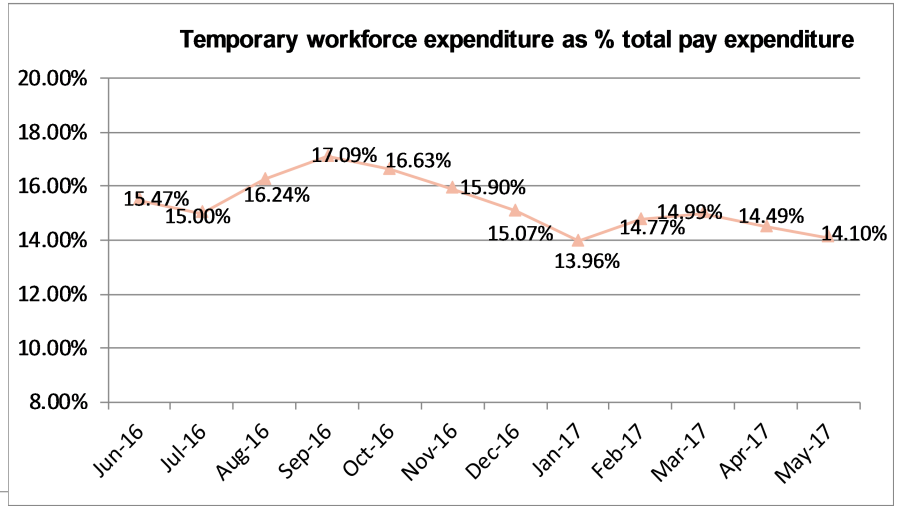
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Starters	77.47	55.43	201.89	91.12	108.74	75.78	53.53	102.74	60.41	58.83	75.80	40.66
Leavers	49.13	55.91	166.06	53.30	91.42	26.83	56.14	51.80	43.14	69.99	62.51	38.83

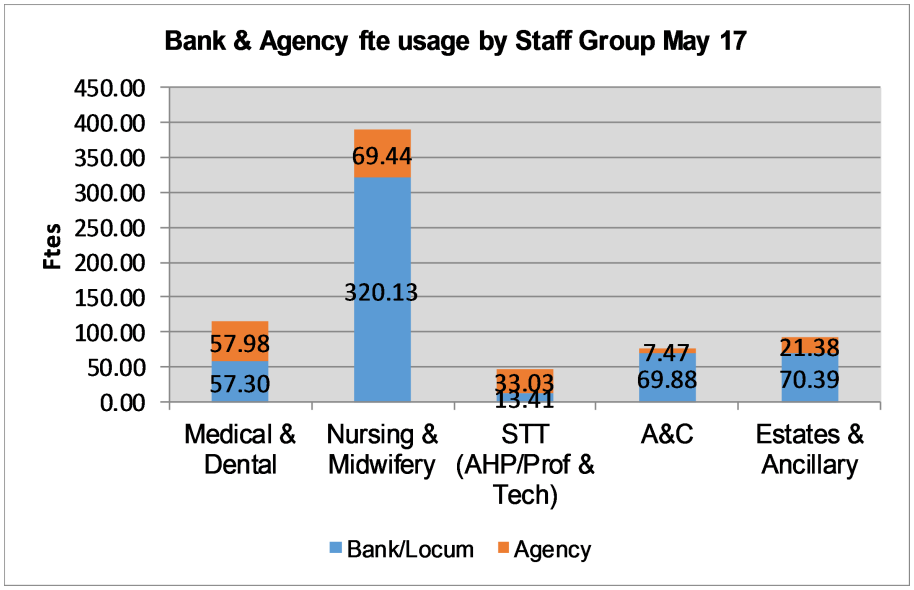
5. Workforce Expenditure

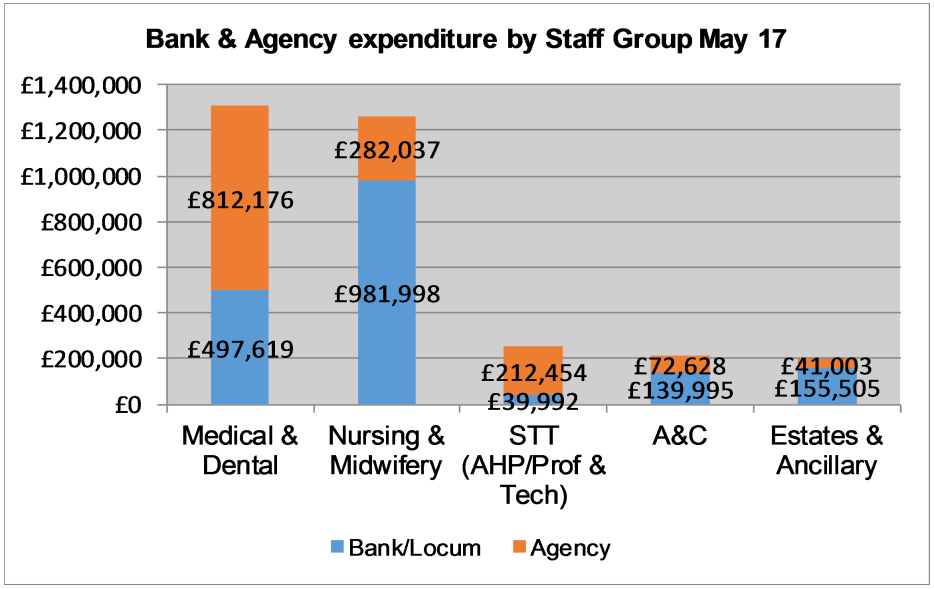


	30-Apr	31-May	30-Jun	31-Jul	31-Aug	30-Sep	31-Oct	30-Nov	31-Dec	31-Jan	28/29-Feb	31-Mar
2015/16	5633	5628	5644	5631	5625	5651	5680	5508	5519	5550	5596	5667
2016/17	5684	5721	5760	5764	5806	5853	5895	5949	5905	5960	5988	6012
2017/18	6011	6018										









There has been a reduction in the budgeted establishment in May, in respect of East Sussex Better Together posts, to allow for the fact that there is a long term recruitment plan to recruit to these posts and they will not be filled immediately. This reduction of c.60 ftes is slightly offset by new escalation posts in Medicine, the Emergency Department and on the Irvine Unit and some additional posts in Sexual Health, Child Development and Acute Paediatrics.

Temporary workforce expenditure has increased by a net £9K but this is due to an increase of £103K in bank expenditure, whilst agency expenditure has decreased by £78K and overtime expenditure by £17K this month. The increase in bank expenditure is partly due to accruals from expenditure in 2016/17 being paid. There were also additional locums covering vacancies in Urgent Care.

There is some evidence of agency usage reducing either due to permanent recruitment or shifting to bank or locum cover. This was the case, this month, in Anaesthetics and General Surgery, where medical agency usage reduced, and similarly for allied health professionals in EDGH Radiology and Ultrasound departments. Agency usage also reduced in the Musculokeletal service due to recruitment whilst, in Midwifery, there has been a shift from agency to bank usage. In Out of Hospital, some old agency invoices previously accrued were reviewed and reversed when it transpired that the shifts had not been worked.

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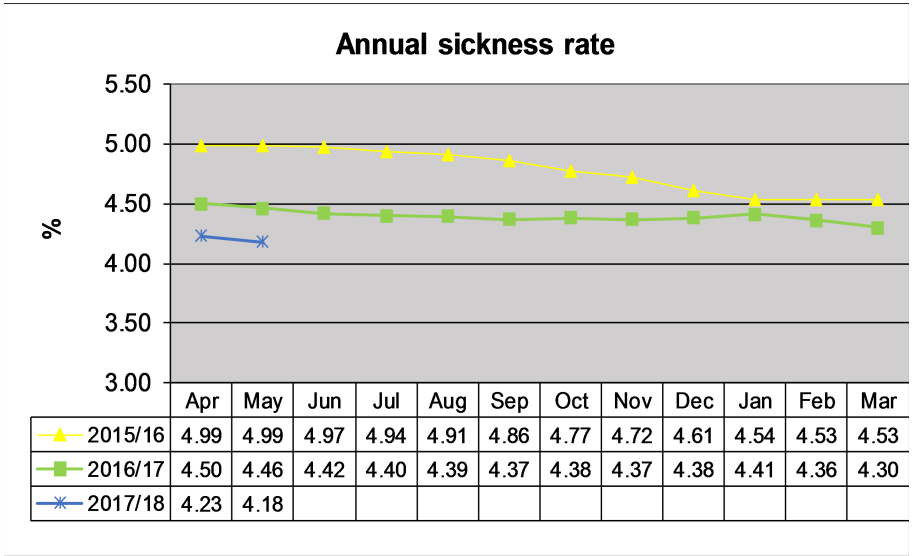
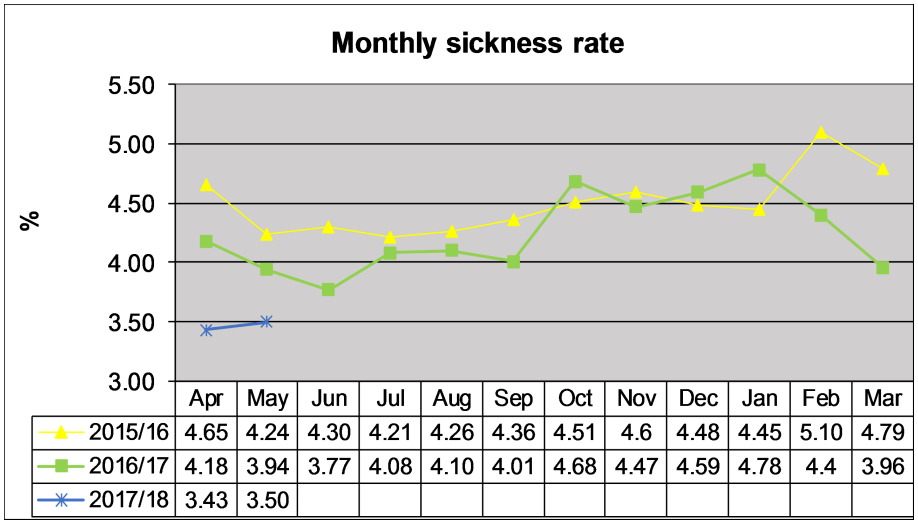
6. Absence



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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	4.36	4.30
2017/18	4.23	4.18										



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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	4.4	3.96
2017/18	3.43	3.50										

Monthly sickness has increased by 0.07% to 3.50%, this month but the continuing trend remains below that of previous years. Accordingly, the annual sickness rate continues to fall, down a further 0.05% this month to 4.18%.

Monthly sickness rates remain highest in Urgent Care at 6.86% (though this was a reduction of 0.19% on April) and Clinical Admin Management at 5.19%.

Anxiety/stress/depression is the highest notified reason for sickness at 17% of sickness absence in month and there has been a significant increase of 391 fte days lost for this reason in May (the total figure was 1116 fte days lost).

The Psychology and Counselling service presently have a 6 – 8 week waiting time, though Occupational Health & Wellbeing (OH &W) have implemented a weekly referral meeting where all new referrals are triaged and sign-posted elsewhere if urgent support is indicated.

OH&W are developing a new stress policy and are also encouraging managers to take a different approach to the completion of the stress risk assessments whereby they work through the assessment with their teams to develop an action plan and find solutions collectively, involving OH & W for additional support where necessary.
Overall, the number of management referrals to OH&W, for all issues, has been increasing with 164 referrals in May 2017 compared to 116 in May 2016.

The second highest reason was musculoskeletal problems (other than back problems) at 16% of sickness

7. Mandatory Training

Mandatory training course	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Induction %	93.70	93.15	95.43	95.99	95.76	95.11
Fire %	84.46	85.31	84.35	84.53	83.32	84.35
Moving & Handling %	87.98	89.06	89.02	89.45	88.71	89.23
Infection Control %	86.98	86.84	87.25	87.65	86.89	87.55
Info Gov %	84.21	85.70	84.24	87.25	83.74	84.26
Health & Safety %	88.59	89.09	88.51	87.55	87.63	88.09
Mental Capacity Act %	95.02	95.43	95.48	95.68	95.96	96.04
Depriv of Liberties %	96.89	97.42	97.67	97.88	98.07	98.04
Safeguard Vuln Adults	85.87	86.76	87.22	87.49	88.24	88.62
Safeguard Child Level 2	83.16	84.44	86.35	86.42	86.78	87.13

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	79.80%	87.37%	95.00%	86.36%	85.86%	77.27%	90.48%	87.50%	82.74%	86.31%	81.13%	86.34%
Medicine Division	85.09%	86.80%	92.83%	86.29%	86.72%	86.98%	93.81%	96.91%	88.49%	85.58%	n/a	82.42%
Out of Hospital Care Division	82.92%	87.49%	97.32%	87.29%	73.98%	86.40%	97.69%	99.45%	86.27%	83.84%	n/a	73.58%
Diagnostics Anaesthetics & Surgery	82.53%	87.69%	94.92%	84.89%	87.40%	90.00%	97.25%	98.86%	90.72%	90.07%	n/a	84.88%
Womens Childrens & Sexual Health Division	82.90%	89.80%	95.65%	87.07%	79.45%	84.05%	96.25%	97.60%	88.27%	87.15%	85.17%	76.66%
Estates & Facilites	86.15%	90.60%	100.00%	94.53%	90.09%	93.33%	n/a	n/a	n/a	n/a	n/a	86.33%
Corporate	89.00%	95.62%	94.57%	90.56%	90.94%	89.48%	98.37%	99.01%	91.80%	89.78%	91.67%	83.83%
TRUST	84.35%	89.23%	95.11%	87.55%	84.26%	88.09%	96.04%	98.04%	88.62%	87.13%	85.04%	81.18%

Most subjects have increased compliance rates this month. The mandatory training matrix has been forwarded to Divisions and trainers to monitor and chase as usual. Learning & Development will be undertaking a detailed analysis to identify those staff who are not complying with their mandatory training on a regular basis and working with managers to address this.

Further analysis of Trust Induction figures will be undertaken this month. The reduction this month may be due to a number of starters failing their IG assessment which has had a negative impact on the overall numbers whilst a number of Health Care Assistants are still required to complete the online training. This will be monitored and chased as necessary.

The increase in the appraisal rate this month is partly due to managers reviewing their reports and sending in updates for appraisals not hitherto reported.

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

8. Engagement

Following the publication of the Staff Survey, the three corporate priorities have now been widely shared with staff and colleagues. These are:-

- **Continue to develop ESHT as a good place to work and ensure patient care is our organisation's top priority**. We will improve the quality of staff experience and improve staff health and wellbeing through a range of programmes
- **Further reduce the number of staff experiencing bullying and harassment from colleagues, patients and public**. We will continue to work with our Speak Up Guardian to ensure that continued support is in place for all our staff
- **Improve good communication between managers and staff**. We want to be more transparent and better communicate how feedback has influence decisions and when it hasn't. We also want our messages to be more simple and consistent.

Each division has also identified their local priorities. Progress will be measured through regular pulse surveys every quarter.

The Trust awards took place in May with over 250 staff attending . In July there will be a celebration of the work of those staff who support education and learning in the workplace. A number of nominations are also being put forward for entry into the HSJ Awards.

The Senior Leaders transformation programme "Leading in Excellence" will start in August 2017.

A new management induction programme will be introduced from September which will clarify expectations of all new staff and equip them with the information they need in their first 100 days in post

A number of engagement events to keep staff up to date and involved with what is happening in the Trust are taking place in May/June. The Leadership Conversation focused on our financial performance and the 4 hour A&E target. Joint workshops with East Sussex County Council and the CCG are also taking place on the proposed new models of care across East Sussex

The staff suggestion scheme for reducing waste is now live on the Intranet and feedback on suggestions is being published in team brief, as well as to individuals. A number of roadshows encouraging more ideas from staff will happen in July.

Staff Engagement have been running a number of events for Carers Weeks, highlighting the support that is available for those colleagues with Caring responsibilities

Activity

ACTIVITY

1. Activity overview

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	May-16	Var	Yr	Last Yr	Var	
Primary Referrals	M	9047	9552	8858	9169	9206	8991	9332	7671	8735	8693	10235	7985	9215	9047	1.9%	17200	18296	-6.4%	
Cons to Cons Referrals	M	1422	2006	1648	1448	1500	1438	1481	1321	1514	1413	1781	1412	1655	1422	16.4%	3067	2828	7.8%	
First OP Activity	M	9876	10839	9868	10707	10990	11653	12490	10642	10907	10567	11849	8637	9776	9876	-1.0%	18413	19729	-7.1%	
Subsequent OP Activity	M	23403	24446	22053	23389	23933	22845	25168	21861	24899	23354	27101	21106	24602	23403	5.1%	45708	46619	-2.0%	
New:FU Ratio	M	2.4	2.3	2.2	2.2	2.2	2.0	2.0	2.1	2.3	2.2	2.3	2.4	2.5	2.4	0.1	2.5	2.5	0.0	
Elective IP Activity	M	697	656	715	649	670	682	717	619	642	644	715	586	665	697	-4.6%	1251	1293	-3.4%	
Elective DC Activity	M	3839	4119	4036	4199	4207	3932	4165	3754	4086	3831	4435	3433	4183	3839	9.0%	7616	7360	3.4%	
Non-Elective Activity	M	3772	3791	3878	3801	3663	3721	3789	3966	3719	3494	4076	3751	4043	3772	7.2%	7794	7810	-0.2%	
A&E Attendances	M	9573	9239	10144	9711	9470	9397	8989	9136	8771	7951	9442	9571	10063	9573	5.1%	19634	18288	6.9%	
Admissions Via A&E	M	2398	2363	2408	2302	2215	2381	2416	2620	2465	2241	2623	2547	2638	2398	10.0%	5185	4755	8.3%	
Ambulance Conveyances	M	3068	2995	3133	3092	3051	3138	3163	3331	3223	2886	3156	3211	3279	3068	6.9%	6490	5916	8.8%	
Average LOS Elective	M	3.4	3.0	3.1	2.4	3.1	2.7	2.5	3.1	2.6	2.9	3.5	2.7	2.8	3.4	-0.6	2.77	3.10	-0.3	
Average LOS Non-Elective	M	5.8	5.5	5.6	5.9	6.1	6.1	5.9	6.1	6.3	6.5	6.2	5.5	6.1	5.8	0.3	5.82	5.96	-0.1	

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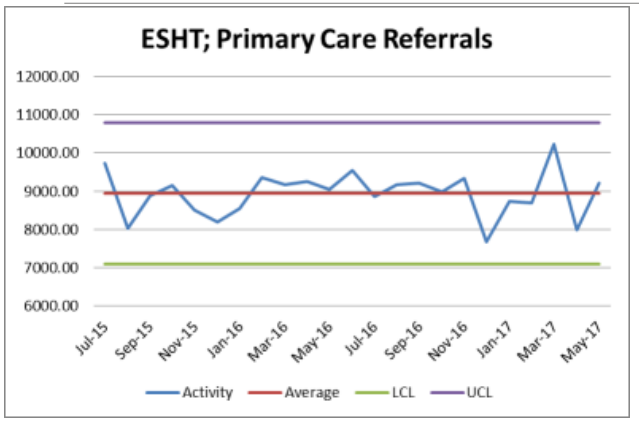

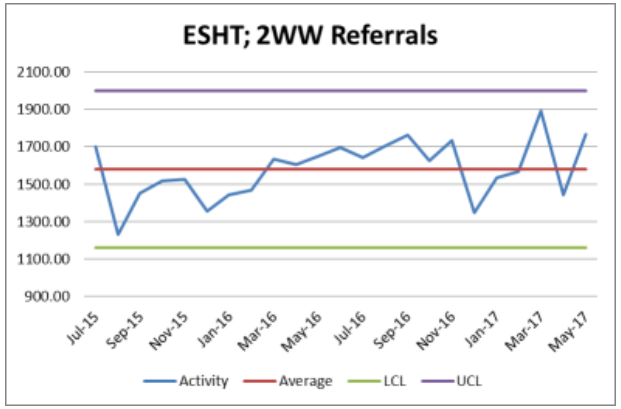

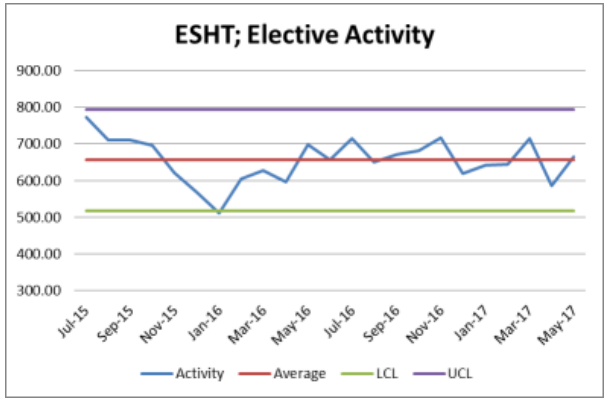

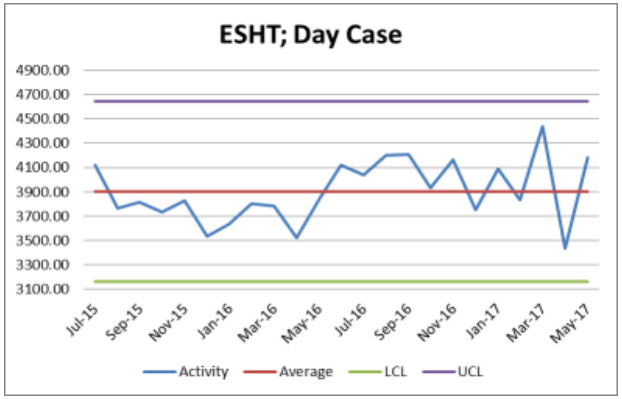

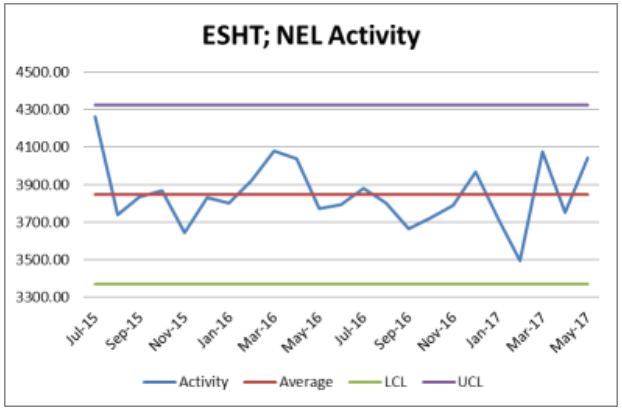

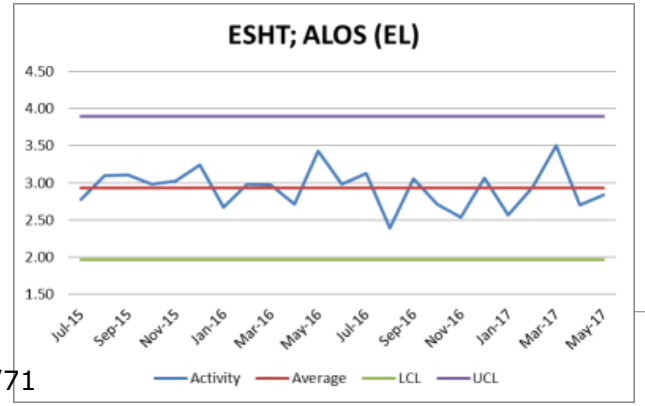

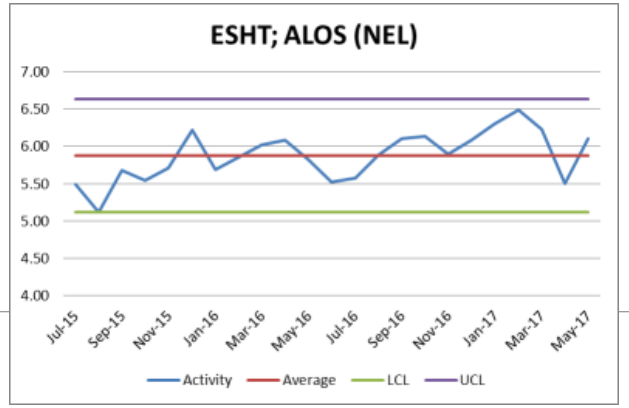

Community

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	May-16	Var	Yr	Last Yr	Var	
Community Nursing Referrals	M	3765	3953	3992	3969	4092	4151	4173	3992	4704	4275	4514	3736	4320	3765	14.7%	8056	7663	4.9%	
Community Nursing Total Contacts	M	35466	35963	33689	34970	32817	33514	33373	33012	36620	34041	37856	33224	36685	35466	3.4%	69909	69091	1.2%	
Community Nursing Face to Face Contacts	M	20046	19492	19042	19672	18721	19414	19205	18918	20282	18472	21237	19171	20748	20046	3.5%	39919	39159	1.9%	
% Patient Facing Time	60.0%	56.5%	54.2%	56.5%	56.3%	57.0%	57.9%	57.5%	57.3%	55.4%	54.3%	56.1%	57.7%	56.6%	56.5%	0.0%	57.1%	56.0%	1.1%	
Community Nursing ALOS	42.0	23.9	21.8	19.5	20.4	19.3	17.3	16.6	16.3	13.5	12.6	11.1	8.2	4.2	23.9	-19.7	6.09	24.76	-18.7	
SALT WL <13 Weeks %	85.0%	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%	100.0%	0	
Podiatry WL <13 Weeks %	85.0%	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%	100.0%	0	
Dietetics WL <13 Weeks %	85.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.7%	100.0%	98.6%	100.0%	100%	0	99.0%	100.0%	-0.01036	
MSK WL <13 Weeks %	85.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	81.0%	96.5%	94.5%	13.4%	100%	-0.866446	49.7%	100.0%	-0.5032	
SALT Total WL	M	160	175	176	202	182	149	130	140	128	133	139	153	146	160	-14	299	306	-7	
Podiatry WL Total WL	M	830	862	998	842	942	633	418	293	284	284	380	335	305	830	-525	640	1671	-1031	
Dietetics WL Total WL	M	32	144	43	65	54	30	64	39	43	74	69	141	50	32	18	191	105	86	
MSK WL Total WL	M	101	116	1922	1922	105	1641	1265	1938	2087	434	2029	1388	242	101	141	1630	202	1428	
IP ALOS (including Irvine Stroke Unit)	M	33.3	25.8	30.9	36.0	28.5	27.0	26.9	32.3	35.0	33.8	38.0	28.4	33.1	33.3	-0.2	30.71	31.96	-1.3	
IP Activity (including Irvine Stroke Unit)	M	97	85	85	85	81	84	93	85	69	75	85	88	85	97	-12.4%	173	189	-9.2%	

East Sussex Healthcare NHS
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Access and Delivery overview:

Intermediate Care:

Significant reduction in LoS for Bexhill Irvine Unit Generic and Rye. Slight increase in LoS for Bexhill Irvine Unit Stroke (although remains within the YTD average) and Firwood House.

We continue to embed Red to Green and review of all patients over 14 days within BIU, this is due to be rolled out to all other IC units in the next 2 months.

As agreed at the last IPR BIU and Rye have converted back to commissioned bed stock in May due to not securing additional funding from CCG to retain escalation beds.

To note BIU were requested to escalate in May, this was achieved. HR and redeployment processes in place.

Joint Community Rehabilitation Teams:

Reduction in referrals in April, however there remains a challenge to maintain waiting times for non urgent referrals. April saw an increase in meeting urgent referrals targets however there was a reduction in ability to meet targets for routine referrals.

There continues to be targeted work with key referrals of non-starter groups and working with ILT teams in delivery an integrated Duty and Triage function (commenced 19th April).

Work on Key worker model and integrated competencies to reduce duplication and improve efficiencies to be developed.

Community Nursing:

Report now broken down to ILT level. Reduction in referrals in April, remains above baseline target but will review this to establish is seasonal variation of change to referral profile.

Working with Integrated Duty and Triage function as part of the integrated work within localities to streamline pathways and avoid duplication where possible. Workforce modelling and capacity demand being finalised as part of the community rebasing project.

East Sussex Healthcare NHS
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Access and Delivery overview:

Community AHPs:

Maintain 13 week waiting time target with the exception of:

MSK in H&R: increase in referrals over last 6 months and vacancies has led to an increase in waiting times, successful recruitment and reallocation of resources has reduced wait to 6 weeks in May.

MSK neuro physiotherapy: increase in wait is due to change in clinical pathways and acuity of patients referred into the service

Dietetics H&R: increase in referrals Feb and March along with annual leave over holiday period has led to an increase in patients waiting, Team are working to address this.

Frailty Practitioners:

Positive response from recent promotion of service within the community – increase in referrals from primary care. Knock on effect on capacity within the team and highlighted some challenges with delay in patients being accepted by other services.

Crisis Response:

Slight reduction in referrals in April, variety of strategies to improve utilisation of Crisis Response.

Trial with 2 wards for Discharge to Assess model from May.

Challenges with onward referrals to other services after 72 hour period.

2020 Metrics

2020 METRICS

East Sussex Healthcare NHS
NHS Trust

2020 Metrics: Safety & Quality

Indicator Description	Target	Previous Months				Current Month			YTD			Trend
		May-16	Feb-17	Mar-17	Apr-17	May-17	May-16	Var	This Yr	Last Yr	Var	
Total patients safety incidents reported	M	1078	1235	1247	1066	1150	1078	6.3%	2216	2132	3.8%	
Total Non-ESHT patients safety incidents reported	M	244	151	151	139	179	244	-26.6%	318	564	-77.4%	
Falls Assessment Compliance	M	93.9%	88.9%	91.8%	90.1%	90.4%			90.2%			
Pressure Ulcer Assessment Compliance	M	86.0%	93.2%	92.1%	89.4%	85.9%			87.6%			
No of MRSA cases	0	0	0	0	0	0	0	0	0	0	0	
No of CDI cases	4	7	2	2	1	5	7	-2	6	9	-3	
No of MSSA cases	0	0	0	0	0	0	0	0	0	2	-2	
Mixed sex accomodation breaches	0	7	0	0	0	6	7	-1	6	7	-1	
No of complaints reported	R	55	41	55	41	52	55	-5.8%	93	130	-39.8%	
All ward moves	M	2344	2110	2307	2109	2247	2344	-4.3%	4356	4647	-6.7%	
Night ward moves	M	434	406	385	368	370	434	-17.3%	738	904	-22.5%	
Crude Mortality Rate	M	1.7%	2.1%	1.7%	1.8%	1.7%	1.7%	0.0%	1.7%	1.9%	-0.2%	
HSMR (CHKS)	100		104									

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
		May-16	Feb-17	Mar-17	Apr-17	May-17	May-16	Var	Yr	Last Yr	Var	
A&E Performance (4 hour wait)	95.0%	85.0%	76.0%	80.7%	80.1%	81.4%	85.0%	-3.7%	80.8%	84.5%	-3.8%	
A&E 12 Hour trolley waits	0	0	0	0	0	0	0	0	0	0	0	
A&E Unplanned re-attendance	5.0%	3.3%	2.7%	3.1%	3.0%	3.2%	3.3%	-0.1%	3.1%	3.3%	-0.2%	
A&E Time to Initial Assessment (% Ambulance conveyances within 15 minutes)	M	93.1%	81.7%	79.7%	80.9%	80.8%	93.1%	-12.3%	80.9%	93.7%	-12.8%	
A&E Time to Treatment (% within 60 Minutes)	M	40.1%	48.5%	43.0%	41.1%	40.4%	40.1%	0.3%	40.7%	43.4%	-2.7%	
A&E Left before seen	5.0%	2.2%	1.0%	1.2%	1.5%	1.4%	2.2%	-0.8%	1.4%	2.1%	-0.7%	
Non Elective Conversion Rate	M	24.6%	27.8%	27.5%	26.4%	26.0%	24.6%	1.5%	26.2%	25.5%	0.7%	
A&E Cubicle Waiters (average number per day)	M	51	56	50	51	48	51	-3	8	8	0	
Zero Length of Stay NEL admissions	R	610	451	584	621	683	610	10.7%	1304	1266	2.9%	
% Zero LOS NEL Ambulatory admissions	M	40.5%	35.8%	38.5%	42.4%	41.5%	40.5%	2.4%	41.9%	42.0%	0.0%	
Total Non Elective Beddays	M	22694	22397	23194	22164	23011	22694	1.4%	45175	46368	-2.6%	
RTT Incomplete (%patients waiting over 18 weeks)	92.0%	90.7%	89.3%	90.8%	90.8%	92.3%	90.7%	1.6%	91.5%	90.4%	1.1%	
RTT 52 Week waiters	0	0	0	0	0	0	0	0	0	0	0	
Diagnostic performance (% patients waiting over 6 weeks)	1.0%	2.7%	1.2%	1.4%	5.0%	2.3%	2.7%	-0.4%	96.4%	97.2%	-0.8%	
Cancer 2WW standard	93.0%	95.6%	98.4%	98.1%	96.8%				96.8%	95.8%	1.0%	
Cancer 2WW standard (Breast Symptoms)	93.0%	98.5%	98.8%	98.7%	96.7%				96.7%	95.9%	0.8%	
Cancer 31 Day standard	96.0%	99.4%	98.8%	97.1%	98.1%				98.1%	99.0%	-0.9%	
Cancer 31 Day subsequent drug treatment	98.0%	100.0%	100.0%	100.0%	100.0%				100.0%	100.0%	0.0%	
Cancer 31 Day subsequent surgery	94.0%	100.0%	94.1%	94.1%	100.0%				100.0%	100.0%	0.0%	
Cancer 62 day urgent referral standard	85.0%	68.3%	69.9%	76.3%	76.0%				76.0%	68.0%	8.0%	
Cancer 62 day screening standard	90.0%	66.7%	66.7%	85.7%	80.0%				80.0%	80.0%	0.0%	
Delayed Transfer of Care	3.5%	5.7%	7.6%	7.3%	8.6%	6.3%	5.7%	0.6%	7.4%	5.5%	1.9%	
Outpatient appointment cancellations < 6 weeks	R	29	44	46	51	37	29	21.6%	88	43	51.1%	
Outpatient appointment cancellations > 6 weeks	R	1033	1124	1378	1247	1387	1033	25.5%	2634	2154	18.2%	

East Sussex Healthcare NHS Trust

2020 Metrics: Leadership &Culture

Indicator Description	Target	Previous Months				Current Month			YTD			Trend
		May-16	Feb-17	Mar-17	Apr-17	May-17	May-16	Var	Yr	Last Yr	Var	
Trust Turnover rate	10.0%	10.0%	10.0%	10.3%	11.0%	11.0%	10.0%	1.0%	11.0%	10.1%	0.9%	
Temporary costs and overtime as a % of total paybill	10.0%	14.7%	14.8%	15.0%	14.2%	14.1%	14.7%	-0.6%	14.2%	14.9%	-0.7%	
Proportion of staff with up to date annual appraisal	85.0%	89.8%	79.1%	79.0%	79.3%	81.8%	89.8%	-8.0%	80.6%	89.1%	-8.6%	

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


WHAT
MATTERS
TO YOU
MATTERS
TO US
ALL

Financial Special Measures Update

Meeting information:	
Date of Meeting: 25/07/17	Agenda Item: 11
Meeting: Trust Board (Public)	Reporting Officer: Jonathan Reid

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

The Trust has been in Financial Special Measures since October 2016 and has made significant process in strengthening both the financial governance for the organisation, the level of ambition and the capacity for delivery over the past nine months. Following intensive review by the Finance and Investment Committee, and by NHS Improvement, the detailed components of the Trust's financial plan have now been validated and approved. These will be reviewed in further detail at the Finance and Investment Committee on 27th July on behalf of the Trust Board. Key elements of the most recent iteration of the financial plan are attached for review by the Trust Board. The latest FSM review is on 18 July 2017, and the Trust will provide an update at the meeting.

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

The Finance and Investment Committee has reviewed the details of the Financial Plan for 2017/18 on a monthly basis since January 2017. The Trust is delivering at Q1, and the key risks to the plan – income and efficiency savings – have been identified and mitigated. The Trust is now focusing on securing full delivery of the plan and the control total.

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

The Trust Board are asked to review and evaluate progress on the finalisation of the financial plan for 2017/18, noting that the Trust plan has been reviewed by both the Finance and Investment Committee and by NHS Improvement through the Financial Special Measures team.

East Sussex Healthcare NHS
NHS Trust

EAST SUSSEX HEALTHCARE NHS TRUST

Financial Special Measures
Board Update – 26th July 2017

Jonathan Reid, Director of Finance
26/07/17

Executive Summary – Key Messages

East Sussex Healthcare NHS
NHS Trust

- The Trust is on track for delivery of £28.7m of CIPs, achieving the £36.4m control total.
- We now have a very high level of confidence in achieving the control total.
- We are delivering the 17/18 control total with purpose and pace, and we have fully delivered the plan in the first 3 months of the year.
- CIPS currently stand at £34.8m; over 20% above the guaranteed delivery – recognising that there is risk in the programme, but ensuring mitigation.
- Our plans and actions are built on strong foundations:
  - Culture turned around
  - Leadership aligned and focused on delivery
  - System engaged
- We have already invested in 53 people in targeted areas to ensure delivery, 7 more remain to be found and will be in place in August 2017.
- Feedback from NHSI due diligence review affirms good levels of staff engagement, motivation and commitment to full delivery.
- The local health economy financial gap is £52.6m, including £44m CCG QIPP plans. At Month 3 activity and income is as per the Trust plan.
- Planning, delivery, monitoring, risk management and reporting are now a single continuous process - ensuring delivery in 2017/18, and readiness for 2018/19. We will not repeat finalising a plan so late in the year. For 2018/19 we intend to have a full plan in place by 31st December 2017.

East Sussex Healthcare NHS
NHS Trust

Financial Plan for 2017/18

The profiled financial plan reflects the efficiency programme shown below:

Trajectory for Delivery	£m													
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total	16/17
Contract Income	28.7	28.4	29.3	29.5	29.1	29.7	30.1	29.4	29.6	29.9	28.2	29.8	351.9	333.6
Income	3.4	3.1	3.3	3.2	3.2	3.2	3.1	3.1	3.1	3.1	3.1	3.1	38.1	42.8
Pay	(23.1)	(23.5)	(23.5)	(23.4)	(22.8)	(22.9)	(22.4)	(22.4)	(22.7)	(22.7)	(22.7)	(22.7)	(274.8)	(269.6)
Non-Pay	(13.6)	(12.0)	(13.1)	(12.9)	(12.7)	(13.1)	(12.6)	(12.5)	(12.6)	(12.5)	(12.6)	(11.3)	(151.6)	(153.3)
Total	**(4.6)**	**(4.1)**	**(4.1)**	**(3.6)**	**(3.2)**	**(3.0)**	**(1.8)**	**(2.4)**	**(2.6)**	**(2.2)**	**(4.0)**	**(1.1)**	**(36.4)**	**(46.5)**

Financial Improvement Plans	£m													% of Turnover
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total	
Contract Income	0.4	0.4	0.7	0.7	0.7	0.8	0.7	0.7	0.6	0.5	0.4	0.4	7.0	1.80%
Income	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.1	0.28%
Pay	0.0	0.0	0.0	0.0	0.6	0.5	1.0	1.0	1.0	1.0	1.0	1.0	7.2	1.84%
Non-Pay	0.3	0.3	0.3	0.8	0.8	1.3	1.4	1.5	1.6	1.5	1.5	2.0	13.4	3.44%
Total	**0.8**	**0.8**	**1.1**	**1.6**	**2.3**	**2.7**	**3.3**	**3.3**	**3.3**	**3.2**	**3.0**	**3.5**	**28.7**	7.36%

Procurement & Grip & Control savings start to ramp up

Agency and Premium Pay changes start to make an impact

Impact of service changes in CSR starts to deliver

February is a shorter month

Procurement savings

The plan is delivering at Month 3 – for the rest of the year, the Trust focus is on bringing down pay and non-pay costs.

Progress in Q1

East Sussex Healthcare NHS
NHS Trust

Summary of position vs budget	Plan YTD	Actual YTD	Variance
Income	96.3	96.4	0.1
Pay	(70.1)	(69.9)	0.2
Non Pay	(38.9)	(39.3)	(0.3)
Total Operational Deficit	(12.8)	(12.8)	(0.0)

Operational highlights

- There has been a larger than anticipated impact of moving to HRG4+, whilst the movement for the Trust is understood to be positive it has created inter-divisional movements.
- In total contact income is ahead of plan.
- ESBT investment (and pay costs) remain below plan leading to variances in OOH.
- Estates and Facilities; car parking and laundry income are both slightly behind plan.
- Central and corporate are ahead of plan on contract income relating to last year. Corporate vacancies and over delivery on other income off set overspends in non pay.
- All adverse variances are reviewed through Finance and IPR discussions.

Trust Summary

- **Overall the quarter one plan (pre STF) has been delivered, however the month was not without it's challenges.**
- **Improved grip and control measures ensured delivery of the financial position. Escalation capacity has been closed during June.**
- **The Trust has generated sufficient funds to enable it to create a £0.5m provision against contract challenges**

CIPs

- CIPs have delivered YTD
- There are some small differences across categories and workstreams

	YTD		
	Plan £m	Actual £m	Variance £m
Income	1.67	1.88	(0.2)
Pay	(0.0)	(0.0)	(0.0)
Non-Pay	0.97	0.76	0.2
Total	2.63	2.64	(0.0)

Workstreams

East Sussex Healthcare NHS
NHS Trust

Workstream	Income £m	Contract £m	Pay £m	Non-Pay £m	Total £m
Clinical Services Review	0.00	0.00	4.32	2.00	6.32
Data Quality and Clinical Networks	0.00	3.94	(0.10)	0.00	3.84
Elective Pathways	0.08	2.62	(0.42)	3.78	6.07
Grip & Control	0.00	1.90	0.00	4.24	6.14
Commercial Income	1.03	0.00	0.00	0.36	1.38
Procurement	0.00	0.00	0.00	4.60	4.60
Patient Flow	0.00	0.19	0.46	0.04	0.69
Agency & Premium Costs	0.00	0.23	5.59	0.00	5.82
Central Risk Adjustment	0.00	(1.86)	(2.67)	(1.60)	(6.14)
Total	**1.11**	**7.02**	**7.18**	**13.41**	**28.72**

The boxes below give a brief explanation of how savings will be realised.

Clinical Services Review –
Reduction in LOS, resulting closure of 12 beds, review of efficiency and effectiveness resulting in either withdrawal of services or increased productivity, these will result in substantive staff changes, but ultimately it will reduce the reliance on bank and agency, through redeployment of staff into vacancies. Target is £6.3m, but only £3.5m has been approved by FISC to date, the target remains the same and to be represented at FISC at end of August

Data Quality & Clinical Networks –
Improvement in capture of activity and outcomes, and improved external income management

Procurement –
Reduced spend by consolidation of suppliers and products, substitution of products, tighter control of purchasing. Better Prices, efficient working and waste avoidance

Elective Pathways –
Contract Income – Multiple projects driving improvement in productivity in outpatients, endoscopy & cardiology.
Non-Pay – Increased efficiency resulting in reduced Trust outsourcing

Patient Flow –
Contract Income - Improvement in capture of activity resulting in increased income
Pay & Non-Pay - Reduction in LOS, resulting in bed closures, to date 33 beds have closed and a further 10 beds to close. All specialties have been allocated LOS targets.

Grip & Control –
Contract Income – This relates to the management of 16/17 income dispute
Non-Pay – Avoidance of costs in the original plan

Agency & Premium Costs –
Reduction in £9m premium pay costs, this is offset by an increase in substantive costs through better management and retention of staff, this delivers a net wte reduction of 12.6 WTE.

Commercial Income–
Maximising existing commercial opportunities and better contract management

Central Risk Adjustment – this is a balancing figure, but the Trust recognises that there is a higher risk on Workforce and CSR

Contract Income CIPs 2017/18

East Sussex Healthcare NHS Trust

- 2016/17 was the first year of a full PBR contract - prior to this the Trust was on a cap and collar contract. Activity capture continues to improve. Agreement has been reached on 16/17 contract challenges.
- The overall plan has £8.9m of schemes associated with contract income, with a £1.9m risk adjustment.
- £4.4m directly results from an improvement in recording of activity which will flow through PBR.
- £2.6m results from increased productivity and a focus on outpatient activity.
- £1.9m avoids income loss by strengthened clinical and managerial process around readmissions.
- Level of risk adjustment kept under review, but Q1 forecast indicates Trust income on plan for year

Workstream	£m
Data Quality & Clinical Networks, Patient Flow & CNS Activity	4.4
Elective Pathways	2.6
Grip & Control	1.9
Contract Income Total	8.9
Central Risk Adjustment	(1.9)
Contract Income Total	7.0

Improvement in the capture of activity resulting in increased income.

Multiple projects including better capture of activity and improvement in productivity in outpatients, endoscopy & cardiology.

This relates to the mitigation of the 16/17 disputed items, through improved management of readmissions.

Key message: we have £7m of contract income CIPs included in our income plan and this has been shared with CCG's. Q1 Income plan has been delivered.

Pay 2017/18

The plan includes £7.2m of pay savings, this is driven by a reduction in premium pay costs resulting in cheaper staff and a reduction in 124 WTE's through service changes and bed closures.

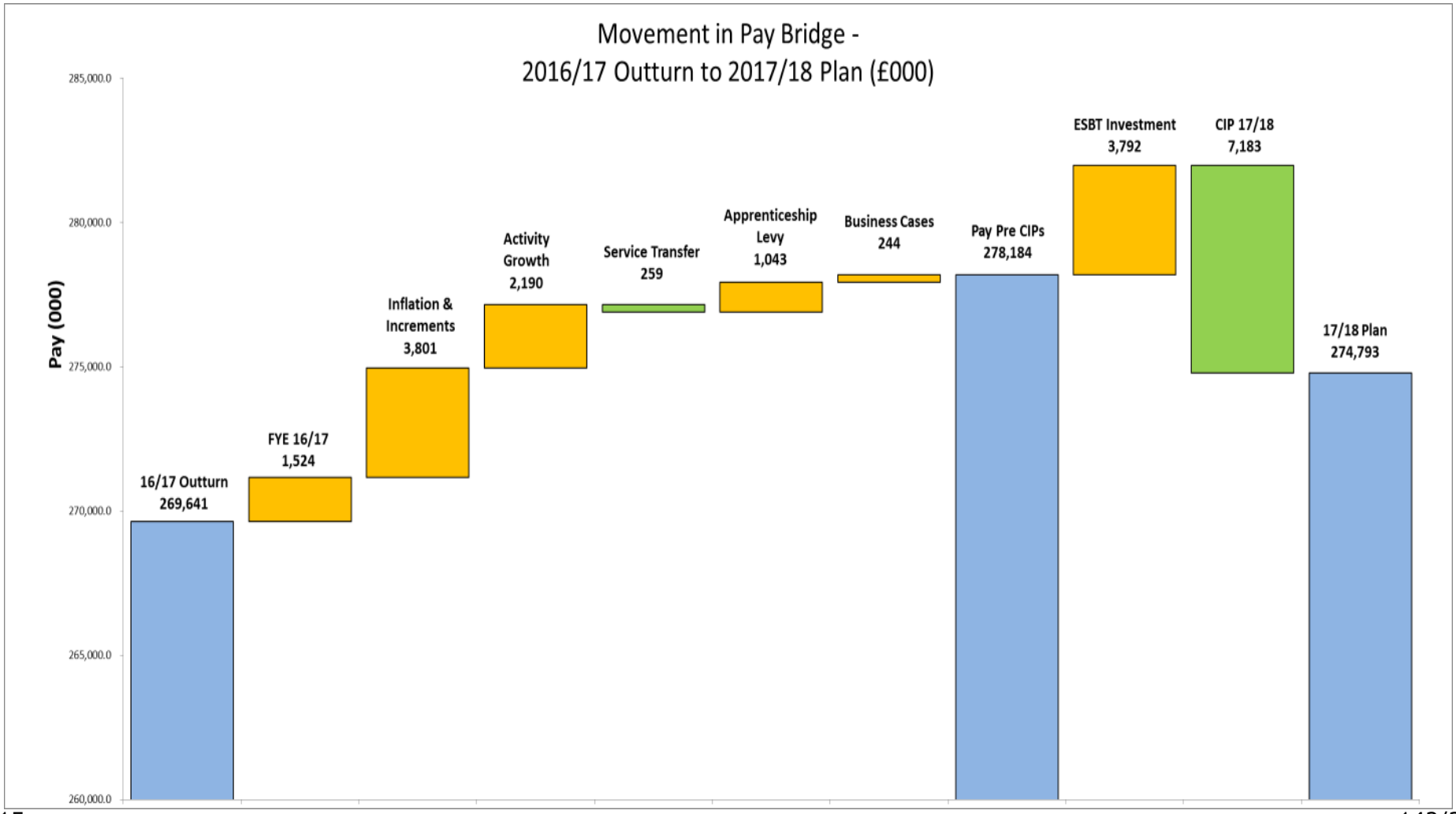
- The Trust is targeting £9.8m of pay savings, but has applied a £2.7m risk adjustment. There is confidence in delivery of workforce savings due to specialist expertise and a proven delivery model in other Trusts.

- Examples of key actions being taken are:
  - Cease agency HCA – £270k commenced June 2017
  - Re-launch of internal bank – £900k commenced June 2017
  - Redesigning services leading to closing 12 beds – £1.3m planned September 2017
  - Reducing recruitment timeframes - £185k commenced
  - Increased use of apprenticeships - £60k commenced
  - Improving Medical Rostering and Leave planning – £650k planned September 2017
  - Reducing sickness - £453k commenced

- The 2 workstreams with highest risk are CSR and Agency & Premium Pay. The Trust has secured additional resource for both workstreams and each has a weekly executive led review meeting, with direct support from DoF and DFI.

Pay Bridge 16/17 to 17/18

The bridge below shows the total movement from 16/17 outturn to 17/18 plan, including the impact of community investment and CIPs



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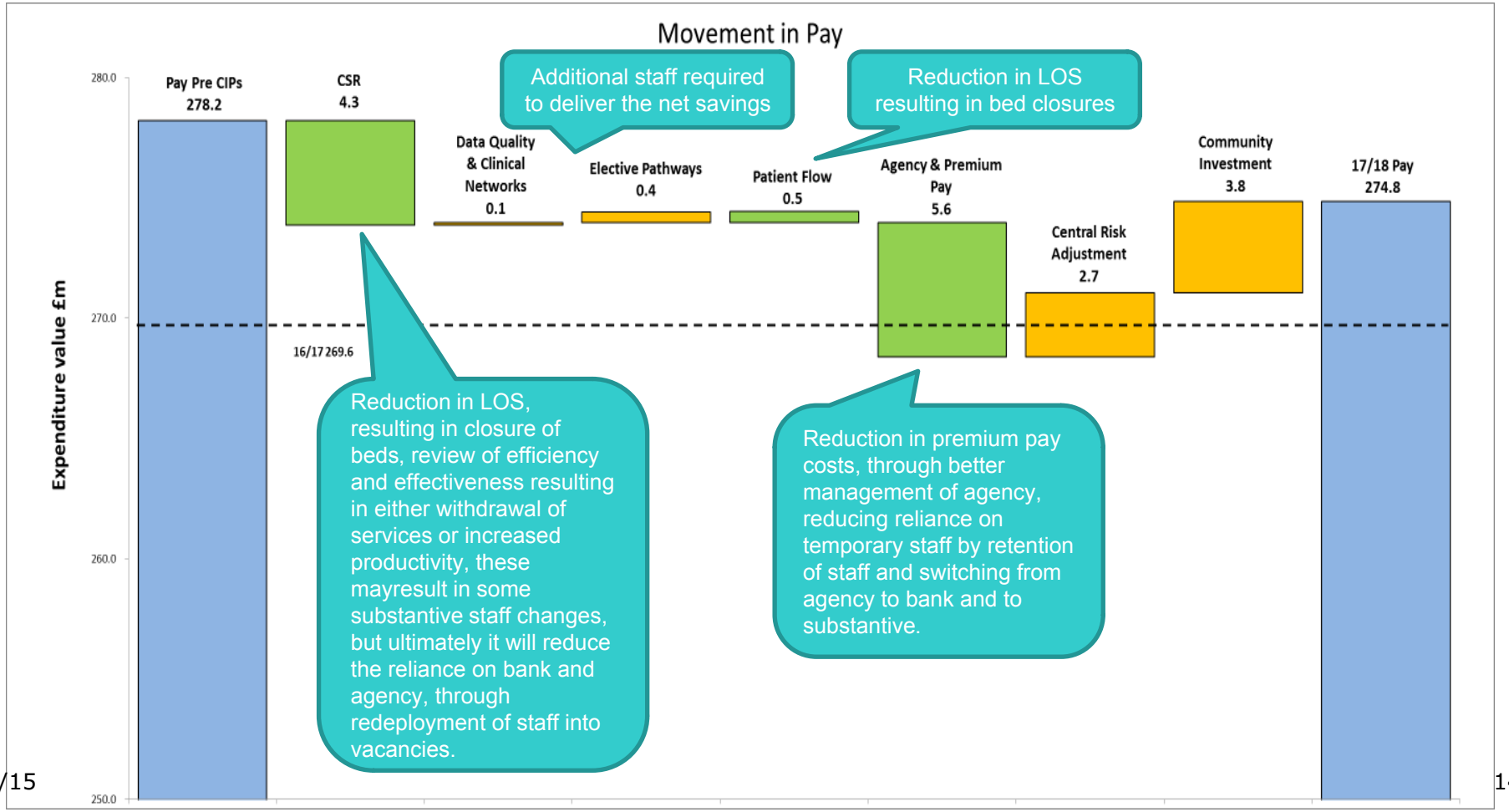
NHS Trust

Pay Bridge

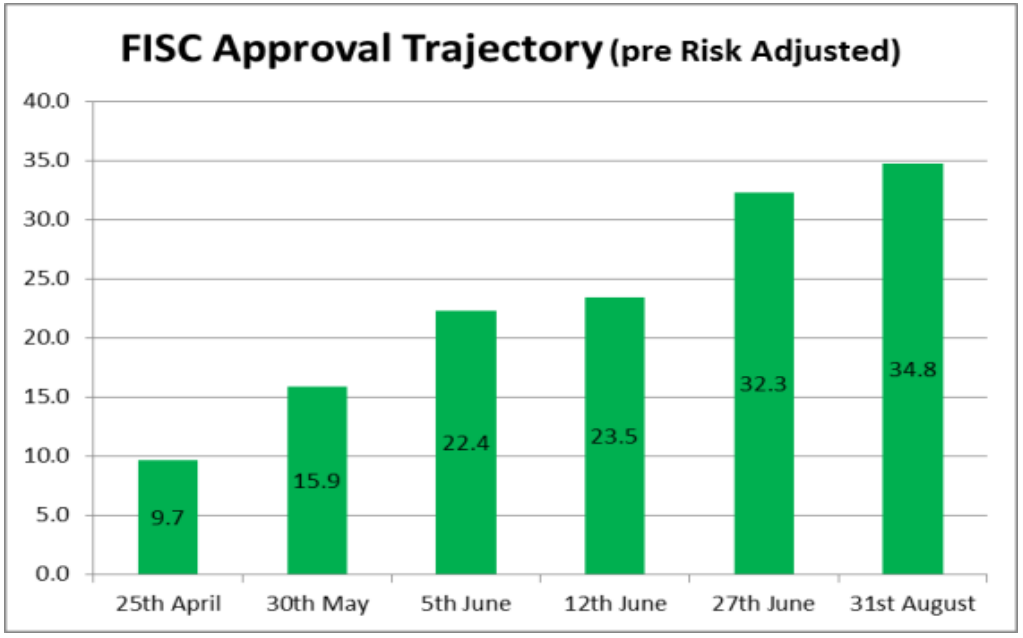
- The 2 main savings areas are CSR and Agency & Premium Pay
- The Trust recognises that these areas are higher risk and has therefore applied a central risk adjustment
- The increase in costs on Data Quality & Clinical Networks and Elective Pathways is required to deliver the savings
- The start position includes inflation, growth, apprenticeship levy and service changes



Approvals Trajectory and Pipeline

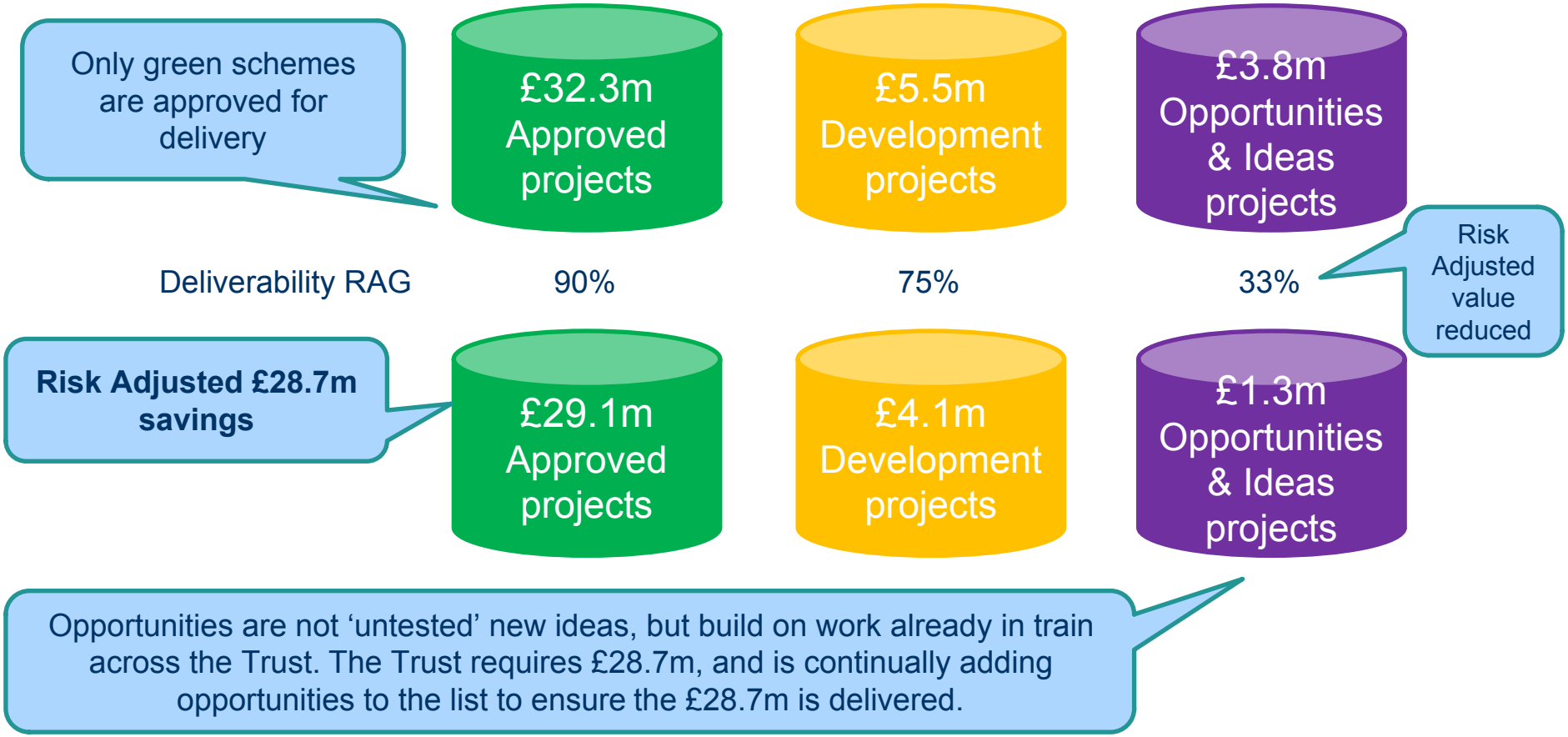
East Sussex Healthcare NHS
NHS Trust

- The Trust has approved through FISC the full plan of £28.7m required in 2017/18.
- The Trust trajectory was to have £34.8m approved by the end of June. The total approved now stands at £32.3m.
- £2.5m of schemes were deferred for strengthening - these will be approved by FISC in August.
- The expected trajectory against the £34.8m target is below. In addition we will continue to progress schemes to mitigate any slippage or non-delivery of existing schemes.



Project Status

This is the updated project 'hopper' status showing the value that has been agreed by FISC



Securing Resource

Trust capacity has increased since 2016 in two key areas:

- 25 WTE Operational Delivery Managers – in post, and being trained
- 19 WTE Delivery Support/ Project Leads/ Specialists

As at July 2017, and following review with NHSI colleagues and Trust Finance and Investment Committee, CIP delivery requires 16 WTE further resources per slide overleaf:

- 9 WTE identified and allocated to workforce and CSR
- 7 WTE still required for commercial/ procurement and operations

Capacity to deliver

East Sussex Healthcare NHS
NHS Trust

The Tables below shows the additional resource to add capacity to deliver the plan.
Green – secured and in process of being secured individual interims, Gold – internal resource redeployed and temporary backfill, Blue – Single supplier

Workforce (£5.8m)	
Role	WTE
Programme Delivery Lead	0.8
Skills:	
Experienced Programme Lead	
Understanding of key workstream issues	
Deliverables:	
Co-ordination of workstreams	
Support for Director of HR	
Communications and Engagement	

Clinical Services Review (£6.3m)	
Role	WTE
Delivery Support	1-3
Skills:	
Service redesign skills/ analytical skills	
Ability to engage with consultants	
Deliverables:	
Specification of programmes	
Agreement of delivery plans	
Implementation support	

Operational	
Role	WTE
Patient Flow (£0.7m)	1
Skills	
Capacity and demand management	
Operational engagement	
Deliverables:	
Reduction in LOS	
Improved A&E Performance	
Closure of Beds	

Other	
Role	WTE
Commercial Specialist	1
Skills	
Commercial Experience	
Negotiation skills	
Deliverables:	
PMU Contract	
Laundry Re-provision	
P2P Review	

Procurement (£4m)	
Role	WTE
Category Manager	1
Skills:	
Procurement Experience	
Outsourcing and Triage/Referral Management	
Deliverables:	
Corporate spend	
Multi-functional devices	
Healthcare activity outsourcing	

Medical Job Planner	1
Skills:	
Medical Contract Expertise	
Job Planning and Roster Management	
Deliverables:	
Support to MD	
Refreshed Job Plans - Sept 2017	
New Deliverables - Jan 2017	

Finalised draft of the PID has identified key areas where support is needed

Outpatients (Productivity)	1
Skills	
Management & delivery of waiting lists	
Outpatient productivity	
Deliverables:	
Reduction in outsourced activity	
Reduction in waiting list	
Reduction in DNA's & improved utilisation of clinics	

Contracting Specialist	1
Skills	
NHS Contracting Experience	
Negotiation skills	
Deliverables:	
Minimise Income Risk	
Resolution of contracting disputes	
Secure commissioner support for service changes	

Category Manager	1
Skills:	
Procurement Experience	
Product Choice	
Deliverables:	
Reduction in surgical spend	
Alignment of product contracts	
Support for broader procurement stream	

Roster/Workforce Mgmt Project	1-3
Skills:	
Roster Management	
Clinical Engagement	
Deliverables:	
Refreshed Nursing Roster/ Safecare	
New Policies and Procedures - all staff	
Delivery of temporary workforce workstream	

Pathology	1
Skills	
Experience of service redesign	
Analytical skills	
Deliverables:	
Pathology Efficiencies	
Reductions of requests	

Elective Care Programme	1+
Skills	
Experience of service redesign	
Analytical skills	
Deliverables:	
Reduction in waiting list	
Day Surgery Increase	
Reduction in Readmissions	

The requirement has been reviewed by the Finance & Investment Committee..

Planning for 2018/19

The table below shows the Trusts latest assessment of the financial position for 2018/19. New CIPs of £14.6m will be required to deliver the 18/19 Control Total of £26.1m.

Timeline for 18/19 Financial Plan:

- August – F&I Committee agree 18/19 Planning Timetable
- September – FISC to commence review of 18/19 savings
- October – FISC continues review of 18/19 savings
- November – Draft 18/19 Financial Plan presented to F&I Committee
- December – Final 18/19 Financial Plan agreed by F&I Committee

We intend to have as firm a plan for next year by December 2017 as we do for this year at July.

Indicative 18/19 Plan	£m
Q4 Run Rate extrapolated (adj for y/e)	(31.6)
Pay Inflation	(3.8)
Non-Pay Inflation	(2.1)
Tariff changes	0.8
Contingency	(4.0)
New CIPs schemes	14.6
Deficit 18/19 pre new CIPs	**(26.1)**
Control Total	(26.1)

17/18 CIPs Carry Forward	9.9
New CIPs schemes	14.6
Indicative CIP Requirement 18/19	**24.5**

These numbers are based on the assumptions that were included in the 18/19 planning submission, updated for Q4 run rate.

Next steps

- Now that the planning is complete the focus needs to be solely on delivery, building on M1-3 results
- Resources fully secured by August 2017
- Continued development of pipeline
- Early work on 2018/19 – developed with the F&I Committee
- Timetable for 3 year plan to deliver breakeven position by 2020/2021.
- Board and Executive focus and determination to deliver

East Sussex Better Together Alliance Accountable Care Model – Future Organisational Arrangements

Meeting information:			
Date of Meeting:	25 July 2017	Agenda Item:	12
Meeting:	Trust Board	Reporting Officer:	Dr Adrian Bull, Chief Executive

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

Strong progress has been made during the first 150-week phase of East Sussex Better Together (ESBT) to redesign care pathways and services, and much of the initial transformation work is now core business. However, as reports to the Board have previously highlighted, this is not enough to ensure the required transformation and secure a sustainable health and care system and quality services for the population we serve. We have now arrived at a point where we need to decide what the embedded structure for our ESBT model needs to look like in the future, to deliver our objective of a fully integrated and sustainable health and social care system for our local population in the long term

Sovereign governing bodies of the constituent ESBT Alliance organisations are ultimately responsible for making decisions about the delivery vehicle for the future ESBT model, and we along with partner organisations and subject matter experts were represented at an options appraisal panel on 22 June 2017. The attached papers outline the process undertaken and the evaluation criteria used to assess the four options.

This options appraisal indicated that a stronger Alliance arrangement (option 3) – which we could establish by April 2018 – moving towards full integration (option 4) in the longer term, would deliver the best opportunity for addressing challenges and ensuring future sustainability.

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

12 July: ESBT Executive Alliance and ESBT Governing Board

18 July: East Sussex County Council Cabinet

26 July: Eastbourne, Hailsham and Seaford & Hastings and Rother CCG Governing Bodies

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

It is recommended that the Trust Board agree the following:

1. A new health and care organisation (Option 4) as the preferred option for the ESBT Accountable Care Model and agree the proposed map for implementation by 2020 (Appendix 5), noting that the key next steps and phasing for implementation will take place over the summer.

2. Strengthening the current ESBT Commissioner Provider Alliance arrangement by April 2018 by implementing the following elements:

    - A fully integrated governance structure to support a single pooled health and social care commissioning budget;
    - A single point of leadership for delivery and how services are organised, and;
    - Reinforcing performance and monitoring against an integrated Outcomes Framework

    And note that subject to agreement by the Council Cabinet and CCG Governing bodies the development of a single point of leadership for strategic commissioning and a single pooled budget for our ESBT health and care economy.

East Sussex Better Together Alliance Accountable Care Model –

Future Organisational Arrangements

1. Background

1.1 East Sussex Better Together (ESBT) is our whole system (£1billion) health and care transformation programme, which was formally launched in August 2014, to fully integrate health and social care across the ESBT footprint in order to deliver high quality and sustainable services to the local population. The partners in ESBT are Eastbourne, Hailsham and Seaford (EHS) CCG, Hastings and Rother (HR) CCG and East Sussex County Council (ESCC), East Sussex Healthcare NHS Trust (ESHT) and Sussex Partnership NHS Foundation Trust (SPFT) are an associate member. The programme covers a population base of approximately 370,000. We have a combined resource of approximately £1.042billion, the majority of which is used to commission primary, community, acute, mental health and social care services from ESHT, SPFT, GP Practices and providers in the independent care sector and voluntary sector.

1.2 Our shared vision is that by 2020, there will be a fully integrated health and social care economy in East Sussex that ensures people receive proactive, joined up care, supporting them to live as independently as possible and achieving the best outcomes. This includes strengthening community resilience through an asset-based approach that enables local people to take ownership of their own health and well-being through proactive partnerships. Ultimately by working together we aim to achieve high quality and affordable care now and for future generations and improve the safety and quality of all the services we commission and deliver.

1.3 The first 150-week phase of the programme has focussed on redesigning and transforming services to improve health and social care outcomes. As a consequence we have established a range of integrated services including Health and Social Care Connect, Joint Community Re-ablement and Locality Teams that have improved client and patient experience and supported more people. We have also established excellent whole system partnerships, scoping the issues and solutions, and agreeing the necessary framework for the delivery of whole system care pathways. We have made significant progress in all these aspects, and much of our initial transformation work is now core business. As reports to the Board have however previously highlighted, it is clear that this is not enough in itself to ensure the required transformation and secure a sustainable health and care system and quality services for the population we serve. We have now arrived at a point where we need to decide what the future structure needs to look like to embed all the changes we have already made.

1.3 As our initial 150 week transformation programme draws to a close our next phase is to ensure we fully exploit the opportunities of accountable care, and as we transition to the new ESBT Alliance arrangement we are ensuring a keen focus on delivering in-year improvements as a system and developing the governance to identify the best legal vehicle for the delivery of ESBT into the future. We are now focusing on building a new model of care, accountable care, that integrates our whole system: primary prevention; primary and community care; social care; mental health; acute and specialist care, so that we can demonstrably make the best use of the £860m collective resource we spend every year to meet the health and care needs of the people of East Sussex.

1.4 In line with this, in December 2016, the Board supported continued work to develop a local fully integrated Accountable Care Model (ACM) across the ESBT footprint, involving a transitional year in 2017/18, and to establish a commissioner-provider alliance as the most effective way to develop the evidence base further in East Sussex. An Alliance

Agreement and other arrangements have now been finalised and agreed by each the of ESBT Alliance constituent organisations and were collectively agreed by the ESBT Alliance Governing Board on 27th June.

1.5 This report focusses on the outcomes of the options appraisal exercise undertaken in June 2017 to identify the most appropriate future delivery vehicle for our ESBT model of care.

2 Progress in 2017/18

2.1 The Alliance Agreement and underpinning governance structure provide 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 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. To date we have developed the following elements of our shadow accountable care system:

- A formal ESBT Alliance Agreement to provide the framework to operate as an ESBT Alliance
- An integrated governance structure, and a framework for the Alliance arrangement itself, detailing which organisations in the health and care system are involved and in what capacity
- A Strategic Commissioning Board (SCB) with EHS CCG and HR CCG to jointly undertake responsibilities for population needs assessment and commissioning health and social care through oversight of the Strategic Investment Plan (SIP), as well as overseeing and assuring the delivery of health and social care services in the 2017/18 test bed year
- A pilot integrated Outcomes Framework has been developed to support the role of the Board (SCB) in the 2017/18 test-bed year.
- An integrated Strategic Investment Plan (SIP) was agreed for 2017/18 by commissioners to align health and social care investment, as part of a medium-term financial plan, to deliver the transformation in how care is provided across the ESBT footprint and establish a clinically and financially sustainable system.
- An integrated financial reporting system to enable the planning and control of ESBT resources through regular monitoring of expenditure against the plan, with corrective action to be taken in year, if required, by the Strategic Commissioning Board.
- Arrangements for patient and citizen integration into the governance framework

2.2 The recent learning from the Kings Fund[1] based on the UK NHS Five Year Forward View Vanguards and international examples of best practice[2] indicates that forming a commissioner-provider alliance for the transitional phase puts us in a strong position to make significant progress within the current regulatory framework. We are now moving into a phase of undertaking the necessary learning and development, with support from NHS Improvement (NHSI), NHS England (NHSE) and the Care Quality Commission (CQC) as the system regulators, to design our future ESBT Alliance ACM, 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 high quality services for our population.

[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)

3 Options appraisal of the future ESBT legal delivery vehicle

3.1 The vehicle for our future model must provide the right platform to enable us to improve the quality of services, improve health outcomes and reduce inequalities across the ESBT footprint offering integrated, person-centred care in a clinically and financially sustainable way. In particular the future organisational form must enable us to deliver the following benefits:

- a reduction in variation and improved outcomes for local people;
- improved population health and wellbeing;
- improved experience of health and care services;
- achievement of our ESBT objective of system balance by 2020/21 and;
- improved connections with other elements of service delivery where working on a larger population basis within the Sussex and East Surrey Sustainable Transformation Partnership.

3.2 In order to design our future ESBT Alliance ACM, we have developed and carried out an appraisal of the options for the delivery vehicle of our future model with our ESBT partners. As signalled in discussions with our stakeholders, the latest learning from the Kings Fund and NHS Vanguards[3] indicates that there are a small number of clear options to explore to help us deliver the future ESBT new model of accountable care:

- **Prime Provider or Prime Contractor (Option 1)** - where one provider holds the contract and acts as an integrator of the services through a subcontracting model.
- **Corporate Joint Venture or Special Purpose Vehicle (Option 2)** – where parties agree to form a limited company or limited liability partnership e.g. a forming a new corporate joint venture or special purpose vehicle to deliver a single contract for the whole population, or parts of it.
- **Alliancing: Commissioners and Providers (Option 3)** – a virtual arrangement where parties agree to work together in an Alliance without forming separate legal entity or physically changing existing organisational structures.
- **Forms of organisational merger or new organisation (Option 4)** – for example this could mean building on the NHS Trust legal framework to establish a new East Sussex Health and Care NHS Trust,that would take a lead role across the system, providing the majority of services in the ESBT area.

3.3 It should be emphasised that there is no definitive evidence base for the options over and above what we have learned and recorded from international best practice and the emerging vanguards in the UK in making our case for change. Our learning must be iterative and any recommendation is at a relatively high level, demonstrating our direction of travel to best meet our ambition and needs. There will be an implementation period where much greater detail will emerge and a comprehensive engagement plan for this phase will be implemented. There will also be clear milestones from April 2018 onwards, of what we need to achieve and by when in order to ensure the necessary momentum for success.

3.4 To reflect this, the ESBT Accountable Care Development Group (ACDG), which brings together key stakeholders such as the Local Medical Committee (LMC) and Healthwatch with leads from each partner in the ESBT Alliance, has taken steps to ensure we have a robust process that builds consensus locally. This comprised developing and agreeing evaluation criteria and an options appraisal exercise to test appetite locally for the four options.

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[3] *New Care models: Emerging innovations in governance and organisation form (Kings Fund, October 2016)*

3.5 The focus of this exercise is about the way the ESBT partner organisations arrange themselves in the future to deliver our aims and objectives in the most effective way i.e. it is a potential change to the way we structure our organisations in order to deliver better services, rather than a change to services themselves. We have widely discussed ESBT service improvements with local populations and will continue to involve local people and others in improvements to specific care pathways and services.

4 Options appraisal panel

4.1 The sovereign governing bodies of the constituent ESBT Alliance organisations are ultimately responsible for making decisions about the delivery vehicle for the future ESBT model, and these organisations were represented on the options appraisal panel by senior clinicians and managers. In order to make fully informed decisions about scoring the options appraisal, a panel process was undertaken and supported by three categories of representative:

- Clinical and managerial leaders from each of the constituent ESBT Alliance organisations who were responsible for making decisions about scoring the options against the criteria, after discussion about each option as a whole panel
- Representatives from other organisations that are integral to understanding how the system operates, and that have a key stake in determining the preferred vehicle to deliver the ESBT objectives, for example the LMC, GP Federations, NHS England and Healthwatch. These representatives were invited to contribute views and help agree the scoring but didn't undertake the final scoring.
- Subject matter experts, i.e. members of the Accountable Care Development Group, Workforce Group and IT Board plus others such as Principle Social Workers and Chief Nurses, who were invited to advise the panel representatives on the advantages and disadvantages of specific options but not undertaking scoring.

4.2 We also had early engagement with the NHS national new models of care assurance process, and NHS England also attended the session; we will continue to engage with this as appropriate.

5. Options appraisal exercise and evaluation criteria

5.1 The options appraisal exercise, which took place on 22 June, had the following aims:

- Arrive at a consensus view across our ESBT Alliance about the preferred direction of travel for our Alliance in the future;
- Understand and agree the key steps and the timetable involved to get there, and;
- Agree our priority actions for implementation from April 2018.

5.2 The exercise was facilitated by an independent expert chair.

5.3 A set of evaluation criteria were developed for the options appraisal together with a suggested process, which was tested with key stakeholders and discussed at the local Shaping Health and Care events in May, including views about weightings. The criteria are standard measures which were chosen because they were already well known and understood. They have previously been developed with input from stakeholders in relation to previous local options appraisal exercises to assess different delivery options for health and care services and have since been further tested.

5.4 The criteria with the percentage weightings as are as follows:

- Quality and safety – 15
- Clinical and professional sustainability - 20
- Access and choice - 15
- Deliverability - 10
- Financial sustainability 10

5.5 To reflect the nature and ambition of this whole system options appraisal, two additional criteria were created to reflect the need to make judgements about the right organisational form to provide the framework for a transformed health and care system:

- Transformation (for sustainable services) – 20
- Governance and accountability - 10

5.6 The weighting of the criteria was tested in discussions with stakeholders where Access and Choice was felt to be of high importance followed equally by Transformation, Financial Sustainability and Quality and Safety. The approach taken to weightings reflects the nature of the options appraisal exercise which is aimed at ensuring sustainability for all health and care services in the ESBT area through identifying the best delivery vehicle for achieving this and our objective of building consensus about our preferred direction of travel for ESBT overall, outlining the key steps to get there and making best use of the flexibilities that are expected to become increasingly available at a national level. All options would be expected to demonstrate ability to deliver high quality safe services that are accessible and support choice, however, the final preferred option would also be expected to demonstrate to a high level the ability to effect the system transformation needed to deliver workforce and financial sustainability within an appropriate timescale.

5.7 A series of joint ESBT staff engagement events were also held during May and June to share information about the options appraisal exercise and organisational forms, grow understanding and test the options to inform how the preferred option was reached. The key criteria and the list of indicators of what good looks like in relation to each of the criteria is attached at Appendix 1.

5.7 In addition to the options appraisal criteria the ACDG produced an information pack for the panellists bringing together some general characteristics and issues about the four options; where they are similar; and how they differ. This was not intended to be a comprehensive assessment, but a consideration of the kinds of issues and risks that might be anticipated with each option, based on our current understanding. The Information pack is contained in Appendix 2, and it contains the following detail:

- High level detail about each of the four options, how they might work, general characteristics and potential risks
- A high level Brief Review of HR and workforce implications for each option
- A high level Brief Review of Digital and IT implications for the options
- Key Public Health assessment criteria and technical requirements

5.8 In addition, the following supplementary information was produced to further support understanding

- Diagrams illustrating the potential governance and decision-making for each of the four options; these are not presented as the definitive article but are intended to be illustrative guides based on our current understanding (attached at Appendix 3)
- Case study examples from other areas in the UK; to give an understanding of how the different options are being implemented (Appendix 4)

5.9 An initial Equalities Impact Assessment (EIA) screen of the four options was also undertaken. In summary this initial screening did not identify any immediate negative impacts on protected characteristic groups but concluded that a full equalities impact assessment would be required as part of the next stage of the process, taking in relevant data, engagement of protected characteristic groups. It also suggested there should be two separate processes to consider implications for both the workforce and the local population. The EIA is available on request.

6. Outcomes of the options appraisal exercise

6.1 After all the panellists, contributors and subject matter experts had discussed each option the representatives from the ESBT Alliance member organisations scored each option against the seven weighted criteria, using the guidance set out below:

Score	Scoring Guidance
1	Option fails to meet objectives
2	Option performs ok against objectives but doesn't represent an improvement on the current system
3	Option performs reasonably well against objectives and represents a modest improvement on the current system
4	Option performs significantly well against objectives and represents a significant improvement on the current system

6.2 The overall outcome of the scoring exercise was as follows:

Criteria (weighting in brackets)	Option 1 Prime provider/ prime contractor 'integrator'	Option 2 Corporate Joint Venture	Option 3 Alliancing Commissioners and Providers	Option 4 Forms of merger or new organisation
Transformation (for sustainable services) (20)	1.33	1.67	2.33	3.00
Governance and Accountability (10)	1.58	1.75	2.67	3.17
Quality and safety (15)	1.67	1.83	2.75	3.00
Clinical and professional sustainability (20)	1.58	1.75	2.42	2.92
Access and choice (15)	1.67	1.75	2.42	3.08
Deliverability (10)	1.42	1.00	2.58	2.08
Financial Sustainability (10)	1.58	1.17	1.92	2.83
Average weighted score	**1.54**	**1.61**	**2.44**	**2.90**

6.3 Overall option 4, a new health and care organisation scored the highest on average as it was felt to deliver the best opportunity for long term sustainability overall and significant improvements compared to the way we are currently organised. This was followed by option 3, a more formal commissioner provider alliance arrangement. Options 1 and 2 were the least preferred options, some way behind. The following points were also noted:

- Options 4 and 3 scored the highest overall and tended to score the highest for each category as well.
- Option 4 finished top and option 3 finished second for six of the seven categories, with one notable exception being deliverability, where option 4 finished second to option 3, acknowledging the complexity of implementing a new health and care organisation when compared with a virtual Alliance arrangement.
- There was far less appetite across the panel to implement options 1 and 2, as it was not felt that they would add any value to our current system and these have therefore been discounted.

6.4 A map was discussed, accepting that option 4 has a longer lead in and the aim should be to have this in place by April 2020. Acknowledging that a start on option 3 has already been made with our ESBT Alliance, it was suggested that strengthening our current Alliance arrangement by April 2018 would be a necessary stepping stone. As a result the following practical steps are proposed to accelerate implementation in the context of year on year delivery of improvements:

- Single point of leadership for strategic commissioning;
- A single pooled budget for our ESBT health and care economy with EHS and HR CCGs;
- A fully integrated governance structure to support a single pooled budget of c£850m;
- Single point of leadership for delivery and how services are organised;
- Strengthened performance and monitoring against an integrated Outcomes Framework, and;
- An integrated approach to regulation.

6.5 The level of organisational change needed to incrementally move to option 4, building on what we have already set in train through our current commissioner provider alliance, is set out in the map in Appendix 5. Further detail is being developed to support the map and the phasing of delivery, and comprehensive plans will be established to ensure robust implementation of our preferred direction of travel. Further reports to Board will make recommendations regarding the implementation of specific elements of the map, given the significant potential implications of the proposed changes, both for 2018 and longer-term, for the discharge of the Board's statutory and financial responsibilities.

7 Conclusion and Recommendations

7.1 This report focuses primarily on the ESBT health and social care system. The potential scale of the proposed changes will have a significant impact on ESHT as well as the other partners. The work will continue to be developed with clear consideration of both aspects.

7.2 Strong progress has been made during the first 150-week phase to redesign care pathways and services, and much of our initial transformation work is now core business. As reports to Board have previously highlighted however, it is clear that this is not enough in itself to ensure the required transformation and secure a sustainable health and care system and quality services for the population we serve. We have now arrived at a point where we need to decide what the embedded structure for our ESBT model needs to look like in the

future, to deliver our objective of a fully integrated and sustainable health and social care system for our local population in the long term

7.3 The Board has previously agreed that moving to a fully integrated model of accountable care offers the best opportunity to achieve the full benefits of an integrated health and social care system, and that a transition year of accountable care under an alliance arrangement would allow for the collaborative learning and evaluation to take place between the ESBT programme partners and other stakeholders.

7.4 Discussion and engagement with our stakeholders about the evaluation criteria and the proposed weightings has helped to shape the options appraisal exercise. Undertaking an appraisal of the available options collectively as an ESBT Alliance with the involvement of key stakeholders has contributed to and strengthened our decision-making process. This has helped us to develop consensus locally to identify that overall a new health and care organisation (Option 4) is the preferred legal vehicle to deliver our ESBT objectives, in keeping with the expectations of our local stakeholders.

7.5 Taking practical action during 2017/18 to strengthen our current ESBT commissioner provider alliance arrangement, to incrementally change the way we are organised, will ensure that benefits can be realised both in year, as well as helping us to achieve the longer term objective of implementing a new health and care organisation by 2020. Such action, given the significant potential implications of the proposed changes for the discharge of the Board's statutory responsibilities will be fully considered in further reports. A map setting this out is included in Appendix 5.

7.6 It is recommended that the Trust Board agree the following:

- A new health and care organisation (Option 4) as the preferred option for the ESBT Accountable Care Model and agree the proposed map for implementation by 2020 (Appendix 5), noting that the key next steps and phasing for implementation will take place over the summer.

- Strengthening the current ESBT Commissioner Provider Alliance arrangement by April 2018 by implementing the following elements:

  - A fully integrated governance structure to support a single pooled health and social care commissioning budget;
  - A single point of leadership for delivery and how services are organised, and;
  - Reinforcing performance and monitoring against an integrated Outcomes Framework

  And note that subject to agreement by the Council Cabinet and CCG Governing bodies the development of a single point of leadership for strategic commissioning and a single pooled budget for our ESBT health and care economy.

Dr Adrian Bull

Chief Executive

East Sussex Healthcare NHS Trust

ESBT Future Model Options Appraisal: Scoring Sheet

Option X

Appendix 1

Name:
Organisation:

Score	Scoring Guidance
1	Option fails to meet objectives
2	Option performs ok against objectives but doesn't represent an improvement on the current system
3	Option performs reasonably well against objectives and represents a modest improvement on the current system
4	Option performs significantly well against objectives and represents a significant improvement on the current system

	Appraisal Criteria	**Option X**
Principles and characteristics	**1. Transformation (for sustainable services)** **Key indicators of what good looks like in this category:**	**Weighting 20**
1, 2 ,7, 8, 9 3, 5, 6 2, 7, 8 4, 7, 8 3, 7, 8, 9 1, 2, 7 6, 9 1, 5, 9 1, 5, 9 1,2, 5, 9 1,2, 3, 4, 6, 7, 9 1, 3	• System sustainability with particular reference to primary care; • Scope and scale of services significantly reduce intra-system transactional costs; • Delivery partners outside core service provision work together for the benefit of our local population, including approaches to market development in localities; • Integrated IT system for staff, patients and clients; • 'System-wide' leadership and management culture; • Vertically integrated care system; • Good acute networks across the wider STP delivery platform; • Increase of investment in prevention, primary and community care (including self-care and self-management), to be consistent with the ESBT Alliance Strategic Investment Plan; • Investment in prevention and early intervention reduces average per capita Year of Care cost; • Year on year delivery of the ESBT Alliance Strategic Investment Plan; • Improvements in key deliverables set out in the next steps of the updated NHS Five Year Forward View; • Focus on primary, secondary and tertiary prevention, self- care and self- management, to improve health and wellbeing and reduce health inequalities.	**Score**
Principles and characteristics	**2. Governance and Accountability –** **Key indicators of what good looks like in this category:**	**Weighting 10**
4 5, 6, 8, 9 9 9 7, 8 4, 7, 8, 9 6, 9	• Optimum levels of citizen leadership and governance; • Phased and assured transfer of risk; • CCG and Local Authority statutory functions are discharged; • Collective decision-making and governance structure that aligns with ongoing and continuing individual statutory accountabilities of the constituent bodies; • Optimum levels of clinical and professional governance; • A trusted health and care brand that inspires patient and client confidence; • Delivery within the current regulatory frame work.	**Score**
Principles and characteristics	**3. Quality and Safety –** **Key indicators of what good looks like in this category:**	**Weighting 15**
1, 2, 4, 7 1 6, 8, 9 4, 6, 7, 8 4, 7, 8 3, 4, 7, 8 1, 3, 4	• Uniformly high standards in the management of frailty and LTCs (for example Diabetes, Heart Disease) by integrated primary care, specialist, and community teams; • Provision of care increasingly out of hospital and at lowest level of safe and effective care; • Delivery of constitutional operational standards (A&E, RTT etc.); • Reduction in variation across all services; • Promotion of a safety culture; • Provision of continuity of primary care practitioner, where this exists; • Use of population health management capabilities (i.e. improved prevention, enhanced patient and client activation) to manage avoidable demand.	**Score**
Principles and characteristics	**4. Clinical and Professional Sustainability –** **Key indicators of what good looks like in this category:**	**Weighting 20**
7, 8 1, 7, 8, 9 7, 8	• Provision of the right conditions for innovation, now and into the future; • Delivery of clinically effective care services at lowest level of effective care, and clinical and care excellence; • Workforce flexibility, and recruitment, retention and development of excellent staff across all sectors.	**Score**
Principles and characteristics	**5. Access and Choice –** **Key indicators of what good looks like in this category:**	**Weighting 15**
3, 4 1, 3, 4 1, 3, 4 1, 3, 4, 8 1, 2, 3, 4, 7 3, 4	• Provision of choice and personalised programmes of care for children and adults with LTCs, disabilities and long term care and support needs; • Access to timely care that includes all sections of the community; • Evening and weekend access to GPs (target: 100% of the population covered by March 2019); • Access to community based services to enable people to remain in their own homes; • Patient choice for people with elective (planned) care needs, and increase the use of Personal Budgets and Direct Payments, and Personal Health Budgets (PHBs) where these are coming on line.	**Score**
Principles and characteristics	**6. Deliverability –** **Key indicators of what good looks like in this category:**	**Weighting 10**
5, 6, 9 5, 9 5, 6, 9 5, 6, 9 2, 6, 7, 8, 9 6, 9 1, 5, 9	• Cost to implement this option (system costs including capital costs) is reasonable and viable; • Option can be delivered within a reasonable timescale and no later than 2020/21; • Transition costs are understood and of reasonable value; • Tax, VAT, insurance, procurement of care packages and charging implications are understood and affordable, and are in line with statutory frameworks; • Impacts on health and social care workforce are understood and manageable (Ts&Cs and pensions); • No additional legal risks that will have a significant impact; • No impact on the viability of commissioners and providers outside of the ESBT system.	**Score**
Principles and characteristics	**7. Financial Sustainability –** **Key indicators of what good looks like in this category:**	**Weighting 10**
5, 9 1, 3, 5, 9 3, 5, 6, 9 9 3, 4, 6, 7, 8, 9 2, 7, 8 4, 7, 8, 9	• Efficient working of the system reduces operating costs (including transactional commissioning costs); • Services are transformed to assist with the achievement of financial sustainability; • Financial risk is effectively managed; • Flexibility to respond to changes in future health and care financial regimes; • Organisation/vehicle operates as a going concern, able to meet the financial requirements of regulators and statutory bodies such as HMRC; • Improved provider productivity and reduction in variation • Incentivisation of outcomes and performance improvement	**Score**

ESBT future legal vehicle options appraisal information pack

Introduction

This pack has been produced to support a facilitated and open discussion on Thursday 22nd June, with the following aims:

- arriving at a consensus view across our ESBT Alliance about the preferred direction of travel for our Alliance in the future, and;
- growing our understanding of the key steps and the timetable involved for getting there.

The current learning from the UK Vanguards and the Kings Fund[1] indicates that there are a number of clear options to explore for new models of accountable care to help us deliver the future ESBT model:

- Prime provider/prime contractor 'integrator'
- Corporate joint venture (provider collaboration)
- Alliancing: commissioners and providers
- Forms of merger or new organisation

It should be emphasised that there is no definitive evidence base for the options over and above what we have learned and recorded from international best practice and the emerging vanguards in the UK in making our case for change. Our learning must be iterative and the recommendation following this options appraisal will be at a relatively high level, demonstrating our direction of travel to best meet our ambition and needs. There will then be an implementation period where much greater detail will emerge and a comprehensive engagement plan for this phase will be implemented. This information pack provides summarised information about the four options. Whilst not a comprehensive assessment, consideration has been given to the kinds of issues and risks that might be anticipated with each option, based on current understanding.

This information should be read in conjunction with 'The Future ESBT Model Options Appraisal Exercise' paper, which has been previously agreed by the ESBT Alliance as our approach to considering the legal vehicle options, and sets out our key criteria for assessing them along with indicators of what good looks like.

[1] New Care models: Emerging innovations in governance and organisation form (Kings Fund, October 2016)

1 High level detail, how it might work, general characteristics and risks for each option

Option 1: Prime provider/prime contractor 'integrator'

This is a commercial arrangement where a lead provider is identified that will hold the single contract with the CCGs and ESCC as integrated commissioners, and the lead provider would sub contract the services to the individual service providers within a system of accountable care.

How it might work

- There is one provider/integrator who acts as the host, holding the PACS-plus contract on behalf of other providers. The host contract holder can act solely as an 'integrator' who sub contracts with other providers to ensure delivery and performance, or they can also provide some of the services/activity themselves
- The host contractor would need to put in place arrangements to support collaborative delivery. For example this could be through forming a Provider Alliance arrangement with other providers where decision making by the providers is delegated from each provider to their member(s) who sit on a partnership Board which binds their organisations together
- Risk and reward are shared through agreed contractual arrangements, the alliance arrangement would need to be sufficiently strong to effectively pass risk and reward between the alliance partners
- The Provider Alliance would put in place a Board which could have its own has its own Executive Team to cover off the key roles and portfolios e.g. Chief Executive Officer, Medical Director etc. etc.

General Characteristics	Potential Risks
• Organisations remain separate and retain sovereignty for governance and decision-making, subject to the terms of the Alliance Agreement • High reliance on the contract to govern the relationship • Bonuses or penalties for individual organisational performance • Little sharing of assets • Time limited for a contractually specified period contract management • Clear contractual allocation of risks and responsibilities • Ease of contracting for commissioners as they are negotiating with a single provider • Easy to setup operating structure • Able to use NHS Standard Contract with minimal tailoring • Role of commissioners limited to governance of main contract • Performance management and monitoring of the sub-contracted providers is the responsibility of the prime contractor • Ability to design and deliver transformation/transition of the services is managed by a single provider • Fast decision making • Competitive tendering and procurement may be necessary	• There is limited incentive for closer collaboration or integrated care at the sub-contractor level • Primarily a risk transfer mechanism rather than risk sharing, though the Alliance Agreement could mitigate this. • Potentially too high risk to offer a fully or majority integrated contract and services via this type of contract – better suited to sub sections of services and pathways that are delivered by multiple providers. • Whichever organisation assumes 'lead contractor' role has a disproportionate amount of power and risk versus the other providers • Typically more suited to mature markets and well understood demand/services • As the prime contractor has to manage all transferred risks, this requires a provider who has experience in this role • Lack of check and challenge on prime contractor decisions • Difficult to align objectives of the prime contractor with other stakeholders in the health economy not in-scope • Competitive tendering may have a negative impact on collaborative working relationships between providers • Potential confusion of role if strategic commissioners also retain some assessment or provider functions • Different terms and conditions remain for majority of staff creating potential inequalities for staff doing similar/comparable role but with different employer. Could lead to employment relations issues, poor morale, poor motivation and retention

Option 2: Corporate joint venture (provider collaboration)

This would consist of key organisations such ESCC, ESHT, CCGs and potentially others forming a special purpose vehicle or other corporate joint venture (i.e. a new company) to hold a single contract for the whole population, or parts of it.

- ESCC, ESHT and possibly the CCGs and SPFT could partner in a corporate joint venture/special purpose vehicle (SPV) which holds the PACS-plus contract
- The company is established as a company limited by shares. This could take a number of forms, for example a Community Interest Company
- Control of the SPV or Community Interest Company is divided between the owning partners
- The partners in the Joint Venture would provide cash flow for the Joint Venture
- Smaller partners such as GP Federations could put in low amounts of cash flow or a nominal amount with potential consequences for their level of reward and/or control of the entity
- GPs could agree to a way of collectively representing themselves as service providers within the SPV / Community Interest Company
- Regulators would need to confirm that they are content with the approach through ISAP and/or a transaction review

General Characteristics	Potential Risks
• Keep existing separate organisational governance and add in a shared governance arrangement for the new company • Shared decision-making with agreed voting rights • A separate organisation pooling resources to deliver shared objectives • Partners each have a direct stake in the new company and shared rewards or costs • Sharing of some assets within the joint venture • Can hold contractual arrangements in its own right • Promotes a robust risk share arrangement and aligns objectives. • SPV agreement will clearly state nature, responsibilities and terms and conditions of the relationship between the parties • Ability to share the risks and rewards with partners-Incentivises closer collaboration and innovation • Access the expertise of other independent or public sector partners • Combined group of providers to create sufficient capacity to address opportunity • Single SPV entity provides clear accountability to commissioners • Legal contracting SPV structure should be sufficiently commercially defined for private sector investors to fund transformation of services	• The current statutory framework does not give NHS Trusts the power to set up or participate in corporate bodies (only Foundation Trusts are able to do this) • Substantial time and resources required in developing and agreeing the SPV agreement • Slower decision-making until all negotiations are completed • Potentially difficult to align the group of providers who have their own management style, culture and background • VAT/Tax implications • Trust between providers required to co-operate effectively • Potential confusion of role if strategic commissioners also retain some assessment or provider functions • Different terms and conditions remain for majority of staff creating potential inequalities for staff doing similar/comparable role but with different employer. Could lead to employment relations issues, poor morale, poor motivation and retention

Option 3: Alliancing commissioners and providers

A form of contractual joint venture, whereby the partners remain separate legal entities but objectives, incentives, sharing of risks, collective accountability and contracting for outcomes are aligned across multiple providers, which could include the CCGs, ESHT, ESCC and others such as SPFT, and allowing primary care to participate as providers as appropriate at scale.

How it might work

- The providers remain separate legal entities, continue to directly employ their own staff but are bound together by an alliance agreement. In this option, a PACS-plus contract is not let instead the alliance would overlay existing contracts
- A process would be used to identify providers interested in participating in the Alliance, allowing primary care to interact as desired at scale through Federations or other arrangements
- The commissioners and providers come together in a contractual alliance to deliver PACS-plus services under their existing contracts with the commissioners
- Decision making by the commissioners and providers is delegated from each organisation to their member(s) who sit on an Alliance Governing Board on behalf of their organisation
- An overarching robust alliance arrangement which manages risk and reward sharing is put in place
- Services are delivered by the individual members under their existing contracts
- The commissioners (EHS and HR CCGs and ESCC) act as system integrators through holding the budgets and working collaboratively
- The Alliance would likely put in place a governance structure which could have its own has its own Executive Team to cover off the key roles and portfolios e.g. Chief Executive Officer, Medical Director etc.

General Characteristics	Risks
• Shared governance arrangements are overlaid onto separate sovereign organisational governance arrangements • Shared decision-making with agreed voting rights • Willingness to work flexibly to meet shared objectives • Shared rewards or costs of working together • Limited sharing of assets • The arrangement is virtual and there is no ability for the Alliance to enter into hold contracts in its own right • Contracting continues to be undertaken separately by the partner organisations • Time limited • Commissioners and providers share risk • Both incentives and risk sharing is driven by collective for meeting outcomes • Existing bilateral contracts can be retained (less disruption) • System solutions can be co-designed • Offers ability to quickly adapt to changing population/demand without need to enter formal contract variations • Ability to align objectives of Alliance with other stakeholders in the health economy not in-scope. • All parties share the Alliance agreement with common objectives and outputs -win or lose together	• Effort and resource is needed to initially develop the alliance contract. • Would be dependent on existing culture and trust -mutual trust and spirit of openness are pre-requisites for success. • Complex governance arrangements • Potential for reduced clarity on delivery responsibilities. • Commissioners retain risk or that Commissioners will exert too much influence on the Alliance and prevent the required transformation. • Tension between Commissioner/Provider wishes and 'best for Service' decision-making. • Potential confusion of role if strategic commissioners also retain some assessment or provider functions • Different terms and conditions remain for majority of staff creating potential inequalities for staff doing similar/comparable role but with different employer. Could lead to employment relations issues, poor morale, poor motivation and retention

Option 4: Forms of merger or new organisation

For example this could mean using the NHS Trust legal framework to form a new local NHS Health and Care Trust and create a new single health and care organisation responsible for providing the majority of services for the ESBT area. The new organisation would hold the single contract as well as sub contract with other providers to deliver the outcomes.

How it might work

- A new Health and Care NHS Trust for East Sussex is created jointly by ESCC and ESHT, and possibly the CCGs and ESHT as well. The new entity will hold the 'PACS-plus' contract as well as all other contracts for local legacy health and care services thereby creating a single 'Accountable Health and Care Trust or Organisation' for East Sussex
- ESHT and ESCC would use their powers under section 77 of the 2006 Health Act to create a Care Trust. Care Trusts have been established to bring together in one legal entity the commissioning and provision of health and social care services. Care Trusts are set up when the NHS and Local Authorities agree to work closely together, usually where it is felt that a closer relationship between health and social care is needed or would benefit local care services
- New governance and leadership arrangements are put in place which satisfy all partners and regulatory bodies
- The organisation could be built from the registered GP list to be routed in localities , with GP leadership at Governor, Board, Executive, Managerial, Hospital and Neighbourhood (Locality) level
-

General Characteristics	Risks
• Single governance and decision-making • Single management structure • Full pooling of assets which can be redeployed as needed • Full pooling of the risks and rewards of different activities within the organisation • Long-term arrangement • Full flexibility and leadership over totality of resources (workforce, financial, IT and estates*)* • Evolution of a new organisation using existing provider as the vehicle is a less complex model and potentially quicker. • The other advantages are very similar to Option 1 in that a single organisation and leadership team is accountable for the governance, and delivery of the services. It offers synergies from coordinating and removing duplication from local services. • System solutions can be co-designed	• Merger could be unwieldy if it involves multiple organisations. • If merger involves an NHS Trust and NHS Foundation Trust with other providers of NHS healthcare services may require Competition and Markets Authority (CMA) review - process can be detailed and lengthy. (e.g. if SPFT were merging part of their services with ESHT) • High risk (all the eggs are in one basket), but potentially higher rewards • Limited levers of control/influence for strategic commissioners • Cultural issues • Little experience of such models in UK and limited experience of staff in leading them

2 High Level Brief Review: HR and Workforce

Our Accountable Care Workforce Group has undertaken a high level review of the four options to identify impacts and differences relating to workforce.

Key points for option 1 prime provider/prime contractor 'integrator'

- Preparation for TUPE transfer (scoping of 'in scope' services and staff)
- Dealing with complexities of where roles are spread across in and out of scope functions, e.g. back office functions).
- Agreement on whose terms and conditions for new posts/new recruits (how to harmonise yet retain sovereign organisations, e.g. ILT Manager posts are a mix of health and ESCC employees undertaking same role) and resulting employment relations issues
- Potentials for managing redundancies (if they are likely to arise due to integration of functions) and complexities of different T&Cs and protection of recognised continuous service
- Staff comms and engagement/partnership working is vital to support retention of staff and bring about change with minimal employment relations issues.
- Scoping of contracted out functions and impact of decision on how functions are to be provided in the future (e.g. could staff be 'in scope' for transfer?)
- Consultation on transfer (and organisational change). Managing the transfer and issues post transfer
- Organisational Change Framework that all partner employers and TU reps sign up to (will ensure change process is managed fairly and consistently)
- Leadership development/support to line managers to achieve consistent and fair approach
- Workforce planning to ensure workforce is right fit for new organisation/structures/job roles

Key points for option 2 corporate joint venture (provider collaboration)

- Agreement on whose terms and conditions for new posts/new recruits (how to harmonise yet retain sovereign organisations, e.g. ILT Manager posts are a mix of health and ESCC employees undertaking same role) and resulting employment relations issues
- Managing redundancies (if they are likely to arise due to integration of functions) and complexities of different T&Cs and protection of recognised continuous service
- Preparation for TUPE transfer (scoping of 'in scope' services and staff)
- Dealing with complexities of where roles are spread across in and out of scope functions, e.g. back office functions.
- Scoping of contracted out functions and impact of decision on how functions are to be provided in the future (e.g. could staff be 'in scope' for transfer?)
- Consultation on transfer (and organisational change). Managing the transfer and issues post transfer
- Organisational Change Framework that all partner employers and TU reps sign up to (will ensure change process is managed fairly and consistently)

- Greater OD agenda/investment required to achieve shift in working as an alliance/new models of care
- Leadership development/support to line managers to achieve consistent and fair approach
- Workforce planning to ensure workforce is right fit for new organisation/structures/job roles

Key points for option 3 alliancing: commissioners and providers

- Agreement on whose terms and conditions for new posts/new recruits (how to harmonise yet retain sovereign organisations, e.g. ILT Manager posts are a mix of health and ESCC employees undertaking same role)
- Dealing with complexities of where roles are spread across in and out of scope functions, e.g. back office functions).
- Scoping of contracted out functions and impact of decision on how functions are to be provided in the future (e.g. could staff be 'in scope' for transfer?)
- Organisational Change Framework that all partner employers and TU reps are signed up to (will ensure change process is managed fairly and consistently)
- Staff loyalties divided between Alliance and sovereign organisation
- Employment relations issues that may arise out of similar roles but on different T & Cs
- Greater OD agenda/investment required to achieve shift in working as an alliance/new models of care
- Leadership development/support to line managers to achieve consistent and fair approach
- Workforce planning to ensure workforce is right fit for new organisation/structures/job roles

Key points for option 4 forms of merger or new organisation

- Equity of T&Cs for new staff (and current staff once harmonisation programme/appointments process completed). Harmonisation of pensions required.
- Large scale organisational change and impact on current resources to deliver change plus impact on recruitment and retention during organisational change.
- Employment relations issues arising out of organisational change
- Managing redundancies (if they are likely to arise) and complexities of different T&Cs and protection of recognised continuous service
- Preparation for TUPE transfer (scoping of 'in scope' services and staff). Consultation on transfer (and organisational change). Managing the transfer and issues post transfer
- Scoping of contracted out functions and impact of decision on how functions are to be provided in the future (e.g. could staff be 'in scope' for transfer?)
- Organisational Change Framework that all partner employers and TU reps are signed up to (will ensure change process is managed fairly and consistently)
- Workforce planning to ensure workforce is right fit for new organisation/structures/job roles
- Potential for large scale appointments process for local structure changes/new roles)
- OD/system development plan to support transformation

3 High Level Brief Review: digital and IT

Our ESBT Digital Programme Lead has undertaken a brief high level review of the four options and the following summarises the key differences relating to digital. Broadly speaking, when it comes to digital interoperability, the characteristic and risks for each of the four options from a digital perspective fall into two categories of organisational form:

1. Single organisation i.e. one legal entity in whatever form this takes e.g. option 2 corporate joint venture (provider collaboration) and option 4 forms of merger or new organisation
2. Separate but joined organisations in whatever form this takes e.g. option 1 prime provider/prime contractor 'integrator' or option 3 alliancing: commissioners and providers

1. Single Organisation:

Characteristics

- Removes barriers to change ("I don't work for your organisation and you can't tell me what to do")
- Simplifies Information Governance
- Removes data sharing issues wholesale as we'll no longer be sharing between organisations
- Enables and possibly requires consolidation of contracts and licensing arrangements
- Enables migration onto the same back office systems (like email)
- A single network and technical architecture
- Single IT service (service desk, support etc.)
- Single portfolio of work for prioritisation
- Single PMO and Gateway processes

Risks

- We will probably have to address some of the licensing and contractual elements as part of creating the new organisation (to avoid breaching certain legal contractual terms) which could distract from other work
- Will be complex and difficult to achieve (but ultimately delivers the most rewards for interoperability)

2. Separate but joined organisations

Characteristics

- Progress with digital integration is carried out in much the same way as the current status quo
- Easier to roll back if the collaboration doesn't work out

Risks

- Critical benefits relating to successful Accountable Care delivery (i.e. the necessity of interoperability) are harder to achieve
- Information sharing is complex and difficult
- Licensing and contract management is complex and difficult
- Federating email etc. is difficult (for example the NHS can't provide access to NHS mail to non-NHS Orgs)
- Access to each-others' systems is technically awkward
- Scheduling and prioritising work across a number of technical teams is slower than it would be with one team (although they have been doing a sterling job so far)

4 Key Public Health assessment criteria technical requirements

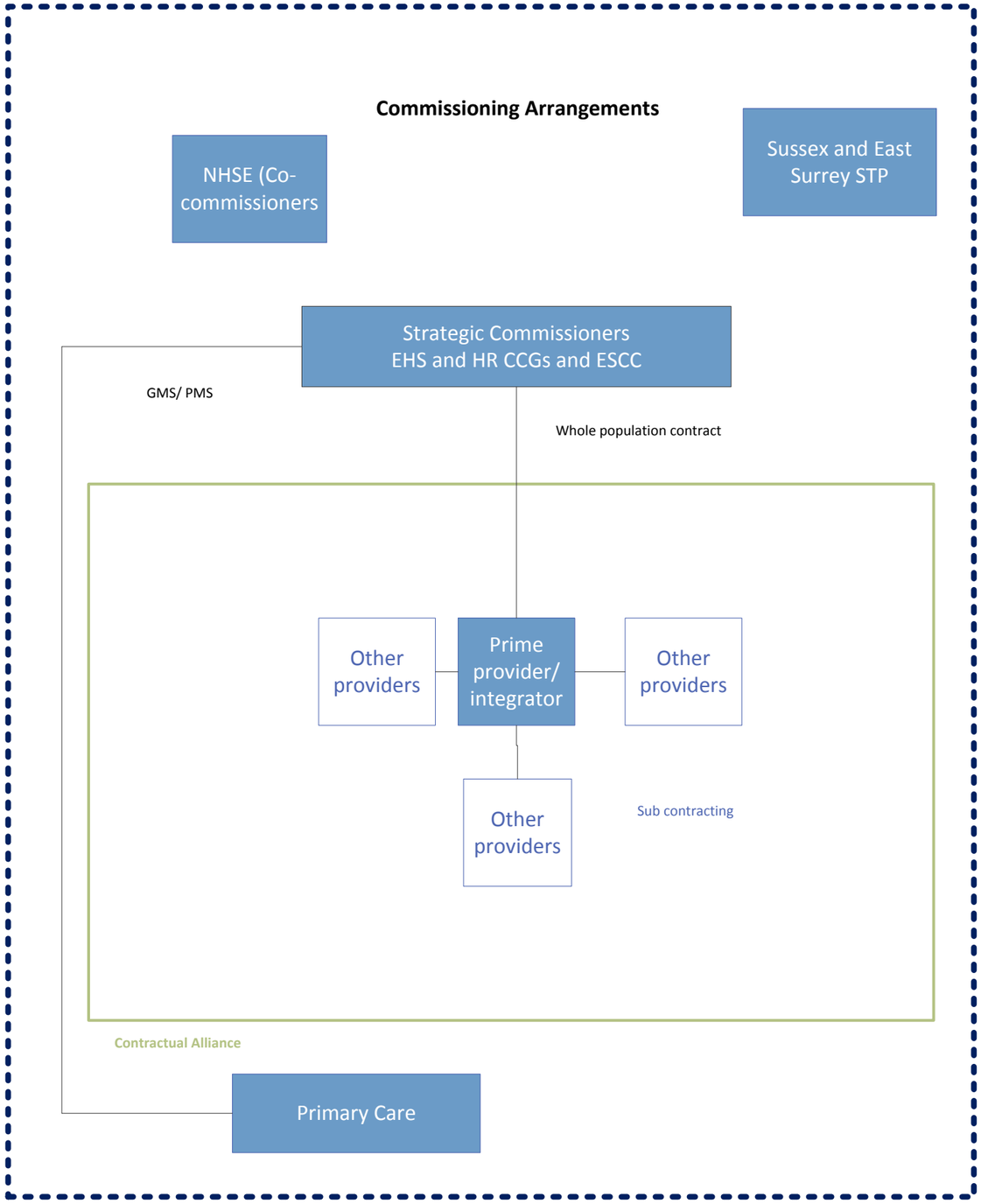
Our Public Health Team has reviewed elements of the criteria and indicators of what 'good' looks like from a Public Health perspective and has added the following definitions and technical requirements to those indicators, where this can be drawn out

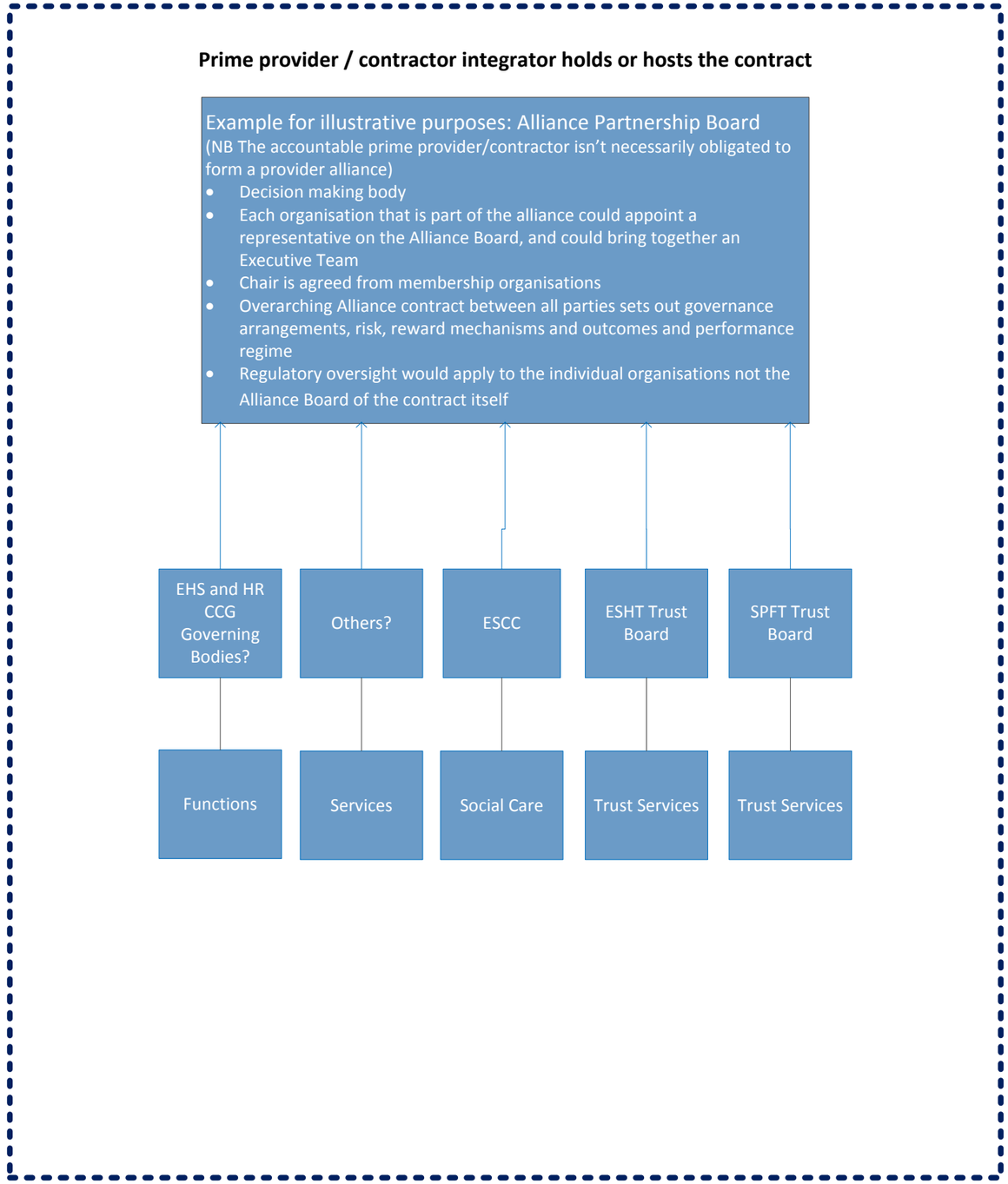
TRANSFORMATION		Definition	Technical requirements
1 (h)	Can the option create the conditions to shift the investment in prevention, primary and community care and be consistent with the ESBT Alliance Strategic Investment Plan?	Allows a population approach to planning wellbeing and care services, using person-level and population data to organise support and care around people's needs and preferences, not those of organisations.	1. A clear link between population-level on demographic need and the planning of services and allocation of resources. 2. Ability to develop data system and capabilities that give deep understanding of the population and the skills and expertise to interrogate, interpret and communicate data. Connected, interoperable data sets that can be accessed across all care settings 3. Business intelligence systems in place that analyse health and care needs at the wider population level 4. Services that are designed based on patient segmentation approach, including risk stratification and evidence of effectiveness
1(i)	How well does the option enable investment in prevention and early intervention and reducing the average per capita Year of Care Cost?	The form of the organisation is able to invest in prevention and early intervention, reduce transactional costs, drive out waste and improve quality to reduce costs.	1. No legal or organisational barriers to redistributing funding to most effective part of the system. 2. Clear mechanisms for identifying and comparing benefits, cost avoidance, effectiveness and savings from different parts of the system over differing time scales. 3. Services that are designed based on patient segmentation approach, including risk stratification and evidence of effectiveness 4. Allows flexible use of capacity and capability across disciplines and organisational professional boundaries to foster shared ownership and prioritisation of prevention (primary, secondary and tertiary) across whole pathways
1 (l)	How well does the model deliver primary secondary and tertiary prevention and embed self-care and self-management to improve health and wellbeing and reduce health inequalities?	The model delivers wellbeing and care services designed to provide pathways that promote health and wellbeing, recovery and independence based on individual and population need.	1. Ensuring prevention (primary, secondary and tertiary), self-care and supported self-management are embedded across all clinical pathways using the clinical programmes approach 2. Active health promotion when individuals come into contact with health and care services (making every contact count) 3. Services are designed based on patient segmentation approach 4. A specific focus on preventative services that are tailored to the needs of different communities 5. Planning services that are accessible for people with different protected characteristics and which consider the potential to generate or address health

			inequalities and which prioritise the needs of those who experience health inequalities. 6. Develop a shared preventative approach across organisations in the public, voluntary, community and private sector to deliver services 7. Model recognises and actively utilises service users as assets with an active role in improving their own health outcomes
QUALITY AND SAFETY		**Definition**	**Technical Requirements**
3 (g)	How well will the option make use of population health management capabilities (i.e. improved prevention, enhanced patient and client activation) and manage avoidable demand?	The model effectively embeds prevention, self-care and supported self-management, unlocking to the power and potential of communities to reshape the relationship between service users and health and care services.	1. Ensuring prevention (primary, secondary and tertiary), self-care and supported self-management are embedded across all clinical pathways using the clinical programmes approach 2. Improving patient activation through evidence-based approaches such as health coaching, supported self-management, peer support and education programmes. 3. The six principles for effective local engagement approach are implemented 4. Linking people to community assets and other public services 5. Partnership with local government, community groups, voluntary sector, and other organisations that represent people who use services

DRAFT FOR DISCUSSION Option 1: Prime provider / prime contractor 'integrator':

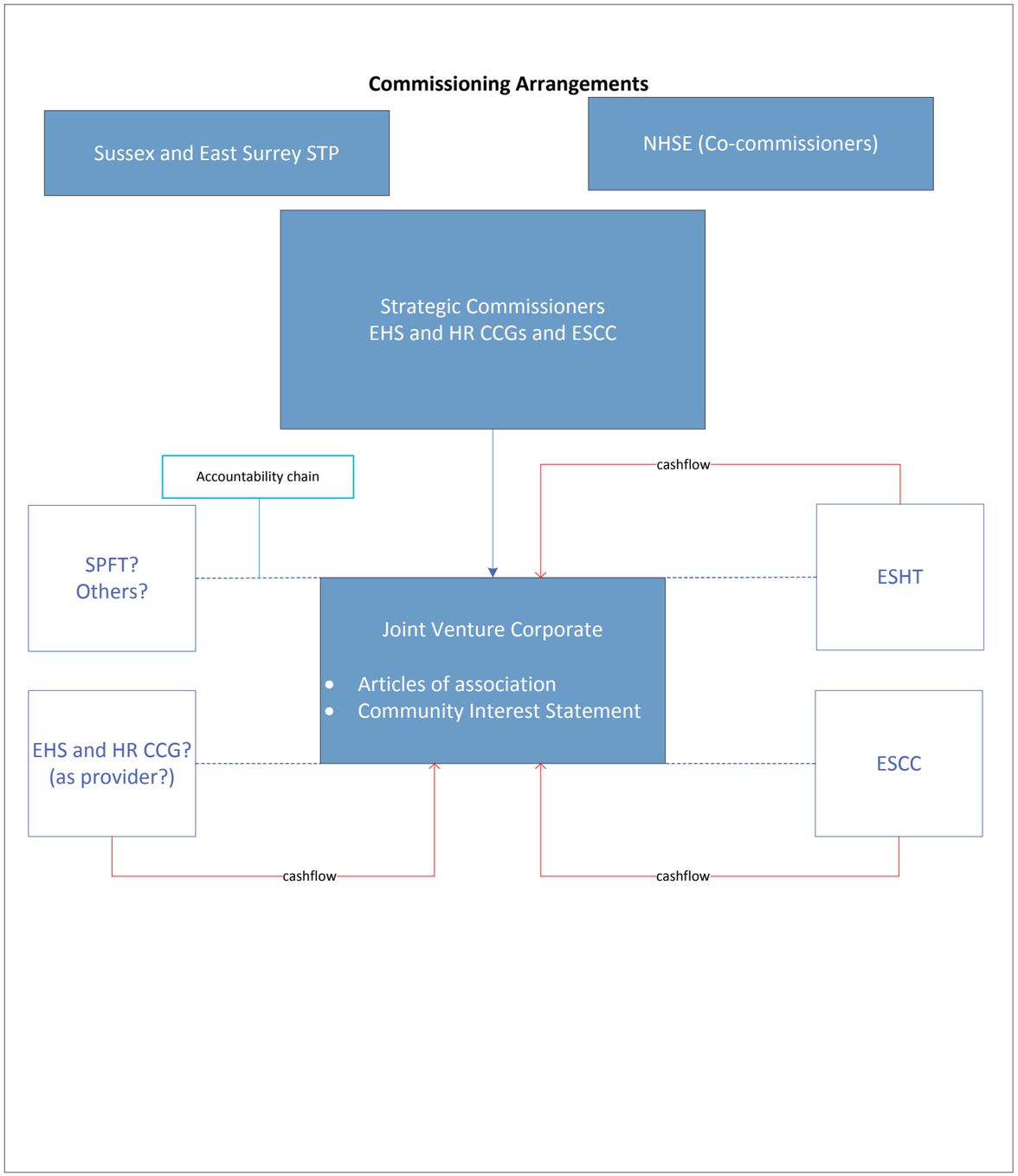
Illustrative Governance Structure and Decision Making - this is not a definitive diagram but an illustration of how the governance might work based on our knowledge to date

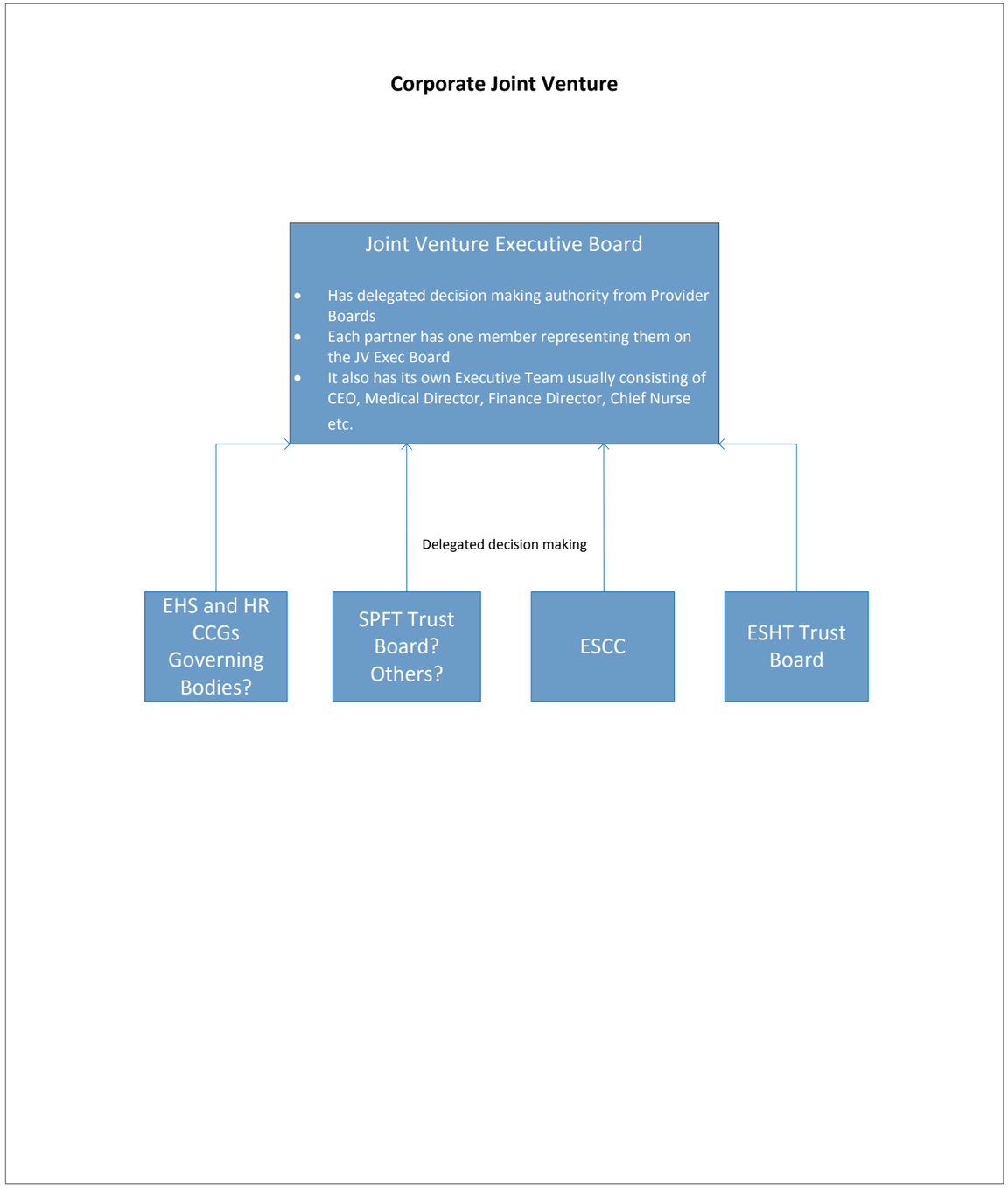




DRAFT FOR DISCUSSION Option 2: Corporate Joint Venture

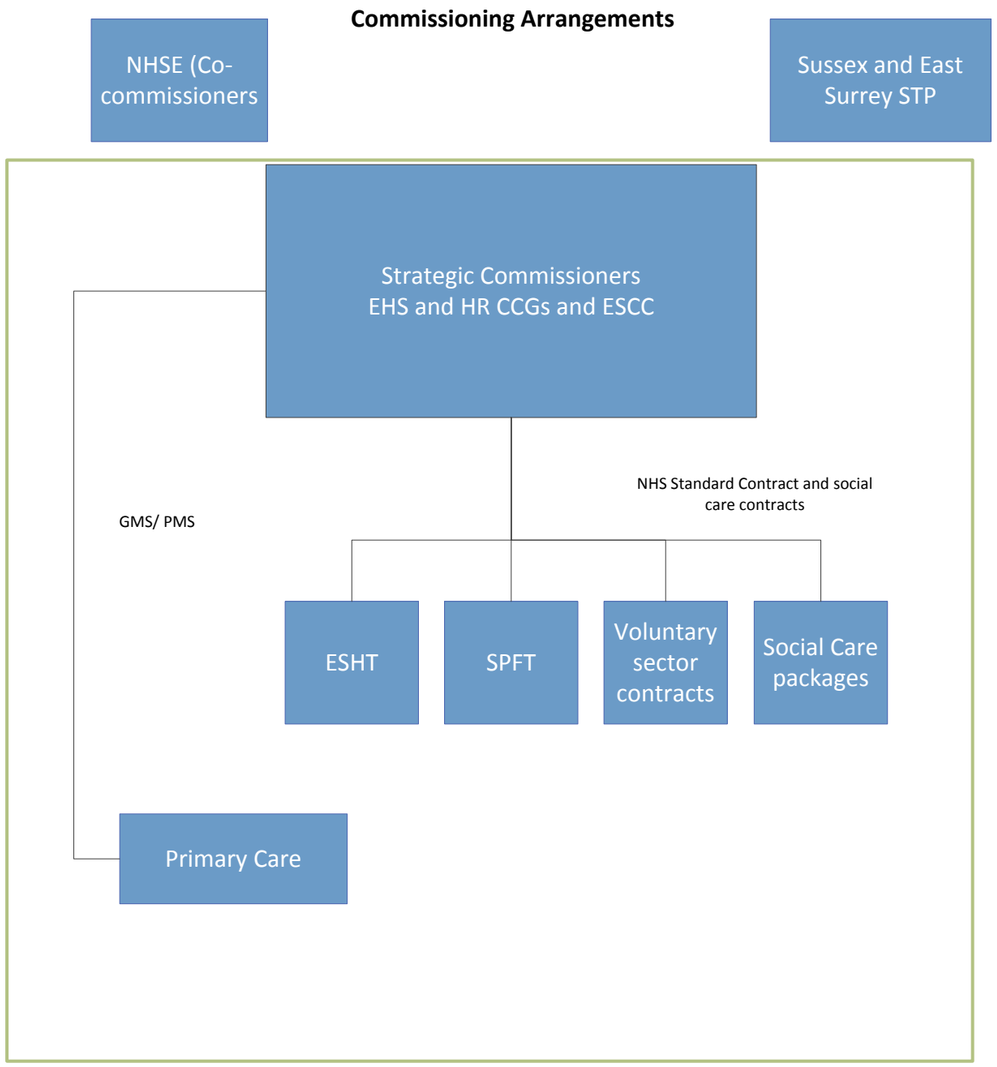
Illustrative Governance Structure and Decision Making - this is not a definitive diagram but an illustration of how the governance might work based on our knowledge to date



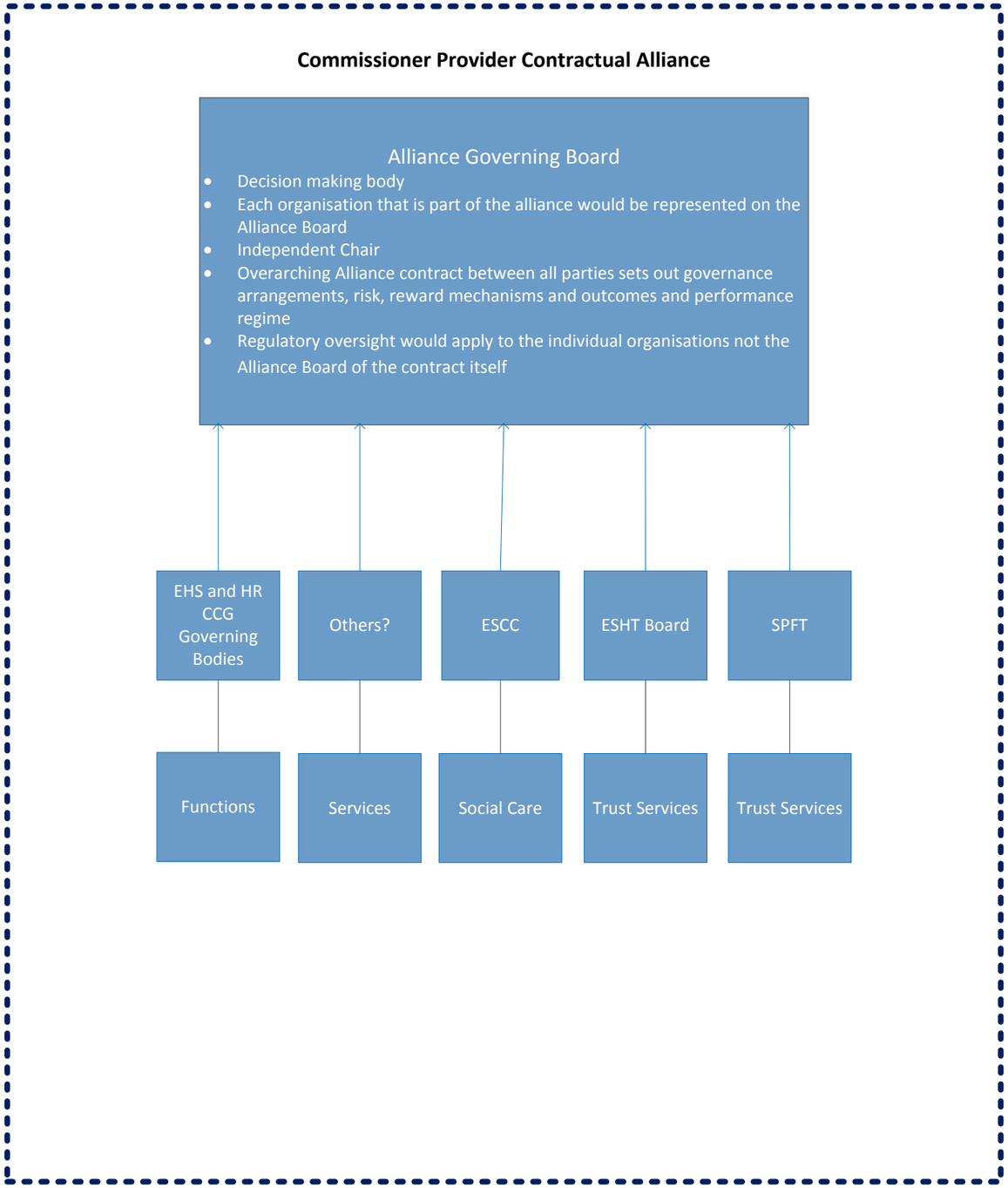


DRAFT FOR DISCUSSION Option 3: Contractual Commissioner Provider Alliance:

Illustrative Governance Structure and Decision Making - this is not a definitive diagram but an illustration of how the governance might work based on our knowledge to date



Contractual Commissioner Provider Alliance



DRAFT FOR DISCUSSION Option 4: New Health and Care NHS Trust: Illustrative Governance Structure and Decision Making - this is not a definitive diagram but an illustration of how the governance might work based on our knowledge to date

Commissioning Arrangements

Sussex and East Surrey STP

NHS England (co-commissioning

Strategic Commissioners
EHS and HR CCGs and ESCC

GMS contract

Whole Population Contract

A 'Health and Care NHS Trust'

Tactical Commissioning with GPs (enhanced services), other NHS Trusts, SECamb, independent care organisations and voluntary organisations

Primary Care

NB This illustrative and is based on examples emerging elsewhere in the UK. It is not a definitive model

Members

- Vote to elect Governors
- Two constituencies: public and staff
- Future electorate could be based around 6 Localities

Governors

- Public Governors
- Elected Governors representing Localities
- Out of ESBT area
- Staff Governors
- **Nominated Governors**
- GP Locality Leads
- Local Authority reps
- Others

Possible Non Executive Backgrounds

- Chair
- Primary Care
- Local Authority
- Mental Health
- Clinical
- Financial
- Strategic/ Business
- Workforce

Executive Directors

- CEO/ Finance Director/Chief Nurse/ GP
- Medical / Social Care/ Workforce
- Strategy / Corporate Affairs

- High degree of devolved autonomy
- Could be led by an Executive Chair (Clinical/ Practitioner)) who also sits on the main Board of Directors, supported by a Managing Director
- Run by an Executive Board?

NHS Improvement and CQC

- Regulation and oversight

A 'Health and Care NHS Trust'

Council Governors – illustrative example

- Holds Board to account
- Appoints the Chair and Non Executive Directors
- Approves significant transactions
- 51% elected by members (Public Governors that must be the majority and Staff Governors)
- 49% appointed (e.g. GP's, Local Authorities, Voluntary Sector etc.)

Board of Directors – illustrative example

- Key decision making body
- A mix of Non-Executives and Executive Directors
- Must be a majority of Non Executives (?)
- Statutory requirements for Executive Directors: Chief Executive (accountable officer) Finance Director, Chief Nurse, Medical Director
- Additional constitutional requirements could include Directors from a Primary Care and Social Care background
- Executive Directors can be a mix of voting and non voting Directors
- Statutory requirement for Non Executive Chair (NED)
- Additional constitutional requirement could include a Primary care NED, Social Care NED

Community

- Locality Teams
- ED & Ambulatory Care
- Urgent Care
- GP out of hours
- Out Patients
- Care Management
- Social care packages
- Residential care
- Primary Care in scope
- Mental Health
- Public Health

Cross-cutting functions

- Pathology
- Radiology
- Pharmacy
- Therapies
- Prevention

Inpatient Services

- Medical Admissions
- Surgical Admissions
- Critical Care and Theatres
- Emergency sites
- Inpatient psychiatric services
- Specialist services

Governance of New Care Models: PACS Examples from the Vanguards

Briefing Paper

1 Introduction

The 23 vanguard sites chosen to develop the multispecialty community provider (MCP) and primary and acute care system (PACS) new care models have been working to pool budgets and integrate services more closely. Some are continuing to use informal partnerships, but others are opting for more formal governance arrangements. Commissioners are grappling with how to contract for the new systems, while providers are exploring how to work together within emerging partnerships, how to allocate funding, and how to share risk and rewards

To support consideration of our options for the future ESBT delivery vehicle, this briefing paper looks at three different approaches being taken by some of the PACS vanguards to contracting, governance and other organisational infrastructure. In the case of PACS, many commissioners are considering contracting with a local hospital trust, or a partnership between a hospital and other providers, to hold a population budget and manage the system. Few commissioners have been interested in engaging an 'integrator' organisation that would hold the population budget and coordinate the contributions of different providers but would not have managerial control of services or established relationships with providers[1].

This paper focuses on developments in three areas chosen as examples to give a flavour of the different approaches being taken: Mid Nottinghamshire Better Together Alliance; Torbay & South Devon NHS Foundation Trust Integrated Care Organisation; and Northumberland - Building a Caring Future.

2 Mid Nottinghamshire Better Together Alliance

The Mid-Nottinghamshire Better Together Programme was established in 2013, and is a partnership between Ashfield and Mansfield Clinical Commissioning Group (CCG), Newark and Sherwood CCG, Nottinghamshire County Council (NCC), seven NHS health providers and voluntary sector partners. An Alliance Agreement contract was agreed from April 2016, entering the partners into a contractual joint venture.

The Alliance is made up of three main elements:

i. the collaborative partnership and governance system
ii. transparency on the respective local budgets for the CCGs and NCC
iii. how the money is spent. This includes elements of the CCG contracts with health provider Alliance Members being linked into the Alliance contract, starting to be developed into outcome based capitated contracts. The CCG and NCC also have other contracts that currently sit fully outside of the Alliance Agreement. Alongside this sits the Council's system for assessing eligibility for and allocating personal budgets for people's individual care and support packages. This includes the option of people taking the money in the form of a Direct Payment to purchase their own services. During the transition phase a selection process will be undertaken to select key social care providers who have a contract with the Council, to join the Alliance.

The CCG plans to link the contracts it holds with the seven potential participating health providers into the Alliance contract, with a commitment to develop and implement new

[1] Kings Fund, *New care models – emerging innovations in governance and organisational form*, Oct 2016, p.4

payment mechanisms using outcomes based capitated contracts. The work is in its very early stages and is one of the main areas for the Alliance to develop further in the transition phase. The Council will not be changing the care and support contracts it holds with social care providers to a capitated model because this does not offer the ability to give individuals who have been assessed as eligible for social care a Personal Budget or Direct Payment. The CCG holds other contracts with providers who are not in the Alliance. These, as well as the Council's single and jointly commissioned contracts, currently sit outside of the Alliance.

The Council will not have to change any of its current commissioning arrangements or contracts due to becoming an Alliance Member but will be obliged where possible to review those contracts and consider how they might become a part of the Alliance arrangements, in line with the Alliance principles. As contracts become due for renewal the Council will continue to be able to consider whether there is benefit to increasingly integrated arrangements with the CCGs and/or other partners, what type of contract is most appropriate and how to achieve strategic countywide economies of scale whilst meeting local objectives.

In addition to the 2 CCGs, the partners who are considering signing the Alliance agreement contract are the seven health providers that were selected following a Most Capable Provider process by the CCGs: Central Nottinghamshire Clinical Services, Circle Nottingham Ltd., East Midlands Ambulance Service, Nottinghamshire Healthcare NHS Foundation Trust, Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, United Lincolnshire Hospitals NHS Trust and the voluntary sector Mid-Nottinghamshire special purpose vehicle 'Together Everyone Achieves More' (TEAM). TEAM was established to enable the value of the 3rd Sector to help shape service transformation and is not itself a provider of services.

There is a commitment to secure the engagement of General Practice in mid-Nottinghamshire within the Alliance; this reflects the significant role of General Practice as a provider of care and support and the key role it can contribute to achieving many of the Better Together objectives. The involvement of General Practice in the Alliance is contingent upon the establishment of a collective federated body or bodies with authority and legitimacy to make binding decisions on behalf of General Practice.

No social care providers are currently signed up to the MoU or part of the Alliance. The Council is preparing to carry out an assessment exercise to identify any provider or providers of the social care services who could sensibly become an Alliance participant. District Councils are not currently signed up to the MoU or the Alliance, however, discussion regarding the options are planned.

3 Torbay & South Devon NHS Foundation Trust

The Torbay Care Trust was formed in 2005, when Torbay Care NHS Trust and Torbay Council entered into an Annual Strategic Agreement (ASA) for the Care Trust to provide Adult Social Care services. This led to the creation of a fully-integrated health and social care trust, which had responsibility for both the commissioning and provision of integrated community health and social care services to people in the Torbay area. Vertical integration with the foundation trust began to be explored once the horizontal integration of community services had been secured.

In October 2015, following a procurement process, the Torbay & South Devon NHS Foundation Trust was awarded the contract and launched as the first Integrated Care Organisation (ICO) in the country to bring together acute, community and social care services to form a single provider organisation delivering health and social care to a local population of 375,000 people. The ICO works to provide a set of agreed outcomes based on a new model of care, through a pool of available resources.

The ASA now contains the NHS commissioner and provider elements and the final savings plans and performance required for 16/17, and outlines what outcomes will be delivered within the financial envelope agreed. Specifically for the Council, it also gives transparency to the delivery of Adult Social Care services on behalf of the Council.

A risk-share agreement is in place, the purpose of which is to facilitate the development of integrated health and social care and secure the quality of services and facilitate the changing the model of care through creating a stable financial environment for multi-year investment and aligned financial incentives. The agreement has been completed with parties from South Devon and Torbay CCG, Torbay Council, South Devon Healthcare Foundation Trust and Torbay and Southern Devon Health and Care Trust. This has included oversight from the non-executives and Governors from the Care and Foundation Trusts, the Governing Body of South Devon and Torbay CCG and the Mayor from Torbay Council.

4 Northumberland - Building a Caring Future (SPV)

Commissioners and providers in Northumberland have a long history of partnership working. A care trust was set up in 2002, with most of the council's adult social care functions delegated to it. Since 2011 operational functions have been delegated to Northumbria Foundation Trust, while the council and the CCG have worked closely together as commissioners, with arrangements including delegation of NHS Continuing Health Care commissioning to the council.

The commissioners started working with Northumbria Foundation Trust and other partners to develop these arrangements further with the aim of establishing an accountable care organisation that would oversee the full range of health and care services for adults. Under the new arrangements, the CCG will transfer its funding for most core NHS services to an accountable care organisation, which will operate as a partnership between Northumbria Foundation Trust; Northumberland, Tyne and Wear NHS Foundation Trust; the mental health provider, and other providers. Northumbria Foundation Trust will hold the formal contract, but it will be managed through a type of partnership arrangement with the other providers. The delegation of the council's operational adult social care functions to Northumbria Foundation Trust will continue.

The accountable care organisation will make all 'tactical' decisions about the deployment of health resources, effectively taking over many of the detailed tasks currently carried out by the CCG. A 'strategic' commissioning function will remain outside the accountable care organisation. This will be supported by a joint strategic commissioning unit hosted by the council and reporting to the statutory CCG board on NHS commissioning and to the council on social care commissioning. Funding for partnership arrangements between the CCG and the council, such as the integrated commissioning of Continuing Health Care commissioning, is expected to remain outside the contract for the accountable care organisation.

Primary care leaders in the county are debating which of five organisational form options could most effectively serve to support their role in the accountable care organisation from April 2017 and will conclude these deliberations later this year. There are no immediate plans to include core primary care in the accountable care organisation's pooled budget.

Commissioners are in the process of developing an outcomes framework as a basis for monitoring and incentivising performance within the new system (rather than using financial incentives). Finally, commissioners plan to establish a small joint commissioning unit within the council to make best use of commissioning resources, while transferring tasks such as contracting with and overseeing individual services to Northumbria Healthcare.

Table 1: Summary of approaches taken at the three vanguard sites

	Mid-Notts Better Together Alliance	Torbay & South Devon NHS Foundation Trust	Northumberland SPV
Scope of services in integrated system	• Acute hospital, community health, social care • Maternity and paediatric care	• Acute hospital, community health, mental health, social care	• Acute hospital, community health, mental health, social care • Core primary care not included at present
Budgets and payments	• Commitment by all parties to move towards an outcomes-based capitated budget covering the vast majority of services for the population	• The integrated care organisation manages the combined budget	• Plan to transfer a whole population budget to a host provider to manage within an alliance of partners
Contracting process	• Under consideration	• A procurement process was held to establish the new provider – Torbay & South Devon NHS Foundation Trust – to merge with the existing Care Trust	• CCG has published a prior information notice with intention of negotiating contract with a host provider foundation trust
Contract duration	• 3 years with option to extend for a further 7 years	• An initial term of 5 years, leading to a 3 year contract renewed annually on a rolling basis beyond the first 5 years	• 10 years
Likely incentives	• Full members can share the risks and rewards from joint activities	• Risk share agreement is in place	• Northumbria Healthcare NHS Foundation Trust and partners likely to be able to invest savings from good performance
Agreed or likely organisational structure	• Will manage virtual managed care organisations through an alliance agreement and governance arrangements • Envisage more substantial changes in the longer term as the group builds experience of working together	• Torbay & South Devon NHS Foundation Trust is providing social care under contract from the local authority, community and acute health services	• Northumbria Foundation Trust to hold budget on behalf of the accountable care organisation partnership, which will deliver acute, community and social services
Population size	• 310,000	• 375,000	• 322,000

ESBT MILESTONE MAP

APR '17

MILESTONE

Stakeholder engagement to inform options appraisal on future organisational form

JULY '17

MILESTONE

Organisational form and development timeline agreed by sovereign organisations

DEC '17

MILESTONE

Clarify menu of options for how primary care, mental health and other parts of system relate to chosen model

APR '18

MILESTONE

Integrated single leadership structure for strategic commissioning function implemented; pooled budget and risk share agreed for strengthened Alliance
Single leadership of delivery function implemented.

APR '20

MILESTONE

Launch of new accountable care organisation

JULY '18

MILESTONE

Business case for accountable care organisation Agreed; NHSE ISAP process initiated

SEPT '18

MILESTONE

Plans for consulting with staff in place, as required

APR '19

MILESTONE

Integrated business infrastructure in place, including potential delegation to STP level

SEPT '19

MILESTONE

New integrated regulatory framework and payment mechanisms agreed

NB this map of high level milestones is intended as a guide, and milestones may be subject to change with detailed implementation planning

Ongoing staff and stakeholder engagement

Year on year delivery of financial balance and quality improvement

Proposed STP governance and leadership model for system wide transformation

Meeting information:			
Date of Meeting:	25 July 2017	Agenda Item:	13
Meeting:	Trust Board	Reporting Officer:	Dr Adrian Bull, Chief Executive

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 attached briefing documents update on a review of the Sussex and East Surrey STP governance infrastructure and request approval of revised governance arrangements to support improved delivery of the STP.

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

All Sussex and East Surrey STP members: CCG Governing Bodies/ Provider Trust Boards/ Local Authority Cabinets

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

It is recommended that the Trust Board note the review of the current STP governance arrangements and consider the following recommendations:

- Approve in principle the revised STP governance and leadership infrastructure to support the delivery of the STP
- Approve in principle, and authorise the NHS Accountable Officer / Chief Executive to sign, the Draft Memorandum of Understanding for STP Governance. This will provide a mechanism for securing ongoing commitment to sustained engagement with, and delivery of, the STP
- Approve in principle the draft terms of reference for the proposed governance and leadership model

STP - Governance for transformation

1.0 Background

1.1. The NHS Five Year Forward View (FYFV) published in 2014 envisaged an inclusive and whole system approach to service transformation.

1.2 The NHS Shared Planning Guidance for 2016/17 – 2020/21 (published in March 2016) asked every local health and care system to come together to create their own local plan for accelerating the implementation of the FYFV.

1.3 NHS England proposed 44 geographical planning footprints (referred to as Sustainability and Transformation Plans (STP)) to aggregate coherent health and social care communities and to permit 'place based' approaches that could drive the change required to address three gaps: the health and wellbeing, the care and quality and the finance and efficiency gaps.

1.4 The guidance recognised that growing financial problems in different parts of the NHS cannot be addressed in isolation. Instead NHS providers and commissioners were required to come together to manage the collective resources available for services for their local population.

1.5 The most recent national guidance **'Next Steps on the NHS Five Year Forward View'** published on 31st March 2017 highlights the need to strengthen STPs, their leadership and infrastructure. The guidance describes the formation of 'Sustainability and Transformation Partnerships'. These are not new statutory bodies and hence supplement rather than replace the accountabilities of individual organisations. The guidance states it is a case of 'both the organisation and our partners', rather than 'either/or'.

1.6 The guidance outlines that to succeed all STPs need a basic governance and implementation 'support chassis' to enable this type of effective working. All NHS organisations will therefore from April form part of a Sustainability and Transformation Partnership.

1.7 The guidance requires the establishment of an STP board drawn from constituent organisations including appropriate non-executive participation, partners from general practice, and in local government wherever appropriate. The Partnership will also establish formal CCG Committees in Common or other appropriate decision making mechanisms where needed for strategic decisions between NHS organisations.

1.8 The guidance also states, in the unlikely event that it is apparent to NHS England and NHS Improvement that an individual organisation is standing in the way of needed local change and failing to meet their duties of collaboration, the regulators will– on the recommendation of the STP as appropriate – take action to unblock progress, using the full range of interventions at their disposal.

1.9 Also, where this has not already occurred, The Partnership will re/appoint an STP chair/leader using a fair process, and subject to ratification by NHS England and NHS Improvement, in line with the national role specification. NHS England will provide funding to cover the costs of the STP leader covering at least two days a

week pro rata.

1.10 While STPs carry a big burden of expectation, they also represent a huge change in working practices. They mark a move away from a focus on individual organisations and market competition towards system working. Complex, with a large number of stakeholders, each STP also starts from a different point in terms of local relationships. Collaboration with other services and sectors beyond the NHS is needed to focus on the broader aim of improving population health and wellbeing and not just on delivering better quality and more sustainable health care services.

1.11 This move from 'silo' working within organisations to collaborative working in footprints requires governance arrangements to support collective decision-making and action to plan and deliver the changes required.

1.12 The current focus on the new care models identified in the Five Year Forward View, and the transformation of local integrated care services delivered through place-based systems of care, requires organisations to work together to deliver services well. How these new accountable systems are led, directed and held to account will be crucial to their success.

1.13 The Sussex and East Surrey STP has at its core an agreed approach of the Places (ESBT, Coastal, and the North and South of the central corridor) being the building blocks from which decisions and budgets are delegated down to localities and up to the STP where commissioning and/or provision on a larger population basis is evidently beneficial.

2.0 The importance of good governance

2.1 STPs are the latest mechanism to drive system-wide collaboration and planning. They bring with them an important opportunity to improve the way the whole system works together to deliver high quality and sustainable services through new placed based models of care. Since STPs do not change the statutory responsibilities of individual organisations they raise important questions for how governance and engagement will be managed to support collective decision-making.

2.2 Where STPs are beginning to work well, common factors include improved relationships, a focus on place, a clearly articulated story, commitment at all levels and transparency.

2.3 Good governance is the cornerstone of effective and faster decision-making and transparency. It ensures an efficient and effective organisation working in the interests of patients and public by the right people making the right decision at the right time in the right place. Effective governance should drive STP implementation and ensure the best possible decisions are made to support the needs of each population.

2.4 Good governance helps to form closer working relationships and identify areas where duplication can be avoided and incentives aligned. This will mean a cultural shift from maintaining individual power bases to a more collaborative way of working that supports joint decision-making.

2.5 To navigate the many complexities and maintain momentum, governance models

must be clear, robust and flexible. During 2017, practical steps must be taken to implement the vision as STPs take shape in a financial and care context that is already very demanding. This is likely to test governance arrangements – as will the involvement of the public as service and structural changes are subject to consultation.

3.0 Governance issues for STPs

3.1 A number of issues need to be considered to ensure that governance is the driving force behind the STP, and supports effective decision-making that is accountable to patients and the public. Issues include:

- **Accountability**

  Although individual organisations remain accountable for their own plans, there is a need to define who will be accountable for the delivery of the STP, and how the statutory duties for each constituent organisation relate to the broader roles and responsibilities within the STP.

- **Place Based Accountability**

  As the new models of place based care begin working to pool budgets and integrate services more closely, formal governance arrangements need to be developed between the providers working together and the commissioners contracting for the new systems. At the same time the STP governance structures need to assess how to relate to the emerging place based partnerships.

- **Patient and public engagement**

  Governance arrangements must ensure that the perspectives of local communities are considered at every phase of development and delivery. The new models of place based care will play a crucial role as the health and wellbeing delivery vehichle for their local population.

- **Building the right relationships with local government**

  Governance structures must support effective working across place based partnerships and commissioners of both health and social care. The STP will need to help organisations make joined-up decisions for the patients and populations they commonly serve.

- **Organisational structures and efficiencies**

  There is an inherent tension between making decisions quickly to speed up transformation and making the right decisions openly and transparently, with the support of the main stakeholders in the system. A governance structure needs to be streamlined yet facilitate two-way communication with individual trust boards, CCG governing bodies, local authority cabinets and health and wellbeing boards.

- **The clinical voice**

  It is essential that the clinical voice is preserved within STPs and sits equally alongside the managerial voice to drive service transformation and improvement.

- **Independent scrutiny**

No matter how governance structures develop, the non-executive community should be represented throughout the decision-making process to ensure that scrutiny, transparency and decision-making remains firmly in the interest of the public and patients.

- **Audit and assurance**

  The STP should encourage the review of benefits of the different systems and support new ways of working that deliver place-based quality assurance, wider footprint benchmarking, and sharing of learning, as well as forge a closer link with local authorities and their overview and scrutiny function.

4.0 Review of progress in Sussex and East Surrey (SES)

4.1 In Sussex and East Surrey, 24 organisations have come together to form the STP footprint (organisations listed in Appendix A). This health and care system faces significant financial, quality and performance challenges. The NHS financial gap is projected to grow to £653m by 20/21 (£864m for health and social care). However, given the deteriorating financial position, this is likely to be higher. Across the footprint care and quality issues exist particularly in cancer detection and care, mental health, stroke rehabilitation and social support with significant challenges in primary care.

4.2 The initial focus in SES was the development of the STP to address the challenges. The October 2016 STP submission identified key priorities and initiatives to help deliver on the three gaps of improved health and wellbeing, quality of care and financial sustainability.

4.3 The leaders of SES come together regularly within a programme structure to provide direction to the system and delivery of the STP.

4.4 However, the transformation ambition set out in the STP has not been progressing at the pace and scale required to make significant progress on the issues faced. The system leaders are concerned that the programme mechanisms in place are not sufficiently effective to jointly address the deteriorating financial position and the delivery of the STP.

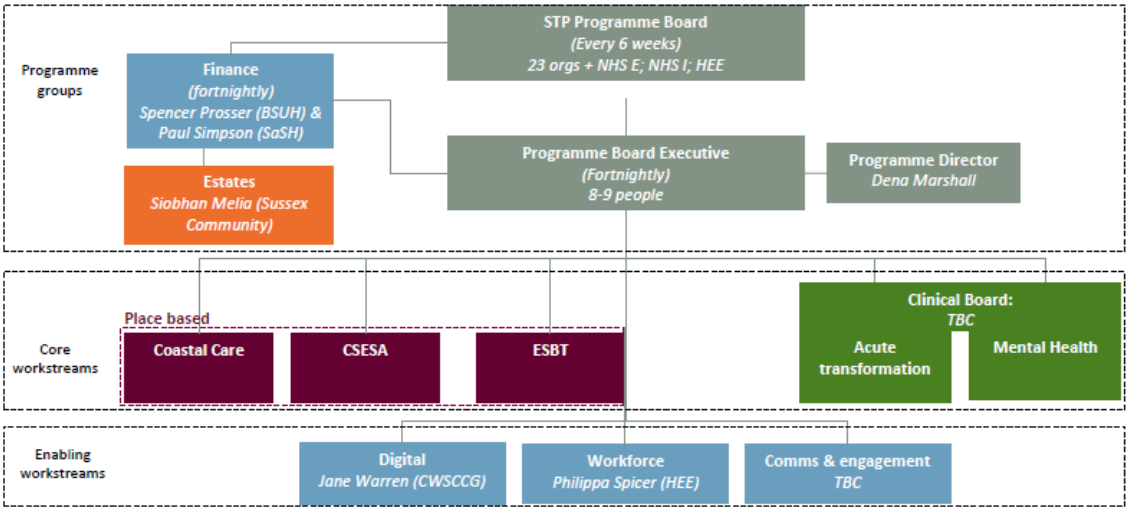
4.5 Consequently, an STP ‘review and refresh’ exercise was commissioned to identify the challenges in the system and ways to move forward. A key component of this work was to review the governance and leadership infrastructure.

4.6 The review has helped to clarify the roles and responsibility of the STP, the interactions with place-based care and the individual organisations. As a result recommendations have been made for revised programme governance and decision making processes to increase effectiveness.

5.0 Current governance arrangements in Sussex and East Surrey

5.1 Since the October 2016 STP submission, the SES leaders have been coming together regularly in a programme executive and programme board to provide direction to the system and delivery of the STP.

Figure 5.1: Existing Sussex and East Surrey STP governance structure



6.0 Outcome of the governance review

6.1 Feedback from interviews, and a workshop with STP system leaders held on 21st February 2017, suggested a general, overall consensus that:

- The current STP governance is not sufficient to support effective collective decision-making, nor is there clarity on where authority and accountability lie
- The current set-up does not have an effective reporting and monitoring mechanism
- This needs resolving quickly

6.2 The outcomes from the workshop identified overall general agreement with the principles and proposed revised governance structure. However, it was emphasised that there was also a need for a change in culture and approach to joint working and that some existing behaviours will need to change to allow the governance structure to work effectively.

6.3 There was also general agreement that organisations will need to delegate more control to place-based accountable care systems, and to the STP overall, to enable effective joint working. This will need to be agreed with each organisation.

7.0 Objectives of the SES STP governance arrangements

7.1 Following the review, and with input from system leaders across the STP, it has been agreed that the objectives for effective governance arrangements in Sussex and East Surrey should be to:

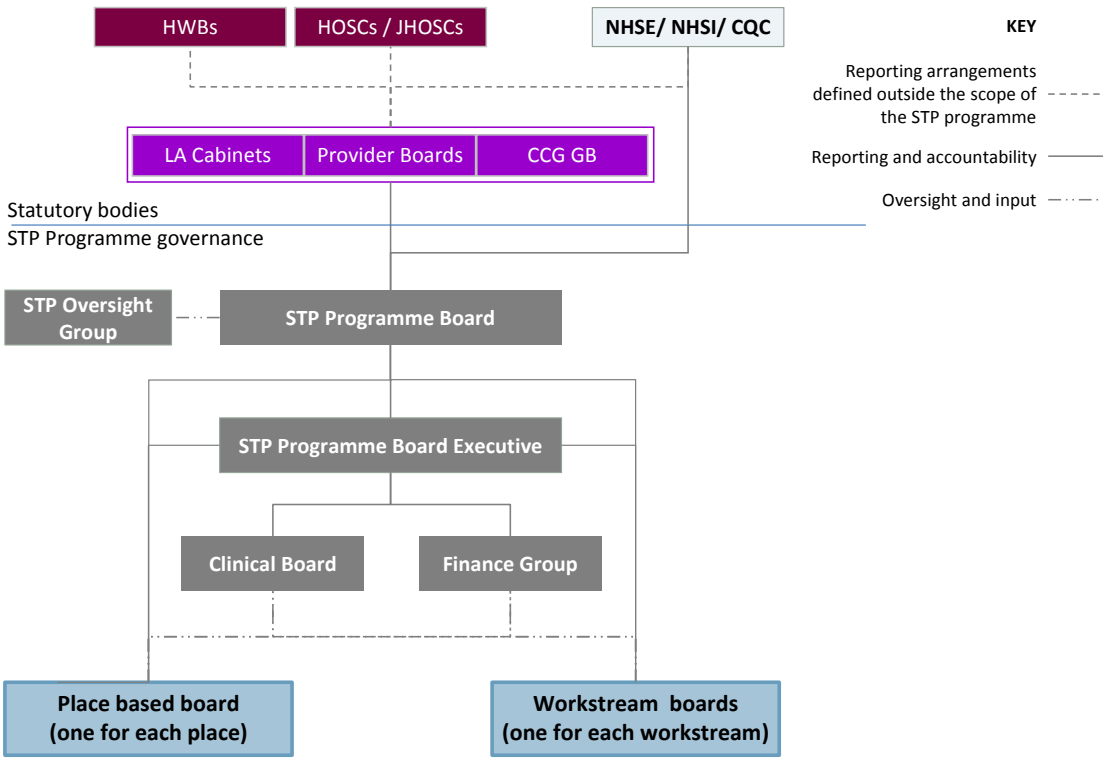
- Support effective collaboration and trust between SES health and social care organisations and the places to work together to deliver the transformation aimed at closing the three gaps

- Define the roles and responsibilities of the leadership
- Provide a robust framework that facilitates more effective decision-making and defines what decisions are made at which level, including place level
- Clarify decision-making authority and accountability, which is aligned with governance of places and individual organisations
- Provide assurance around progress and delivery of both the STP programme and place-based plans
- Clarify the reporting and monitoring mechanism
- Allow for transparent communication between a complex network of stakeholders
- Make the most of the scarce and limited resources available
- Learn lessons from other programme and governance arrangements

8.0 Revised governance structure

8.1 In response a new governance structure has been proposed. Figure 8.1 sets out the relationship between the constituent STP leadership groups, working groups and the statutory bodies.

Figure 8.1 Proposed revised Sussex and East Surrey STP governance structure



8.2 The STP governance arrangements make recommendations for system transformation to the statutory bodies, including all organisational boards. These organisational boards have their own governance and engagement arrangements

with their regulators and other committees (e.g. health and wellbeing boards and health oversight and scrutiny committees).

8.3 Governance relating to statutory bodies is outside the STP programme's governance arrangements and is included in the visual representation (Figure 8.1) to highlight their relevance as stakeholders, especially when considering communications and engagement plans.

8.4 The STP programme is related to health and wellbeing boards in that the STP programme is framed by the Health and Wellbeing Strategies and will, in turn, inform the further development of the Health and Wellbeing Strategies.

9.0 Roles and responsibilities

9.1 The STP Programme is made up of groups with discrete functions that they need to perform to effectively monitor, manage and ultimately deliver the STP.

9.2 The proposed revised role of each group and their related responsibilities are defined in more detail in their individual terms of reference which can be found in Appendix B.

9.3 Membership will reflect the ongoing development of new organisational structures.

Governance Structure	Role and responsibilities
STP Programme Board Membership includes: • Accountable officers of the CCGs • Chief executives of the provider organisations • Chief executives of the local authorities • NHS England and NHS Improvement representatives • Health Education England representative • Clinical Board co-chairs • Finance Group chair • Oversight Group chair Meets once every six weeks	Strategic oversight and delivery of the STP on behalf of all partner organisations across Sussex and East Surrey
	Allow the members, through their representatives, to make aligned decisions
	Assess cross organisational and programme level risks
	Provide overall assurance of STP planning, delivery and risk management
	Ensure appropriate links are made with other SES strategic programmes
	Connect with national bodies and other external organisations (e.g. Clinical Senate, Health Education England) to ensure it draws on the support available
	Feed in best practice and learning from other areas into the development and delivery of the programme
	Align with national policy direction
	Act as a meeting forum and single communication channel with regulators with regard to SES STP and for applications for transformational funding
	Produce options, recommendations, proposals for ratification by the members

Governance Structure	Role and responsibilities
STP Programme Board Executive Membership includes: • STP convenor, Provider SRO • CCG STP SRO • Local authority STP SRO • Clinical Board co-chairs • Finance Group chair • Place-based leadership (SPoL) • Workstream SROs • STP Programme Director • Comms and engagement lead Meets once every fortnight	Act as the engine to drive delivery of the STP Promote consensus on change to be delivered Make recommendations to the STP Programme Board Manage cross organisational and programme level issues, risks and dependencies Oversee the development of the programme plan and its deliverables Ensure that appropriate links are made with other SES strategic programmes Ensure that place-based plans and STP workstreams are aligned and aggregated to the overall outcomes of the STP Provide steer to the wider programme team who will deliver the STP work on a day-to-day basis
STP Clinical Board Membership includes: • Clinical chairs of the CCGs • Medical directors of the provider organisations • Clinical director of the 3Ts • South East Coast Clinical Senate representative • NHS provider trusts nursing director representatives • Primary commissioning practice nurse representative (as required) • Director of adult social services representative (as required) • Director of children's services representative (as required) • Director of public health representative Meets once every fortnight	Review, advise and make recommendations for health and care transformation across Sussex and East Surrey from a clinical and care professional perspective Oversee the development of the clinical strategy Provide clinical and care professional input in, and support to, all STP workstreams and place-based arrangements Promote clinical and care professional consensus on potential options Make recommendations to the STP Programme Board Executive
STP Finance Group Membership includes: • Chief finance officers of the CCGs • Finance directors of the provider organisations • County council finance leads Meets once every fortnight	Ensure the Sussex and East Surrey Sustainability and Transformation Plan delivers financial sustainability across the whole system and uses available resources to best effect Provide financial leadership as well as strategic advice and guidance to develop and deliver the STP and make recommendations to the STP Programme Board Executive on financial matters

Governance Structure	Role and responsibilities
STP Oversight Group Membership includes: • Chairs of the CCGs • Chairs of the provider organisations • Leaders of the local authorities	Provide oversight of the development and delivery of the STP and gives feedback to the Sussex and East Surrey STP Programme Board on elements of the plan
	Provide NHS governing bodies, trust boards and political leaders a forum to steer the development of cross organisational working within the STP remit but does not have statutory or formal responsibilities
	Connect the organisation-based accountability structures with the broader STP programme and provide assurance for STP governance and infrastructure.
Meets once every 2 months	Consider and review political and public engagement ahead of transformation and potential consultation
Place-based boards Frequency of meeting as agreed by each place	Responsible for overseeing the delivery of the place-based plans
	Responsible for delivering the outcomes (health, quality and financial) for their population
	Design, develop and establish new model of care and organisational forms to enable the achievement of these outcomes
Workstream programme/ delivery boards Frequency of meeting as agreed by each workstream	Responsible for overseeing the design and delivery of their workstream to meet the ambition and outcomes required of it to align to the STP
	Provide operational leadership to the workstream programme and ensure operational targets are being met (e.g. timelines, outcomes, milestones).
	Ensure all delivery team members working across organisations are aligned on their effort and expectations set out in the workstream plan and interdependencies with other workstreams are highlighted and actively addressed
	Make strategic recommendations to the STP Programme Board Executive acting as the subject matter experts in the various fields

10.0 Principles for revised SES STP governance arrangements

10.1 Any group of individuals that works together to a common end will develop its own culture. If that culture is to be the right one it will need to be planned and managed. This applies just as much to a grouping of chief executives as it does to any other group. The culture of these groupings will also need to be in keeping with the culture of the organisations that make up the STP.

10.2 A common set of principles identifying the necessary culture and the best ways of working together will support with effective governance arrangements. Constituent organisations' accountable officers should agree these principles and capture them in a **Sustainability and Transformation Partnership 'Memorandum of Understanding'** (MoU). A draft MoU is attached in appendix A.

10.3 The following proposed principles are an amalgamation of good governance principles from elsewhere and input from the SES STP Chairs meeting on 16 February 2017. To be effective the STP programme should have:

10.3.1 **Collective authority**

- Organisational leaders take decisions within their delegated powers and bring to bear the authority of their organisational positions
- Design of meetings facilitates consistent engagement of key leaders with delegation of attendance by exception only
- Formal decision-making rests with statutory organisations, which own and drive the work through their leaders' participation in all elements of the programme

10.3.2 **Inclusivity**

- All decision-making organisations are members of the STP Programme Board
- Wider partners and other stakeholders are often reflected in groups/ forums to support the STP Programme Board
- There are clear arrangements for patient and public engagement

10.3.3 **Clinical leadership**

- STP leaders want to strengthen involvement in the content of the plans particularly among clinicians as well as other frontline staff, patients and the public
- Clinical board is central to the programme's structure
- Clinical leaders and care professionals take on a leadership role
- The clinical/ service workstreams and wider clinical engagement are clinically led

10.3.4 **Efficient process and effective decision-making in place**

- Clear governance structure and reporting arrangements
- A small STP Programme Board Executive supports the STP Programme Board
- Colleagues are able to represent each other, with structures to support this

– The relationship with statutory bodies, and the associated decision-making processes are clear

10.3.5 **Clarity and transparency**

– When considering the scope, aims and priorities of the programme
– Within governance structures, decision making and delegation of authority
– Translating to an open book approach to financial and other data

10.3.6 **Effective programme structure**

– Includes the key elements: clinical transformation, enabling strategies, finance and productivity
– Workstreams are grouped and reporting through clinical, finance and management groups
– Workstreams are supported and resourced appropriately

10.3.7 **Co-production and patient and service user involvement**

– There is active dialogue between people who use services and people who prvide them

11.0 Decision making

11.1 The STP MoU also sets out the decision-making arrangements for the STP. This includes:

11.1.1 **Principle of subsidiarity**

The SES STP has a multi-layered governance structure and decisions will be taken at the appropriate level, whether that is locally, in places or STP-wide. The aspiration is to do work at scale across the STP where it adds value and decisions will be made at that level. Where solutions are most appropriately delivered locally, decisions should be made at that level. This means decisions need to be made as close as possible to the people affected by them. The MoU needs to acknowledge and respect the principle of subsidiarity.

11.1.2 **Degree of consensus required**

It is the collective that makes decisions jointly to bind organisations to action, not individual members from each organisation. No individual member (e.g. the chair) can make binding decisions on behalf of other members. The approach for decision making should first be to seek consensus on issues. The STP will be accountable for the whole of SES population and therefore may be required to intervene or mediate conflicting priorities for the good of the whole population.

11.1.3 **Delegation of authority**

The principles of what needs to be delegated are still to be individually agreed with each constituent organisational body. Formal decisions impacting individual

organisations and those within statutory requirements will be signed off by statutory boards. They may, however, choose to exercise these collectively or delegate some authority to the STP Programme Board. Agreement is needed from statutory organisations on the delegated authority arrangements.

11.2 The STP MoU also includes sections on:

11.2.1 **Reporting mechanism**

Regularly reporting the status of the programme at the various forums is imperative for the successful monitoring of the programme.

11.2.2 **Risk and assurance**

Implementation of STP projects is likely to generate risks that affect more than one organisation. Many financial risks can effectively be pooled with each participant responsible for finding financial resource to cover their share of any cost should the risk not be successfully managed and become a reality. Risks to quality of care cannot easily be subdivided and the consequences of something going wrong with an STP project will impact on the reputation of each of the participants as if they were the sole organisation involved. Clarity about ownership and management of risks is particularly important in inter-organisational projects.

11.2.3 **Escalation process**

Standard programme management procedures should be in place to manage risks and issues at the correct level (for example a workstream issue is addressed by the workstream concerned).

11.2.4 **Dispute resolution**

To a very large degree STPs will depend on the unanimity of the organisations within the footprint. There is no legal mechanism for majority voting or for compelling organisations to submit to plans that their boards in all conscience cannot endorse. However there are also likely to be disagreements as projects progress on matters of detail and these disagreements will need to be resolved. The MoU will anticipate such disagreements from the outset and to agree how they will be addressed and resolved.

11.2.5 **Code of conduct**

Leadership and behavioural change is critical to make the governance work. Behaviours will reflect principles and are defined in the code of conduct within the STP MoU.

11.2.6 **Conflict of interest**

A conflict of interest occurs when an individual’s ability to exercise judgement is impaired or influenced by their involvement in another role or relationship.

11.2.7 **Communication and consultation**

What happens as a result of STPs will play out in the public arena. The public has a legitimate interest in influencing what happens to health and social care services in their area. High quality consultation coupled with transparency and clarity of communication will be essential and needs to be planned for as soon as possible. However the legal duty to consult lies with individual organisations.

12.0 Conclusion

12.1 Governance is the conscience for every organisation, and with the move to align organisational strategy with new place-based ways of working it is important to make sure ideas for governance follow and reflect the new realities of the NHS.

12.2 Done well, governance will assure that the STP programme is accountable to the populations served and that the best possible decisions are made at the right time. If governance is not handled proactively the STP may fail to live up to its potential and leaders will struggle to establish effective ways of working which are needed to translate plans into action.

13.0 Recommendations

13.1 It is recommended that the Governing Body/Board/Cabinet:

1. Approve in principle the revised STP governance and leadership infrastructure to improve support for delivery of the STP which will continue to be reviewed;
2. Approve in principle, and authorise the Accountable Officer/ Chief Executive to sign, the Draft Memorandum of Understanding for STP Governance. This will provide a mechanism for securing ongoing commitment to sustained engagement with, and delivery of, the STP; and
3. Approve in principle the draft terms of reference for the proposed governance and leadership model.

14.0 Next steps

14.1 Continuous review process

Subject to agreement from all constituent members, and taking into account any required amendments, these revised governance arrangements will be adopted by all statutory organisations that constitute the SES STP and the shared MoU will be signed. Due to the changing nature and dynamics of STP development, however, these governance arrangements should be periodically reviewed.

It is recommended that the STP programme instigate an overarching STP programme review process and review all governance on six-monthly basis until the STP programme moves into ‘business as usual’ mode.

APPENDIX A Sustainability and Transformation Partnership Memorandum of Understanding (MoU) to support Sussex and East Surrey governance

This memorandum of understanding is made on [ ] 2017

1 Parties

The parties to this MoU are the following NHS commissioners and providers and local authorities in the Sussex and East Surrey footprint:

1. NHS Brighton and Hove CCG
2. NHS Coastal West Sussex CCG
3. NHS Crawley CCG
4. NHS East Surrey CCG
5. NHS Eastbourne, Hailsham and Seaford CCG
6. NHS Hastings and Rother CCG
7. NHS High Weald Lewes Havens CCG
8. NHS Horsham and Mid Sussex CCG
9. Brighton and Hove City Council
10. East Sussex County Council
11. Surrey County Council
12. West Sussex County Council
13. Brighton and Sussex University Hospitals NHS Trust
14. Central Surrey Health
15. East Sussex Healthcare NHS Trust
16. First Community Health and Care
17. Integrated Care 24
18. Queen Victoria Hospital NHS Foundation Trust
19. South East Coast Ambulance Service NHS Foundation Trust
20. Surrey and Borders Partnership NHS Foundation Trust
21. Surrey and Sussex Healthcare NHS Trust
22. Sussex Community NHS Foundation Trust
23. Sussex Partnership NHS Foundation Trust
24. Western Sussex Hospitals NHS Foundation Trust

2 Background

2.1 NHS Shared Planning Guidance for 2016/17 – 2020/21 asked every local health and care system to come together to create their own Sustainability and Transformation Plan (STP) for accelerating the implementation of the Five Year Forward View (FYFV).

2.2 The Sussex and East Surrey footprint was identified as one of the STP footprint areas in which people and organisations will work together to develop robust plans to transform the way that health and care is planned and delivered for their populations.

2.3 The Parties have agreed to work together to enable transformative change and the implementation of the FYFV vision of better health and wellbeing, improved quality of care, and stronger NHS finance and efficiency.

2.4 The Parties have agreed and submitted their STP in October 2016 but agree that it is a living document that may be varied and updated from time to time.

3 Leadership

3.1 Leadership of the STP should be visible, build consensus and communicate a shared vision for Sussex and East Surrey. The leadership should also provide direction, oversight and motivation for improving health and care and implementation of the STP in Sussex and East Surrey

3.2 The Partnership will re/appoint an STP chair/leader using a fair process, and subject to ratification by NHS England and NHS Improvement, in line with the national role specification. NHS England will provide funding to cover the costs of the STP leader covering at least two days a week pro rata.

4 Duration of the MoU

4.1 This MoU will take effect on the date it is signed by all Parties.

4.2 The Parties expect the duration of the MoU to be for the period of 2017-2021 in line with the duration of the STP or otherwise until its termination

5 Objective

5.1 The Objective of this MoU is to provide a mechanism for securing the Parties' agreement and commitment to sustained engagement with and delivery of the STP to realise a transformed model of care in Sussex and East Surrey

6 Agreed principles

6.1 The Parties have agreed to work together in a constructive and open manner in accordance with the following agreed principles for ways of working and culture:

1. Collective authority
2. Inclusivity

3. Clinical leadership
4. Efficient process and effective decision-making in place
5. Clarity and transparency
6. Effective programme structure
7. Co-production and patient and service user involvement

7 Effect of the MoU

7.1 This MoU does not and is not intended to give rise to legally binding commitments between the Parties.

7.2 The MoU does not and is not intended to affect each Parties' individual accountability as an independent organisation.

7.3 Despite the lack of legal obligation imposed by this MoU, the Parties:

7.3.1 have given proper consideration to the terms set out in this MoU; and

7.3.2 agree to act in good faith to meet the requirements of the MoU.

8 Governance

8.1 The Parties have agreed to establish an STP Programme Board to co-ordinate achievement of the Objective.

8.2 The Parties have agreed terms of reference for the governance infrastructure (Appendix B).

8.3 The terms of reference describe arrangements for aligned decision making of the Parties which they agree is necessary to achieve the Objective.

8.4 Each Party will nominate a representative to the STP Programme Board and notify the STP Leader of his or her name and a deputy who is authorised to attend for him or her in his or her absence.

8.5 The Parties agree that the STP Programme Board will be responsible for co-ordinating the arrangements set out in this MoU and providing overview and drive for the STP.

8.6 The STP Programme Board will meet at least once every six weeks or as otherwise may be required to meet the requirements of the STP.

8.7 The STP Programme Board does not have any authority to make binding decisions on behalf of the Parties.

9 Subsidiarity

9.1 The Parties acknowledge and respect the importance of subsidiarity.

9.2 The Parties agree for the need for many decisions to be made as close as possible to the people affected by them.

9.3 The SES STP has a multi-layered governance structure and decisions will be taken at the appropriate level, whether that is locally, in places or STP wide.

9.4 The aspiration is to do work at scale across the STP where it adds value and decision making will be done at that STP level. Where solutions are most appropriately delivered locally, in such circumstances decision-making should be done at that local level.

9.5 However, the STP will be responsible for the whole of SES population, which requires overall control to ensure one part of the system delivery does not unfavourably impact another part.

9.6 The highest level of oversight and leadership, with decision making abilities is the STP Programme Board. The membership is representative across health and social care in Sussex and East Surrey at executive level.

9.7 This collective of organisational leaders will take decisions within their delegated powers and bring to bear the authority of their organisational positions. By including all health and social care leaders in the STP Programme Board, it supports clear and transparent governance arrangements for decision-making.

9.8 Where a deputy attends in place of a formal member, that deputy assumes the role of the member for that meeting, including the delegated authority afforded to the members.

9.9 The STP Programme Board is responsible for collective decision making relating to the strategic elements of the STP. The types of decisions they will take include:

- Approval of the Sussex and East Surrey STP priorities
- Approval of STP infrastructure and leadership
- Budget for the Sussex and East Surrey STP programme

These key decisions need to be unanimous particularly as they have budget and resource implications.

9.10 For decisions that do need to be taken to statutory organisation boards, the STP Programme Board will make collective recommendations to these bodies (for example service changes).

9.11 The STP Programme Board Executive that reports to the overall STP Programme Board takes STP programme operational-level decisions on a regular basis (the role of this group and related responsibilities are defined in individual terms of reference in Appendix B). These types of decisions will include:

- Resolving STP programme risks and issues that don't need to be escalated to the STP Programme Board
- Reviewing progress and recommending action relating to the STP-wide workstreams and place-based plan delivery

9.12 In all decisions at STP level, the first priority should be to ensure it meets STP-wide targets, benefiting the total population.

10 Degree of consensus required

10.1 The approach for decision making should first be to seek consensus on key issues.

10.2 Where reaching consensus is not possible, a voting approach can be considered with agreed principles regarding quorum and abstentions.

10.3 The degree of consensus should be agreed for each STP constituent group.

10.4 In the absence of agreed majority voting, all decision must be unanimous.

11 Delegated authority

11.1 All STP organisations are collectively accountable for closing the three gaps in care and quality, health and wellbeing and financial sustainability in Sussex and East Surrey.

11.2 To enable efficient system working, statutory organisations will delegate some decision making to the appropriate level through their presentation on STP leadership groups and places.

11.3 For authority delegated to the STP level, members will be responsible for carrying out the necessary engagement with their local organisation or places in order to make the decisions on their collective behalf, and this will be done alongside the regular reporting of progress and content necessary for statutory organisations to maintain oversight of the programme.

11.4 It is proposed that decisions that focus on collective working across STP, that have limited impact on individual organisations, or those that are operational in nature, should be delegated to representatives on the STP groups including the programme board, programme board executive, finance group, clinical board (the role of these groups and related responsibilities are defined in individual terms of reference in Appendix B)

12 Reporting mechanism

12.1 Full status reports and deliverables from all aspects of the programme should be presented at the STP Programme Board Executive.

12.2 Each workstream and place should be providing updates of their progress, upcoming milestones, risks and issues and, decisions that have been made within the reporting period to enable the tracking of collective progress.

12.3 The STP Programme Board will receive summary updates where specific input and action from the board are needed.

12.4 The principle of an ‘open book’ approach between all parties to request for information (e.g. financial data) to ensure transparency.

13 Risk management and assurance

13.1 Each organisation must satisfy itself that risks to the strategy in their totality are being managed effectively, not just those risks that the organisation itself has agreed to own and manage.

13.2 Governing bodies/boards/cabinets will want to be assured in respect of the risks owned by their organisation and of the risks owned by partner organisations if there are consequences across the partnership.

13.3 Where external assurance is sought for footprint-wide risks committees in common to oversee management of risks will be considered.

13.4 The pooling of resources to commission external assurance may also be of use in dealing with footprint- wide risks. But each board will still need to take a view on the value of such assurance and act accordingly.

14 Escalation Process

14.1 When an unanticipated issue cannot be resolved through normal programme management procedures, the issue is escalated to the group they report in to for decisions.

14.2 The group that has identified the issue for escalation should include suggested mitigating actions for review and possible agreement.

14.3 It is the Programme Director who assesses how critical the issue is and, where possible, the highlighting of the issue should be delayed until the next scheduled meeting if no negative impact will be experienced. Only critical issues will be highlighted outside normal meeting schedules.

14.4 The escalation process only applies to issues which cannot be resolved at the appropriate level and require senior involvement, impact more than one programme (workstream or place) or impact the STP-wide programme.

14.5 However, the programme should always strive to address issues at the lowest possible level.

14.6 Where the STP Programme Board needs to escalate an issue, it is the individual organisations leader who takes the issue to their own statutory bodies.

14.7 If the risk or issue only affects a subset of the constituent organisations, it is up to the STP Programme Board chair to decide whether to only approach those organisations that are affected of send it to all.

15 Dispute resolution

15.1 The Parties will attempt to resolve any dispute between them in respect of this MoU by negotiation in good faith.

15.2 All members of the STP programme will make every effort to work collaboratively in the best interests of the Sussex and East Surrey system and actively avoid disputes.

15.3 Individual member's concerns should be raised, in writing, with the STP convenor in the first instance. The STP convenor will attempt to resolve the concern through informal discussion and mediation.

15.4 For disagreement involving the STP convenor, members should approach an alternate STP SRO. That STP SRO will follow the same process of attempting to resolve informally before going down the formal route.

15.5 If agreement still cannot be reached, the STP convenor will propose formal resolution which may involve regulators. Independent mediation should always be the last resort.

16 Code of conduct

16.1 Leadership and behavioural change is critical to making the governance work.

16.2 Behaviours will reflect principles and are defined in the code of conduct as:

- Be ambitious and promote innovation
- Collaborative working focused on collective success to deliver more than the sum of the component parts
- Each member brings their own delegated authority to the table
- Test developing thinking with their organisations to ensure alignment, understanding and ownership across the STP programme
- Members support colleagues to work through difficult issues, sharing analysis before taking action
- All members act in the best interests of service users and the wider SES public
- At all times act in good faith towards each other, building trusting relationships with an open, partnership approach, to avoid surprises
- Share information, experience, materials and skills to learn from each other and develop effective working practices, eliminate duplication of effort, mitigate risk and reduce cost
- Members engage in an open book approach to financial and other data
- Effectively manage internal stakeholders and consult with and engage external stakeholders
- Adopt a positive outlook and behave in a positive, proactive manner
- Actively avoid a culture of blaming others to engender joint responsibility
- Adhere to statutory powers, requirements and best practice to ensure compliance with applicable laws and standards

17 Conflict of interest

17.1 All members involved at all levels of the STP programme are expected to declare a conflict of interest ahead of the discussion it relates to, or as soon as the conflict becomes apparent, to the chair or the group they are a member of.

17.2 It is to the chair's discretion to disqualify the individual from taking part in the discussion.

18 Communication and consultation

18.1 Due to the legitimate public interest in influencing what happens to local health services high quality consultation coupled with transparency and clarity of communication will be an essential part of the STP development and delivery, and will be planned for as soon as possible.

18.2 The legal duty to consult lies with individual organisations.

18.3 However the STP leadership groups have a key role to play in facilitating and co-ordinating actions to fulfil this duty.

19 General provisions

19.1 The Parties agree that this MoU may be varied only with the written agreement of all the Parties.

Signed by the parties or their duly authorised representatives on the date set out above.

Signed by duly authorised for and on behalf of ([PARTY 1])

Signed by duly authorised for and on behalf of ([PARTY 2])

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APPENDIX B – Terms of reference for STP governance infrastructure

STP Programme Board

Terms of reference

Purpose

The STP Programme Board is responsible for strategic oversight and delivery of the Sustainability and Transformation Plan (STP) on behalf of all partner organisations across Sussex and East Surrey (SES), allowing members, through their representatives, to make aligned decisions.

The STP Programme Board assesses cross organisational and programme level risks, provides overall assurance of STP planning, delivery and risk management as well as ensuring that appropriate links are made with other SES strategic programmes.

The STP Programme Board connects with national bodies and other external organisations (e.g. Clinical Senate, Health Education England) to ensure it draws on the support available, feeds in best practice and learning from other areas into the development and delivery of the programme and, aligns with national policy direction.

The STP Programme Board acts as a meeting forum and single communication channel with regulators with regard to the SES STP and for applications for transformational funding.

The STP Programme Board produces options, recommmendations and proposals for ratification by the members.

The purpose and remit of the STP Programme Board will be reviewed as part of the overarching programme governance review or in one year's time, whichever is sooner, and then at least six monthly after that.

The overall remit of this group is to:

- Set strategic direction, scope and priorities for the STP
- Provide oversight of the STP programme and facilitates collective decision-making relating to the strategic elements of the STP
- Review recommendations from the STP Programme Board Executive, providing the necessary challenge and scrutiny to plans
- Delegate such matters as they see fit to the STP Programme Board Executive
- Assess STP programme risks and provide assurance that effective mitigations are in place
- Provide assurance that the STP programme aligns to SES strategy and local programmes of work
- Agree the terms of reference for new programmes of work setting out ambition, outcomes, timescales, resources and success criteris
- Act as the point of escalation to resolve competing priorities and remove barriers that may prevent progress

- Ensure compliance with regulatory framework
- Collectively respond to challenges to system resilience, clarifying with regulators the precise role of the STP
- Support collective engagement with regulators, the public and other stakeholders regarding the STP (public consultation if necessary)

Working with constituent organisations:

- Establish clear agreements on delegated authority from each constituent organisation
- Support the statutory requirements of individual organisations including the need to develop and deliver 'public value'
- Make decisions on behalf of their respective organisation within delegated authority in the development and delivery of STP programme
- Take key decisions for sign-off to individual boards to obtain approval for decision outside delegated authority agreements
- Actively foster cross-organisational relationship building and transparent communication
- Champion the STP programme both within their organisation and within the wider STP footprint

Membership

Representation is across health and social care in Sussex and East Surrey at executive level.

Members will be expected to send an appropriate deputy, who is fully briefed and with adequate delegated authority, where they are unable to attend.

Membership includes:

- Chief officers/ accountable officers of the CCGs
- Chief executives of the provider trusts
- Chief executives of the local authorities
- NHS England and NHS Improvement representatives
- Health Education England representative
- Clinical Board co-chairs
- Finance Group chair
- Oversight Group chair

The following may regularly attend meetings:

- Healthwatch representative
- Communications and engagement lead
- STP Programme Director

Table 1: Initial membership of Sussex and East Surrey Programme Board

Name	Title	Organisation
Michael Wilson	Chief executive and STP convenor **(chairperson)**	Surrey and Sussex Healthcare NHS Trust
Adam Doyle	Accountable officer	NHS Brighton and Hove CCG
Katie Armstrong	Clinical accountable officer	NHS Coastal West Sussex CCG
Amit Bhargava	Clinical accountable officer	NHS Crawley CCG
Ian Ayres	Chief officer	NHS East Surrey CCG
Amanda Philpott	Chief officer	NHS Eastbourne, Hailsham and Seaford CCG NHS Hastings and Rother CCG
Wendy Carberry	Accountable officer	NHS High Weald Lewes Havens CCG
Geraldine Hoban	Chief officer	NHS Horsham and Mid Sussex CCG
Marianne Griffiths	Chief executive	Brighton and Sussex University Hospitals NHS Trust Western Sussex Hospitals NHS FT
Stephen Cass	Chief Executive	Central Surrey Health
Adrian Bull	Chief executive	East Sussex Healthcare NHS Trust
Sarah Billiald	Chief executive	First Community Health and Care
Yvonne Taylor	Chief executive	Integrated Care 24
Steve Jenkin	Chief executive	Queen Victoria Hospital NHS FT
Fiona Edwards	Chief executive	Surrey and Borders Partnership NHS FT
Siobhan Melia	Chief executive	Sussex Community NHS FT
Daren Mochrie	Chief executive	South East Coast Ambulance Service NHS FT
Sam Allen	Chief executive	Sussex Partnership NHS FT
Geoff Raw	Chief executive	Brighton and Hove City Council
Becky Shaw	Chief executive	East Sussex County Council
David	Chief executive	Surrey County Council

McNaulty		
Nathan Elvery	Chief executive	West Sussex County Council
Pennie Ford	Director of assurance and delivery	NHS England
Paul Bennett	Director of Improvement and delivery	NHS Improvement
Philippa Spicer	Local director	Health Education England, Kent Surrey and Sussex
Minesh Patel	Clinical chair, Clinical Board co-chair	NHS Horsham and Mid Sussex CCG
George Findlay	Medical director, Clinical Board co-chair	Western Sussex Hospitals NHS FT
Richard Brown	Medical Director, Surrey & Sussex LMCs	Interim GP Provider representative STP Executive
Paul Simpson	Chief finance officer, Finance Group chair	Surrey and Sussex Healthcare NHS Trust
Beryl Hobson	Oversight Group chair	Queen Victoria Hospital NHS FT

Quorum

A meeting will be quorate with a minimum of fifteen members present including at least the following or their nominated deputy:

- Chairperson
- At least one CCG accountable officer or chief officer
- At least one acute trust chief executive
- At least one mental health trust chief executive
- At least one community provider chief executive
- At least one local authority executive representative
- At least one clinical lead

Meeting frequency

Once every six weeks

Reporting responsibilities, decisions and accountability

The STP Programme Board members will report to their individual constituent organisations.

The STP Programme Board is responsible for making recommendations to the CCG

governing bodies, trust boards and local authority cabinets/health and wellbeing boards to support decision making outside any delegated authority. All STP Programme Board members will steer recommended decisions through their constituent boards for formal statutory sign off, as laid down within their constitutions.

Delegated authority from constituent boards to STP Programme Board members is being explored and could include the following delegated to the STP Programme Board

- Early stages of working leading up to decision
- The development of options for consideration

Constituent organisations will still need to:

- Sign off preferred options
- Make decisions about service change
- Make decisions about governance changes, representation and structural changes that will impact individual organisations

In order to develop recommended decisions, the Chair will work to establish unanimity as the basis for the recommendations of the Board.

Conflict of Interest:

Any actual or potential conflicts of interest must be declared.

Date terms of reference agreed: June 2017

Date terms of reference due to be reviewed: March 2018

STP Programme Board Executive

Terms of reference

Purpose

The STP Programme Board Executive acts as the engine to drive delivery of the Sussex and East Surrey Sustainability and Transformation Plan (STP), to promote consensus on change to be delivered and to make recommendations to the STP Programme Board.

The STP Programme Board Executive manages cross organisational and programme level issues, risks and dependencies, oversees the development of the programme plan, its deliverables and ensures that appropriate links are made with other SES strategic programmes.

It ensures that place-based plans and STP workstreams are aligned and aggregated to the overall outcomes of the STP for the betterment of the population across Sussex and East Surrey.

The group members will provide steer to the wider programme team who will deliver the STP work on a day-to-day basis.

The purpose and remit of the STP Programme Board Executive will be reviewed as part of the overarching programme governance review or in one year's time, whichever is sooner, and then at least six monthly after that.

The overall remit of this group is to:

- Drive STP programme progress within the scope and parameters set by the STP Programme Board
- Provide guidance to the wider programme team (including STP workstreams and places)
- Make recommendations to the STP Programme Board
- Promote consensus on the changes that need to be delivered amongst statutory organisations
- Take operational-level decisions on a regular basis
- Oversee the management of programme resources
- Shape the STP Programme Board's agenda
- Seek input from, and disseminate information from STP Programme Board Executive discussion to, the groups they represent (e.g. the CCG SRO is responsible for collating input from CCGs and communicating this consensus to the STP Programme Board Executive as well as communicating key STP Programme Board Executive discussions to all CCGs).
- Keep an accurate record of discussions that can be shared at the discretion of STP Programme Board Executive members to the groups they represent
- Accept such matters as the STP Programme Board sees fit to delegate

Membership

Members represent the individual group and/or workstreams they are responsible for.

All members will hold each other to account to ensure that they are acting with the aim of transforming health and care for the Sussex and East Surrey population and not on behalf of their own organisations.

Membership is a subset of the STP Programme Board with representation from each care sector.

Members will be expected to send an appropriate deputy, who is fully briefed and with adequate delegated authority, where they are unable to attend.

Membership includes:

- STP convenor, provider SRO
- CCG STP SRO
- Local authority STP SRO
- Clinical Board co-chairs
- Finance Group chair
- Place-based single point of leadership (SPoL)
- Workstream SROs
- STP Programme Director
- Communication and engagement lead
- GP Provider representative

Table 1: Initial membership of Sussex and East Surrey Programme Board Executive

Name	**Role**	**Organisation and title**
Michael Wilson	STP convenor, provider SRO **(Chairperson)**	Surrey and Sussex Healthcare NHS Trust, chief executive
Wendy Carberry	STP CCG SRO	NHS High Weald Lewes Havens CCG, chief officer
TBC	STP local authority SRO	TBC
Minesh Patel	Clinical Board co-chair	NHS Horsham and Mid Sussex CCG, chair
George Findlay	Clinical Board co-chair	Western Sussex Hospitals NHS FT, medical director
Paul Simpson	Finance Group chair	Surrey and Sussex Healthcare NHS Trust, Director of Finance
Katie Armstrong	Coastal Care locality SPoL	NHS Coastal West Sussex CCG, clinical

		accountable officer
Keith Hinkley	East Sussex Better Together locality SPoL	East Sussex County Council, Director of Adult Social Services
Geraldine Hoban	Central Sussex and East Surrey Alliance (North) locality SPoL	NHS Horsham and Mid Sussex CCG, chief officer
Adam Doyle	Central Sussex and East Surrey Alliance (South) locality SPoL	NHS Brighton and Hove CCG, chief officer
Adrian Bull	Digital workstream SRO	East Sussex Healthcare NHS Trust, chief executive
Elizabeth Gill	Urgent and emergency care workstream SRO	NHS High Weald Lewes Havens CCG, chair
Siobhan Melia	Estates & Workforce workstreams SRO	Sussex Community NHS FT, chief executive
Sam Allen	Mental health workstream SRO	Sussex Partnership NHS FT, chief executive
Dan Wood	Communications and engagement lead	Independent Consultant
Richard Brown	Medical Director, Surrey & Sussex LMCs	Interim GP Provider representative
Dena Marshall	Programme director	

Quorum

A meeting will be quorate with a minimum of eight members present including at least the following or their nominated deputy:

- Chairperson
- At least one representative from a CCG
- At least one representative from an acute trust
- At least one representative from another trust

Meeting frequency

Once a fortnight

Reporting responsibilities

The STP Programme Board Executive will report to the STP Programme Board.

Decisions

The parameters for decision making by the Programme Board Executive will be determined by the Programme Board and will fall within the governance framework. In general these will include operational decisions regarding:

- Facilitating programme process (within the scope, timeline and parameters set by the STP Programme Board) and guiding the wider programme team
- Reviewing the work of STP workstreams and place-based plans to enable and support performance improvement and to ensure shared goals and targets are met
- Resolving risks and issues (outside of those that will need STP Programme Board escalation)
- Resolving operational conflicts with regard to dependencies and interdependencies
- STP programme resource management

All other decisions that need to be made outside the above will be escalated to the STP Programme Board with recommendations on how to proceed.

Formal decisions will be taken through the STP partners' respective governing boards for sign off and agreement via the STP Programme Board members.

Conflict of Interest:

Any actual or potential conflicts of interest must be declared.

Date terms of reference agreed: June 2017

Date terms of reference due to be reviewed: March 2018

STP Clinical Board

Terms of reference

Purpose

The purpose of the Sussex and East Surrey (SES) Clinical Board is to review, advise and make recommendations for health and care transformation across Sussex and East Surrey from a clinical and care professional perspective.

As well as overseeing the development of the clinical strategy as part of the SES Sustainability and Transformation Plan (STP), the Clinical Board will also provide clinical and care professional input in, and support to, all STP workstreams and place-based arrangements.

It will strive to promote clinical and care professional consensus on potential options, and make recommendations to the STP Programme Board Executive.

The purpose and remit of the Clinical Board will be reviewed as part of the overarching programme governance review or in one year's time, whichever is sooner, and then at least six monthly after that.

The overall remit of this group is to:

- Provide visible, collective clinical and care professional leadership to the STP programme of work
- Champion the work of the STP with internal and external stakeholders
- Provide clinical and care professional oversight, leadership and input into STP-wide workstreams (starting with acute transformation)
- Provide clinical and care professional oversight, leadership and input into the place-based plans and their respective initiatives. This is in addition to clinical steer already in place in places
- Provide challenge to STP programme using best practice and relevant evidence base and make recommendations, with appropriate input from across partners, to STP Programme Board and STP Programme Board Executive
- Work with the finance group to ensure workstreams and places will deliver impact and improve population health through economic analysis, as well as deliver financial sustainability
- Represent clinicians and practitioners across Sussex and East Surrey with focus being on the broader system instead of individual organisational interests
- Promote clinical and care professional engagement in the development and delivery of the STP
- Champion the STP's clinical and service proposals amongst colleagues, partners and stakeholders

- Ensure views and experiences from the public and patients are included in the development and implementation of plans
- Ensure that plans adopt the principle of co-production and co-design whenever relevant
- Act as interface between the STP and South East Coast Clinical Senate

Work will include:

- Owning and communicating the Sussex and East Surrey case for change
- Reviewing the potential opportunities for improvement and rationalisation of clinical service provision in SES based around the agreed principles of patient safety, improved outcomes and better value for money
- Reviewing the potential implications for social care and prevention in developing new models of care and pathways
- Commenting on and inputting into the emerging plans of the STP workstreams
- Highlighting the need for patient, carer and public involvement, engagement and consultation as appropriate
- Providing clinical leadership and promoting a culture of multi-professional engagement and collaboration

Membership

Clinical / practitioner representation is across health and care in Sussex and East Surrey at a senior level.

Members will be expected to send an appropriate deputy, who is fully briefed and with adequate delegated authority, where they are unable to attend.

Membership includes:

- Clinical chairs of the CCGs
- Medical directors of the provider trusts
- Clinical director of the 3Ts
- South East Coast Clinical Senate representative
- NHS provider trusts nursing director representatives
- Provider trust mental health lead
- Primary commissioning practice nurse representative (as required)
- Director of adult social services representative (as required)
- Director of children's services representative (as required)
- Director of public health representative

The following may regularly attend meetings:

- Communications and engagement lead
- STP Programme Director

Table 1: Initial membership of Sussex and East Surrey Clinical Board

Name	**Title**	**Organisation**
Minesh Patel	Clinical chair **(co-chairperson)**	NHS Horsham and Mid Sussex CCG
George Findlay	Medical director **(co-chairperson)**	Brighton and Sussex University Hospitals NHS Trust Western Sussex Hospitals NHS FT
David Supple	Clinical chair	NHS Brighton and Hove CCG
Katie Armstrong	Clinical chief officer	NHS Coastal West Sussex CCG
Amit Bhargava	Clinical chief officer	NHS Crawley CCG
Elango Vijaykumar	Clinical chair	NHS East Surrey CCG
Martin Writer	Clinical chair	NHS Eastbourne, Hailsham and Seaford CCG
David Warden	Clinical chair	NHS Hastings and Rother CCG
Elizabeth Gill	Clinical chair	NHS High Weald Lewes Havens CCG
David Walker	Medical director	East Sussex Healthcare NHS Trust
Andrew Catto	Chief Medical Officer	Integrated Care 24
Ed Pickles	Medical director	Queen Victoria Hospital NHS FT
Fionna Moore	Medical director	South East Coast Ambulance Services NHS FT
Justin Wilson	Medical director	Surrey and Borders Partnership NHS FT
Des Holden	Medical director	Surrey and Sussex Healthcare NHS Trust
Richard Quirk	Medical director	Sussex Community NHS FT
Rick Fraser	Medical director	Sussex Partnership NHS FT
Peter Larsen-Disney	Clinical director of 3Ts	Brighton and Sussex University Hospital NHS FT
Lawrence Goldberg	Chair	South East Coast Clinical Senate
Fiona Allsop	Director of nursing and quality	Surrey & Sussex Healthcare NHS TrustExec
Emma Wadey	Chief nurse, interim and Director of quality	South East Coast Ambulance Service NHS FT

	and safety	
Liz Mouland	Chief nurse and Director of clinical services	First Community Health and Care
Diane Hull	Director of nursing	Sussex Partnership NHS FT
Cynthia Lyons	Director of Public Health	East Sussex County Council

Quorum

A meeting will be quorate with a minimum of fifteen members present including at least the following or their nominated deputy:

- At least one acute trust medical director
- Between the community and mental health medical and nursing directors, at least one member representing each such service
- At least one acute, community or mental health nursing director
- At least one CCG clinical chair

Meeting frequency

Once a fortnight

Reporting responsibilities

The STP Clinical Board will report to the STP Programme Board Executive.

Decisions

The group provides clinical advice and recommendations to the Sussex and East Surrey STP Programme Board Executive and when required, the STP Programme Board.

Any formal decisions will be taken through the STP partners' respective governing boards for sign off and agreement via the STP Programme Board members.

Conflict of Interest:

Any actual or potential conflicts of interest must be declared.

Date terms of reference agreed: June 2017

Date terms of reference due to be reviewed: March 2018

STP Finance Group

Terms of reference

Purpose

The purpose of the STP Finance Group is to ensure the Sussex and East Surrey Sustainability and Transformation Plan delivers financial sustainability across the whole system and uses available resources to best effect.

The STP Finance Group provides financial leadership as well as strategic advice and guidance to develop and deliver the STP and makes recommendations to the STP Programme Board Executive on financial matters.

The purpose and remit of the STP Finance Group will be reviewed as part of the overarching programme governance review or in one year's time, whichever is sooner, and then at least six monthly after that.

The overall remit of this group is to:

- Provide director level advice and support to the programme, to ensure that the strategy is fully costed, that its impact on the wider health and social care system is modelled and understood and that it meets the requirements to deliver a financially sustainable health system
- Actively participate in discussions to progress financial planning in support of delivery of the STP, including how this relates to local "Place-Based" plans
- Share operational plans and supporting information to help the Finance Group understand the health and care financial picture across Sussex and East Surrey
- Agree the underpinning principles that are most critical to the successful delivery of the STP programme and that should drive operational planning. To do this:
    - The STP financial plan and member organisations' operational plans should deliver the triple aims of the STP
    - The initiatives, in aggregate, should aim to achieve a balanced financial plan across the STP. Initiatives without plans or a low likelihood of delivery will be excluded
    - Organisations should make the most of all available efficiencies, funding sources and opportunities along with reasonable investments for improvement
- Ensure that the proposals and plans developed are financially robust
- Work with the Clinical Board to develop an overall clinical model which will deliver financial sustainability
- Review and sign off the financial content for recommendation to the STP Programme Board
- Review savings plans and monitor in year performance and mitigations and forecast

outturns

- Support each other as professionals and ensure colleagues are kept informed about the work and are engaged as appropriate
- Facilitate resolutions to discrepancies that treat individual organisations fairly whilst acting in the best interests of services users and the health and care system as a whole
- Be ambassadors for the programme and ensure they are financial advocates for proposals

Membership

Financial representation is across health and care in Sussex and East Surrey at a senior level.

Members will be expected to send an appropriate deputy, who is fully briefed and with adequate delegated authority, where they are unable to attend.

Membership includes:

- Chief finance officers of the CCGs
- Finance directors of the provider trusts, including community and mental health trusts
- County council finance leads

The following may regularly attend meetings but by invitation only:

- NHS England specialised commissioning finance lead
- NHS England primary care commissioning finance lead
- STP Programme Director

Table 1: Initial membership of Sussex and East Surrey Finance Group

Name	Role	Organisation
Paul Simpson	Finance director **(chairperson)**	Surrey and Sussex Healthcare NHS Trust
Pippa Ross-Smith	Chief finance officer	NHS Brighton and Hove CCG
Neil Cook	Chief finance officer, interim	NHS Coastal West Sussex CCG
Barry Young	Chief finance officer	NHS Crawley CCG NHS Horsham and Mid Sussex CCG
Ray Davey	Chief finance officer	NHS East Surrey CCG
John O'Sullivan	Chief finance officer	NHS Eastbourne, Hailsham and Seaford CCG

		NHS Hastings and Rother CCG
Alan Beasley	Chief finance officer	NHS High Weald Lewes Havens CCG
Karen Geoghegan	Executive director of finance	Brighton and Sussex University Hospitals NHS Trust Western Sussex Hospitals NHS FT
Jonathan Reid	Director of finance	East Sussex Healthcare NHS Trust
Adrian Baillieu	Director of finance	First Community Health and Care
Tony Barfoot	Finance Director	Integrated Care 24
Clare Stafford	Executive director of finance & performance	Queen Victoria Hospital NHS FT
David Hammond	Director of finance	South East Coast Ambulance Service NHS FT
Graham Wareham	Director of finance	Surrey and Borders Partnership NHS FT
Mike Jennings	Director of finance	Sussex Community NHS FT
Sally Flint	Director of finance	Sussex Partnership NHS FT
Alun Shopland	Finance director	Central Surrey Health, Surrey
Nigel Manvell	Assistant director, finance and procurement	Brighton and Hove City Council
Ian Gutsell	Head of finance	East Sussex County Council
Sian Ferrison or Will House	Transformation and development manager/ Strategic finance manager	Surrey County Council
Chris Salt or Katherine Eberhart	Group manager, financial services/ finance director	West Sussex County Council

Quorum

A meeting will be quorate with a minimum of ten members present including at least the following or their nominated deputy:

- At least two CCG chief finance officers
- At least three provider finance directors

Meeting frequency

Once a fortnight

Reporting responsibilities

The STP Finance Group will report to the STP Programme Board Executive.

Decisions

The group provides financial advice and recommendations to the Sussex and East Surrey STP Programme Board Executive and when required, the STP Programme Board.

Any formal decisions will be taken through the STP partners' respective governing boards for sign off and agreement via the STP Programme Board members.

If an organisation puts forward plans that don't conform to the agreed principles, the Finance Group is responsible for assessing that plan then pursuing and agreeing a resolution that is compatible with delivering the STP programme.

Conflict of Interest:

Any actual or potential conflicts of interest must be declared.

Date terms of reference agreed: June 2017

Date terms of reference due to be reviewed: March 2018

STP Oversight Group

Terms of reference

Purpose

The STP Oversight Group provides oversight of the development and delivery, including systems and processes, of the STP and gives feedback to the Sussex and East Surrey STP Programme Board on elements of the plan.

The group provides NHS governing bodies, trust boards, and local authority leaders a forum to steer the development of cross organisational working within the STP remit, and provides non-executive input, but does not have statutory or formal responsibilities.

They connect the organisation-based accountability structures with the broader STP programme and provide assurance for STP governance and infrastructure.

The STP Oversight Group considers and reviews political and public engagement ahead of transformation and potential consultation.

The purpose and remit of the STP Oversight Group will be reviewed as part of the overarching programme governance review or in one year's time, whichever is sooner, and then at least six monthly after that.

The overall remit of this group is to:

- Provide oversight to the STP to ensure the SES population perspective are considered at every phase of development and delivery of the plan
- Provide oversight also of STP systems and processes
- Enhance communication and engagement with individual trust boards, CCG governing bodies, local councillors and councils, as well as wider stakeholders that could include political and the public relationships
- Provide support and challenge to the pace of the STP development and delivery
- Provide support and challenge to the programme to ensure the STP achieves affordable system sustainability balanced by improved health and social care outcomes and reduced health inequalities for the SES population

- Provide challenge, support and guidance to enable descisions to be made in light of the interests of the health and wellbeing of the population in Sussex and East Surrey
- Facilitate consensus building across organisations in the STP and the public
- Review opportunities for better alignment of health and wellbeing strategies, joint needs assessments and, the achievement of a population based approach to health and care
- Provide assurance for STP governance and infrastructure

Be aware of the need for individual constituent organisations to comply with the relevant statutory requirements

- Play a part in reviewing the achievement following the delivery of STP programme deliverables
- Actively foster cross-organisational relationship building and transparent communication

Membership

Representation is across health and social care in Sussex and East Surrey at constituent board level.

Members will be expected to send an appropriate deputy, who is fully briefed and with adequate delegated authority, where they are unable to attend.

Membership includes:

- Chairs of the CCGs
- Chairs of the provider trusts
- Leaders of the local authorities

The following may regularly attend meetings:

- NHS England South (South East) representative
- Healthwatch representative
- STP Chair
- CCG STP SRO
- LA STP SRO
- STP Programme Director

Table 1: Initial membership of Sussex and East Surrey Oversight Group

Name	**Title**	**Organisation**
Beryl Hobson	Chair **(chairperson)**	Queen Victoria Hospital NHS FT
Dr David Supple	Clinical chair	NHS Brighton and Hove CCG
Kieran Stigant	Lay chair	NHS Coastal West Sussex CCG
Alan Kennedy	Lay chair	NHS Crawley CCG
Dr Martin Writer	Clinical chair	NHS Eastbourne, Hailsham and Seaford CCG
Dr David Warden	Clinical chair	NHS Hastings and Rother CCG

Dr Elango Vijaykumar	Clinical chair	NHS East Surrey CCG
Dr Elizabeth Gill	Clinical chair	NHS High Weald Lewes Havens CCG
Dr Minesh Patel	Clinical chair	NHS Horsham and Mid Sussex CCG
Mike Viggers	Chair	Brighton and Sussex University Hospitals NHS Trust & Western Sussex Hospitals NHS Trust
David Clayton-Smith	Chair	East Sussex Healthcare NHS Trust
Elaine Best	Chair	First Community Health and Care
Judy Oliver	Chair	Integrated Care 24
Richard Foster	Chair	South East Coast Ambulance Service NHS FT
Dr Ian McPherson	Chair	Surrey and Borders Partnership NHS FT
Alan McCarthy	Chair	Surrey and Sussex Healthcare NHS Trust
Peter Horne	Chair	Sussex Community NHS FT
Caroline Armitage	Chair	Sussex Partnership NHS FT
Cllr Daniel Yates	Chair	Brighton and Hove Health and Wellbeing Board
Cllr Keith Glazier	Leader	East Sussex County Council
Cllr David Hodge	Leader	Surrey County Council
Cllr Christine Field	Deputy leader	West Sussex County Council

Quorum

A meeting will be quorate with a minimum of five members present including at least one representative each from CCGs, providers and local authorities, or their nominated deputy.

Meeting frequency

Once every two months

Reporting responsibilities and decisions

The STP Oversight Group is a partnership meeting designed to bring system leaders together and as such does not have statutory or formal responsibilities.

Existing statutory organisations and committees (e.g. Health and Wellbeing Boards) retain their existing accountabilities and decision making remits.

Conflict of Interest:

Any actual or potential conflicts of interest must be declared.

Date terms of reference agreed: June 2017

Date terms of reference due to be reviewed: March 2018

The Workforce Race Equality Standard (WRES)

Meeting information:			
Date of Meeting:	25th July 2017	Agenda Item:	14.1
Meeting:	Trust Board	Reporting Officer:	Kim Novis/Lynette Wells

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 local black and minority ethnic (BME) populations are around 10.5% which is lower than the South East (14%) and England (17%). Eastbourne and Hastings have the highest percentage of BME groups at 13%. BME groups include: White Irish, Other White in addition to Mixed, Asian, Black, Chinese and Other groups. ESHT calculations are formulated according to the WRES technical guidance where White Irish and White Other are not included in BME calculations.

Latest figures produced by East Sussex County Council Equality and Diversity Profile for Hastings and Rother Clinical Commissioning Group in February 2017, highlight East Sussex BME populations excluding White Irish and White other to be 8.3%. Organisations are expected to be representative of the populations they serve and whilst ESHT is overall representative, there are areas within the Trust that are not.

Non-clinical roles overall are also not representative (5.5%). Some AfC pay bands in non-clinical roles remain particularly low in BME staff. The most underrepresented bands continue to be addressed through recruitment processes in the action plan.

2016/17 has seen an increase in BME staff in non-clinical bands 8a and 8d. Bands 7, 8b whilst 8c has seen a reduction in the numbers of BME staff. This is largely due to career progression of BME staff and should be viewed as a positive step towards actively becoming a representative organisation.

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

BME Staff Network (Virtually) July 2017
EDS2/WRES Steering Group 13th July 2017

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

The Board is asked to note the report as assurance that the Trust is having regard to using The Workforce Race Equality Standard (WRES) metrics and is implementing actions and or improvements where race inequality may be identified from the report. Actions seek to improve race equality in the organisation to improve staff experience, enhance patient safety care and experience.

East Sussex Healthcare NHS
NHS Trust

The Workforce Race Equality Standard (WRES)

2016/17

Contents	Page

The Workforce Race Equality Standard

1. Introduction

The Workforce Race Equality Standard (WRES) was introduced by NHS England to all NHS organisations from April 2015. WRES consists of nine metrics that can be used to help NHS organisations identify and address race inequality. East Sussex Healthcare NHS Trust (ESHT) welcomed the new standard which has provided the opportunity to demonstrate our commitment to advancing equality of opportunity for the diverse workforce it employs.

The metrics are used as a tool to help identify and close gaps between Black & Minority Ethnic (BME) and White British, White Irish and White Other (White) staff within the organisation. The standard will continue to support the Trust in becoming an inclusive organisation and meeting its legal obligations as an equal opportunities employer. It will also assist in ensuring the Trust is fulfilling its legal duties to comply with the Public Sector Equality Duty.

Along with the Refreshed Equality Delivery System (EDS2), WRES continues to assist the Trust in ensuring its workforce can be confident that the Trust is giving due regard to using the indicators (below) contained in the WRES to help ensure inequalities are identified and addressed.

The regulators, the Care Quality Commission (CQC) and NHS Improvement (NHSi) will monitor the WRES and EDS2 to help assess whether NHS organisations are inclusive and well-led.

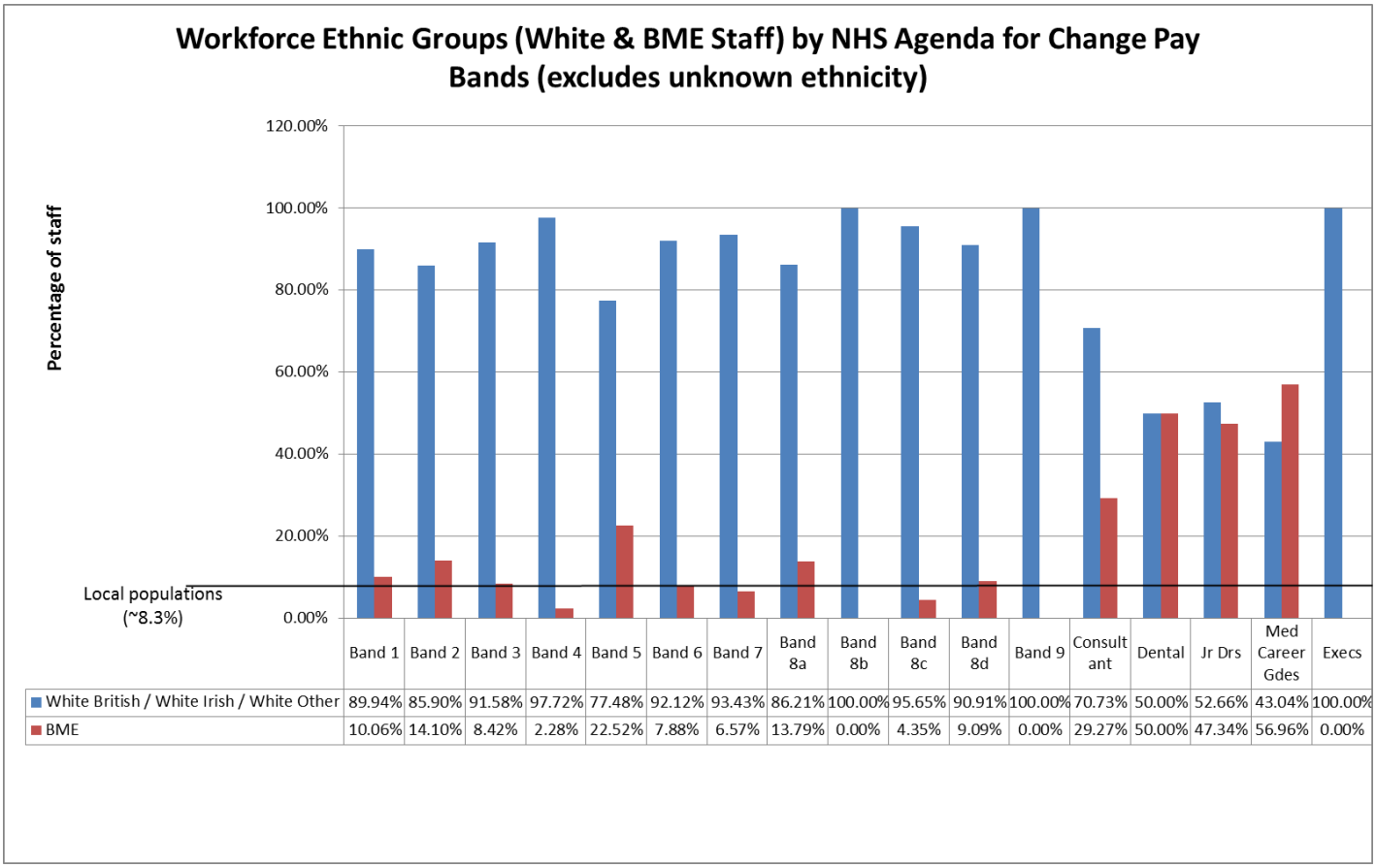
2. Data Collection and Monitoring

The first WRES report (2014/15) highlighted the importance of having processes for collecting robust data. The Trust has continued to explore ways to develop and improve data collection methods during 2015/16 and 2016/17. Data collection methods of staff attending non-mandatory training has continued to prove challenging and therefore caution must be used when forming judgements on the outcomes. The Trust plans to include reminders for managers using Trust communication methods and will continue to explore further options to improve this data risk.

Each year data is produced for the WRES metrics which are then used to identify area's that require improvement. Each metric is considered at the EDS2/WRES steering groups and leads for the action plans are identified accordingly. Through engagement with managers, the BME Staff Network and the wider staff, each action is addressed over the year.

The 2011 Census is still the most up to date information we have available to identify Ethnicity in the local areas. According to East Sussex in Figures, East Sussex "…is less ethnically diverse than the South East region or nationally" (ESiF 2012). The local black and minority ethnic (BME) populations are around 10.5% which is lower than the South East (14%) and England (17%). Eastbourne and Hastings have the highest percentage of BME groups at 13%. BME groups include: White Irish, Other White in addition to Mixed, Asian, Black, Chinese and Other groups. ESHT calculations are formulated according to the WRES technical guidance where White Irish and White Other are not included in BME calculations.

Latest figures produced by East Sussex County Council Equality and Diversity Profile for Hastings and Rother Clinical Commissioning Group in February 2017, highlight East Sussex BME populations excluding White Irish and White other to be 8.3%. Organisations are expected to be representative of the populations they serve and whilst ESHT is overall representative, there are areas within the Trust that are not. These are highlighted in the graph below. These underrepresented bands are further separated by Clinical and non-clinical positions in metric 1. The most underrepresented bands continue to be addressed through recruitment processes, refer to item 6 below.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	Consultant	Dental	Jr Drs	Med Career Gdes	Execs
White British / White Irish / White Other	89.94%	85.90%	91.58%	97.72%	77.48%	92.12%	93.43%	86.21%	100.00%	95.65%	90.91%	100.00%	70.73%	50.00%	52.66%	43.04%	100.00%
BME	10.06%	14.10%	8.42%	2.28%	22.52%	7.88%	6.57%	13.79%	0.00%	4.35%	9.09%	0.00%	29.27%	50.00%	47.34%	56.96%	0.00%

3. Progress from 2015/16 to 2016/17

2016/17 has seen a great amount of development and improvements for staff across the Trust. During 2016/17 East Sussex Healthcare NHS Trust BME Staff Network met for the first time and has continued to meet bi-monthly thereafter. Membership has increased month on month promoting equality across the organisation.

To support the Trust in meeting its legal obligations the Trust has 4 Equality Objectives including ensuring senior BME recruitment remains fair ensuring the Trust continues to be representative of the population it serves. The Trust Equality Objectives were developed using the EDS2 and the WRES indicators. The full document and progress report can be accessed on the Trust website.

2016/17 has seen an increase in BME staff in non-clinical bands 8a and 8d. Bands 7, 8b and 8c have seen a reduction in the numbers of BME staff. This is largely due to career progression of BME staff and should be viewed as a positive step towards actively becoming a representative organisation.

Clinical Bands 1, 2, 4, 5, 8a and dental have increased BME staff. Career grade staff is the only clinical group to have seen a reduction in BME staff. 61.18% of Career grade staff in 2015/16 identified as BME, 2016/17 was 56.96%.

47.34% (figure excludes unknown ethnicity) of Junior doctors (Foundation years 1 and 2) in 2016/17 identified as BME. This is a slight (1.73%) drop from 2015/16. Of the 2015/16 cohort, 13.6% of junior doctors' ethnicity was unknown. This increased significantly in 2016/17 to 33.73%. Including unknown ethnicity alters the percentage significantly to 31.37% identifying as BME; 34.90% identifying as White; and 31.37% ethnicity was Unknown or not stated. Junior doctors do not participate in face to face Equality training and rarely attended the BME Network. Further investigation is required to gain an understanding of how these issues may be addressed for future junior doctors.

4. Highlights of 2016/17

- ESHT Leadership Development and Talent Management Strategy with objectives to embrace diversity including diversity of thought.
- The first BME Staff Network meeting, Chaired by the Chief Executive, took place to develop the Terms of Reference.
- The Equality & Human Rights Lead provided leadership to the BME Network supporting staff with concerns and promoting inclusivity
- The Staff Engagement & Wellbeing Programme Lead supported Network meetings to promote opportunities, career development and staff wellbeing
- Policy groups, individuals and managers engaged with the BME Network when developing relevant policies and procedural documents.
- Cultural Support Workshops continued to be delivered to support overseas doctors with their written and spoken English language skills. The workshops encouraged looking at different backgrounds and sharing cultures.
- Recruitment of many overseas nurses, destinations included the Philippines, Spain and Italy.
- Welcome BBQ's were held for new staff recruited from overseas.

5. Workforce Race Equality Standard Metrics 2016/17

Workforce metrics
For each of these four workforce indicators, the Standard compares the metrics for white and BME staff.

1. **Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce**

Note: Organisations should undertake this calculation separately for non-clinical and for clinical staff

- **76.37% of all staff identified as White British or White Other**
- **12.32% of all staff identified as BME**
- **11.31% of staff's ethnicity was unknown and are excluded from calculations.**

Clinical & Non-clinical

- 17.75% of all clinical staff identified as BME
- 82.25% of all clinical staff identified as White British, White Irish or White Other

- 5.50% of all non-clinical staff identified as BME
- 94.50% of all non-clinical staff identified as White British, White Irish or White Other

Percentage of BME and White staff in each clinical and non-clinical pay band

	Non-Clinical			Clinical		
Band	White %	BME %	BME % 15/16	White %	BME %	BME % 15/16
Band 1	89.51	10.49	11.95	94.12	5.88	3.45
Band 2	94.01	5.99	6.87	76.82	23.18	13.5
Band 3	95.03	4.97	4.12	89.6	10.4	10.95
Band 4	98.70	1.30	1.64	95.38	4.62	3.51
Band 5	95.57	4.43	2.92	74.47	25.53	23.32
Band 6	97.30	2.70	2.44	91.69	8.31	7.99
Band 7	98.33	1.67	4.08	92.86	7.14	6.21
Band 8a	88.46	11.54	7.69	84.95	15.05	10.98
Band 8b	100.00	0	6.25	100	0	0
Band 8c	100.00	0	8.33	92.31	7.69	9.09
Band 8d	90.91	9.09	0	0	0	0
Band 9				100	0	NA
Consultant				70.73	29.27	28.11
Dental				50	50	25
Jr Drs				52.66	47.34	49.07
Career Grade				43.04	56.96	61.18
Snr Mgr	100	0	0	100	0	0
Total	**94.50**	**5.50**	**5.79**	**82.25**	**17.75**	**16.5**

2.	**Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.**
	2016/17 The relative likelihood of white staff being appointed from shortlisting compared to BME staff is 1.02 times greater. **2015/16** The relative likelihood of white staff being appointed from shortlisting compared to BME staff was 1.67 times greater. The 2015/16 data indicated there was an inconsistency in the numbers of BME staff shortlisted in relation to the overall applicants and therefore HR investigated this to establish if there was any unfair practice within the recruitment process. The data indicated that the BME representation at the application stage of the recruitment and selection process is within normal expectation. This representation at shortlisting stage reduces due to non EU applicants being excluded for some posts as they are not in shortage categories and would not be entitled to apply for a certificate of sponsorship. The data indicates that despite the representation of BME applicants increasing at interview stage up to 30%, the BME representation at offer stage reduces by 5% for total Trust recruitment assignments and by 20% for Band 8a and above. The white representation at the offer stage for Band 8a and above is over 90%. (The full report submitted to the People, Organisation and Development Committee can be found in the appendices.)
3.	**Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*** ***Note: this indicator will be based on data from a two year rolling average of the current year and the previous year**
	2015/16 – 2016/17 Staff identified as BME were 1.46 times more likely to enter the formal disciplinary process compared to staff identified as White British, White Irish or White other.
4.	**Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff**
	Available figures demonstrate White staff were 1.95 times more likely to access non-mandatory training compared to BME staff. Note: Caution must be taken when forming judgments on data for those accessing non-mandatory training due to how these data are captured. Line managers often block book places on conferences and university workshops, the booking forms require a line manager's name plus the number of attendees and not necessarily individual names. Therefore identifying members of staff who have attended these non-mandatory training events has proved challenging. Where staff have been identified this has been reported. Improvements to how these data will be collected are currently under review.

National NHS Staff Survey findings For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for white and BME staff	
5.	**KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**
	2016/17 results ❖ 29.18% of White respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. ❖ 34.02% of BME respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. **2015/16 results** ❖ 32.05% of White respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. ❖ 34.04% of BME respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6.	**KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**
	2016/17 results ❖ 26.76% of White respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. ❖ 29.46% of BME respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. **2015/16 results** ❖ 31.51% of White respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. ❖ 34.04% of BME respondents reported experiencing harassment, bullying or abuse from staff in last 12 months.
7.	**KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion**
	2016/17 results ❖ 87.84% of White respondents believed they were provided with equal opportunities for career progression or promotion. ❖ 75.21% of BME respondents believed they were provided with equal opportunities for career progression or promotion. **2015/16 results** ❖ 84.89% of White respondents believed they were provided with equal opportunities for career progression or promotion. ❖ 63.7% of BME respondents believed they were provided with equal opportunities for career progression or promotion.

8.	**Q 17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues**
	2016/17 results ❖ 7.0% White of White staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. ❖ 12.5% of BME staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. **2015/16 results** ❖ 7.8% of White staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. ❖ 10.92% of BME staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background.
Boards Does the Board meet the requirement on Board membership in 9?	
9.	**Percentage difference between the organisations' Board voting membership and its overall workforce**
	All voting members of ESHT Trust Board identify as White British or White other. Vacancies for Trust Board positions are widely advertised and communicated to the NHS BME Network. No applicants identified as BME for ESHT Trust Board positions in 2015/16 and 2016/17. In 2016/17 the Percentage difference between the organisations' Board voting membership and its overall workforce was 12.3% In 2015/16 the Percentage difference between the organisations' Board voting membership and its overall workforce was 13.4%

6. National NHS Staff Survey findings

The Key Findings (KF) 25, 26, 21 and Q17 are questions specific for helping identify race inequality in the NHS workforce. The figures show minor movement which suggest the change is not statistically relevant. The findings were considered when developing the action plan to enhance career progression. Trust wide initiatives are in place to reduce bullying and harassment and are included in the 'ESHT BME Staff Network Terms or Reference'.

Actions for 2017/18

Ensure recruitment practices are reflective of best practice

- Promote BME recruitment with key stakeholders
- Ensure all involved in recruitment and selection have received training in 'Equality & Diversity' and 'Recruitment & Selection'.
- Further study to be carried out to examine the reduction in representation of BME candidates from interview to offer stage by staff group.
- Band 8a and above recruitment assignments to be specifically recorded to identify BME representation for specific roles and at each stage of the selection process.
- Good news examples of BME candidates who have been successful within the Trust-'A day in the Life of' to positively promote BME candidates and encourage them to apply for posts.
- Identify a cohort of BME colleagues who could be present at panel interview for B8 and above. These candidates would be alerted to forthcoming interviews and requested to attend in the first instance. Additional training would be provided to increase the number of BME representatives at panel.
- To engage with the BME network to identify barriers to increasing BME representation in the recruitment and selection process.
- Develop plan to implement actions and measure outcomes.

Improve non-mandatory training uptake data, monitoring and collection processes

- Ensure all managers record all staff completing non-mandatory training and send to Learning & Development to be recorded on staff records.
- Ensure staff are informing their managers and Learning & Development of internal and external courses attended.

Promote the Staff BME Network

- Collaborate with the NHS BME Network to ensure ESHT BME Network operates to its full potential.
- Ensure new staff are informed of the network meeting dates.
- Ensure managers are supporting staff to attend network meetings.
- Facilitate internal events to promote the network.

Celebrate Black History Month

- Provide coaching opportunities for BME staff to develop presentation skills to demonstrate their new skills during Black History Month.
- Invite external inspiring people to deliver talks during Black History Month.

Eliminate racial discrimination and advance equal opportunity in the workplace

- Ensure all managers complete Equality & Diversity training.
- Where reports of discrimination are identified; explore options for additional training to encourage, promote and maintain a safe and positive working environment for BME staff.
- Provide a Network where BME staff can share experience and issues affecting their work and professional development.
- Be proactive in the elimination of racial discrimination.
- Promote and support inclusive leadership,
- Raise the profile of the contribution that BME staff members make to ESHT.
- Offer support and encouragement to underrepresented areas of the Trust.
- Engage with other groups, including other internal and external staff networks, trade unions, employer associations and community groups who share a common agenda
- Include BME staff in the development of relevant policies and decision making processes.
- Identify and share training and development opportunities.

7. Conclusion

There has been good progress over the last year to strengthen workforce race equality. There is always more that can be done and as outlined in the actions above there is a commitment to build and develop existing good practice.

This Report is available in alternative formats upon request. Alternative formats include (but not limited to) Large Print, Braille, Audio, Alternative Community Languages. Please contact the Equality, Diversity & Human Rights Team by emailing esh-tr.equality@nhs.net or Telephone 01424 755255.

Appendix A BME RECRUITMENT PAPER

BME Recruitment

Meeting information:			
Date of Meeting:	30th March 2017	Agenda Item: BME Recruitment	
Meeting:	People & OD Committee	Reporting Officer: Greig Woodfield	

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? No	

Executive Summary:

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

The Trust is committed to ensuring a fair and objective selection process when recruiting to posts within the Trust. This is to ensure that the Trust maximises the number of applicants with the appropriate qualifications, values and behaviours. The Trust is also committed to recruiting a diverse workforce that reflects the needs of the patients and clients to whom we deliver health care services.

The data presented in the WRES indicated that there is inconsistency in the numbers of BME staff shortlisted in relation to the overall applicants and the POD asked for this to be investigated to establish if there was any direct or indirect discriminatory practice within the recruitment process.

The data indicates that the BME representation at the application stage of the recruitment and selection process is within normal expectation.

This representation at shortlisting stage reduces due to non EU applicants being excluded for some posts as they are not in shortage categories and would not be entitled to apply for a certificate of sponsorship.

The data indicates that despite the representation of BME applicants increasing at interview stage up to 30%, the BME representation at offer stage reduces by 5% for total Trust recruitment assignments and by 20% for Band 8a and above. The white representation at the offer stage for Band 8a and above is over 90%.

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

None

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

The following actions have been identified to support the increase in BME representation at all stages of the recruitment and selection process. The POD is asked to review and support the actions.

- Promote BME recruitment with key stakeholders
- Ensure all involved in recruitment and selection have received training in equality and diversity and recruitment and selection.
- Further study to be carried out to examine the reduction in representation of BME candidates from interview to offer stage by staff group.
- Band 8a and above recruitment assignments to be specifically recorded to identify BME representation for specific roles and at each stage of the selection process.
- Good news examples of BME candidates who have been successful within the Trust - 'A day in the Life of' to positively promote BME candidates and encourage them to apply for posts.
- Identify a cohort of BME colleagues who could be present at panel interview for B8 and above. These candidates would be alerted to forthcoming interviews and requested to attend in the first instance. Additional training would be provided to increase the number of BME representatives at panel.
- To engage with the BME network to identify barriers to increasing BME representation in the recruitment and selection process.
- Develop an action plan to support the implementation of the actions and measure the effectiveness.

Recruitment of BME Applicants
Background

The Trust is committed to ensuring a fair and objective selection process when recruiting to posts within the Trust. This is to ensure that the Trust maximises the number of applicants with the best qualifications and the appropriate values and behaviours. The Trust is also committed to recruiting a diverse workforce to reflect the needs of the patients and clients to whom we deliver health care services.

The data presented in the WRES indicated that there is inconsistency in the numbers of BME staff shortlisted in relation to the overall applicants and the POD asked for this to be investigated to establish if there was any direct or indirect discriminatory practice within the recruitment process.

Recruitment Process

Roles are advertised using NHS Jobs and appropriate media. All applicants apply via the on line recruitment tool TRAC. Applicant details (name, ethnic origin, DOB, address and specific disability) are anonymised in the shortlisting process to avoid direct discrimination. Once applicants have been shortlisted and then ranked on scoring, the relevant number of applicants are then invited for interview, it is at this stage that the biographical data becomes visible.

Recruitment Data

All Posts recruited to in the last six months.

	Applicants	% of total	Shortlisting	% of total	Interview	% of total	Offer	% of total
White	16072	74.90	9658	76.30	3453	69.80	2141	74.10
BME	5384	25.10	3001	23.70	1500	30.20	750	25.90
Total	21458		12659		4953		2891	

This data would suggest that the percentage of BME applicants is within the expected norms for East Sussex. The percentage of BME applicants successful at shortlisting does reduce against the percentage presented at application stage. A higher percentage of BME applicants are represented at the interview stage however at offer stage the BME representation reduces.

The reduced representation of applicants at the shortlisting stage is explained by EU nationals being favoured over international candidates as international candidates have to obtain certificates of sponsorship and visas that increase the time to hire and this is visible at the shortlisting stage.

The representation of BME applicants at the interview stage is higher than at applicant and shortlisting stage, however the representation at offer stage could suggest that some bias and discriminatory practises are present in the interview process.

Appointment of BME staff at Band 8a and above

The representation of BME staff employed at Band 8 and above is below that of other grades in the Trust. The information below details the recruitment activity to these posts in the last 6 months

	Applicants	% of total	Shortlisting	% of total	Interview	% of total	Offer	% of total
White	345	76.33	158	79.00	20	66.60	15	93.75
BME	107	23.67	42	21.00	8	26.60	0	0.00
DNWD*	**		**		2	6.60	1	6.25
Total	452		200		30		16	

**Do not want to declare D did not declare (potentially BME)*

*** Not statistically relevant at this stage*

Whilst the representation of BME staff is broadly in line with the Trust average at applicant and shortlisting stage, and the BME representation follows the trust overall trend at interview stage, the representation markedly falls at the offer stage.

Whilst the totals at this stage are small it is significant that there are no declared BME applicants receiving offers. This could indicate a level of bias and discrimination at the offer stage.

BME B8 and above interview panel representation

Currently there is no recording of BME representation on interview panels for B8 posts and above. The Trust actively encourages BME colleagues to be present at interview but there is no formalised process to ensure that they are actually represented.

Key Issues

The key issue is that the data indicates that BME staff are under represented at the applicant offer stage compared to the representation at other stages of the recruitment process. Overt and unconscious bias could exist in the selection process. BME representation on interviews panels for Band 8 is inconsistent and not recorded centrally.

Actions

- Promote BME recruitment with key stakeholders
- Ensure all involved in recruitment and selection have received training in equality and diversity and recruitment and selection.
- Further study to be carried out to examine the reduction in representation of BME candidates from interview to offer stage by staff group.
- Band 8a and above recruitment assignments to be specifically recorded to identify BME representation for specific roles and at each stage of the selection process.
- Good news examples of BME candidates who have been successful within the Trust-'A day in the Life of' to positively promote BME candidates and encourage them to apply for posts.
- Identify a cohort of BME colleagues who could be present at panel interview for B8 and above. These candidates would be alerted to forthcoming interviews and requested to attend in the first instance. Additional training would be provided to increase the number of BME representatives at panel.
- To engage with the BME network to identify barriers to increasing BME representation in the recruitment and selection process.
- Develop plan to implement actions and measure outcomes.

Conclusion

The POD is asked to note the content of this report and approve the actions to increase representation of BME staff through the recruitment and selection process.

Organ Donation Annual Report

Meeting information:			
Date of Meeting:	25 July 2017	Agenda Item:	14L
Meeting:	Trust Board	Reporting Officer:	David Walker, Medical Director

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

The attached executive summary provides an overview of organ donor activity for the year ended 31 March 2017. There were 14 potential DBD (donation after brain death) donors with suspected neurological death and 5 proceeded to donation. There were 25 eligible DCD (donation after circulatory death) donors and 4 proceeded to donation. The outcomes were classified nationally as acceptable levels.

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

Quality and Safety Committee July 17

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

The Board is asked to note the organ donor activity and also to place on record their thanks to Dr Goswami for his continued leadership of organ donation in the Trust.

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**

Executive Summary
Actual and Potential Organ Donors
1 April 2016 - 31 March 2017

NHS Blood and Transplant

East Sussex Healthcare NHS Trust

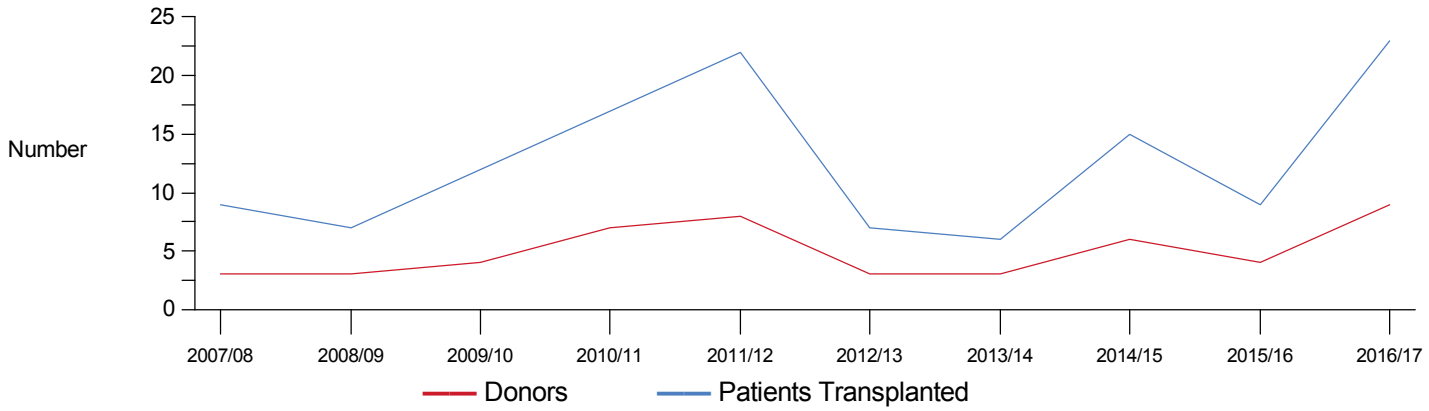
Donor outcomes

Between 1 April 2016 and 31 March 2017, your Trust had 9 deceased solid organ donors, resulting in 23 patients receiving a transplant. Further details are provided in the table and chart below. If you would like further information, please contact your local Specialist Nurse - Organ Donation (SN-OD).

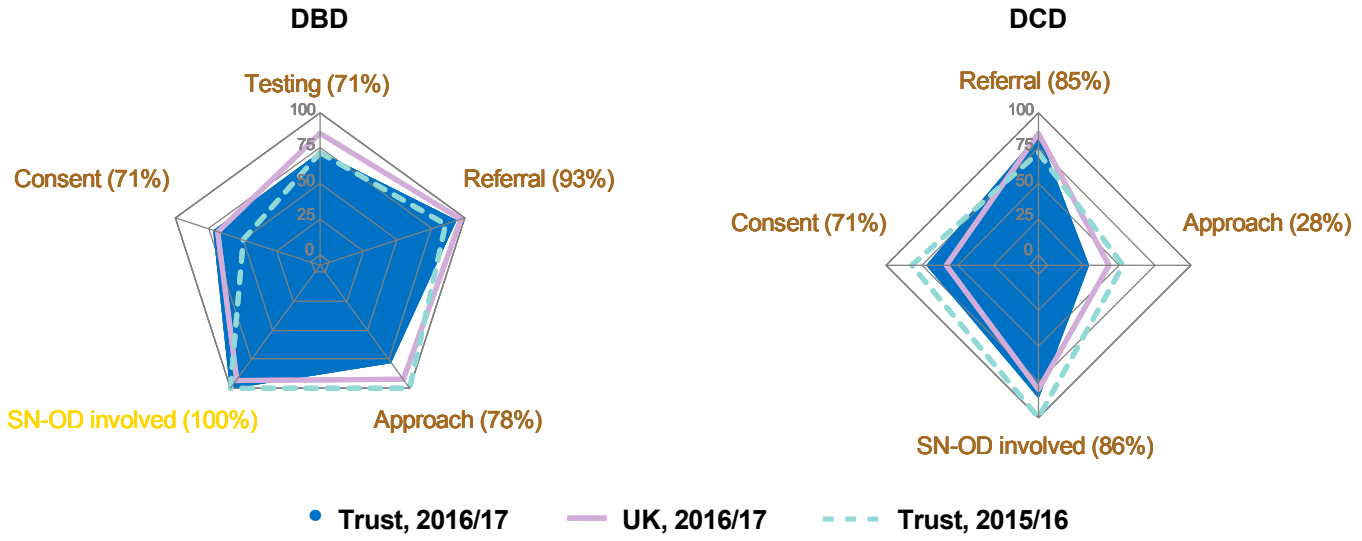
Donors, patients transplanted and organs per donor, 1 April 2016 - 31 March 2017 (1 April 2015 - 31 March 2016 for comparison)

	Number of donors		Number of patients transplanted		Average number of organs donated per donor Trust		UK	
Deceased donors	9	(4)	23	(9)	3.3	(3.3)	3.4	(3.4)

Number of donors and patients transplanted each year



Radar charts of key rates, 1 April 2016 to 31 March 2017



The blue shaded area represents your Trust's rates for 2016/17. The latest UK rates and your Trust's rates for the equivalent period in the previous year are superimposed for comparison. The fuller the blue shaded area the better. The colour of the rate label on each of the radar charts indicates the Trust performance as shown in the appropriate funnel plot (included in the detailed report) using the gold, silver, bronze, amber, and red (GoSBAR) scheme. Additionally, the funnel plots in the detailed report can be used to identify the maximum rates currently being achieved by Trusts with similar donor potential.

Key numbers and rates

There are nine measures on the Potential Donor Audit (PDA) which are most likely to affect the conversion of potential donors into actual donors. A comparison against funnel plot boundaries has been applied by highlighting the key rates for your Trust as gold, silver, bronze, amber, or red. Funnel plots can be found in the detailed report. Between 1 April 2016 and 31 March 2017, your Trust met a statistically acceptable level in all of these measures. Of the 14 potential DBD donors with suspected neurological death, 5 proceeded to donation and 9 did not proceed. Of the 25 eligible DCD donors, 4 proceeded to donation and 21 did not proceed. Further details are provided below. Caution should be applied when interpreting percentages based on small numbers.

	DBD					DCD				
		2016/17		2015/16			2016/17		2015/16	
	Target	Trust	UK	Trust	UK	Target	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]		14	1,775	7	1,747		33	6,204	36	6,500
Referred to SN-OD		13	1,728	6	1,684		28	5,308	26	5,402
Referral rate %		B *93%*	*97%*	*86%*	*96%*		B *85%*	*86%*	*72%*	*83%*
Neurological death tested		10	1,522	5	1,477					
Testing rate %		B *71%*	*86%*	*71%*	*85%*					
Eligible donors[2]		9	1,444	4	1,404		25	4,237	21	4,205
Family approached		7	1,329	4	1,296		7	1,815	11	1,942
Approach rate %		B *78%*	*92%*	*100%*	*92%*		B *28%*	*43%*	*52%*	*46%*
Family approached and SN-OD involved		7	1,236	4	1,180		6	1,460	11	1,511
% of approaches where SN-OD involved		G *100%*	*93%*	*100%*	*91%*		B *86%*	*80%*	*100%*	*78%*
Consent ascertained		5	917	2	891		5	1,055	9	1,113
Consent rate %	*72%*	B *71%*	*69%*	*50%*	*69%*	*68%*	B *71%*	*58%*	*82%*	*57%*
Expected consents based on ethnic mix		4		3			4		7	
Expected consent rate based on ethnic mix %		*74%*		*74%*			*57%*		*61%*	
Actual donors from each pathway		5	819	1	786		4	565	3	564
% of consented donors that became actual donors		*100%*	*89%*	*50%*	*88%*		*80%*	*54%*	*33%*	*51%*
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

Further Information

- A detailed report for your Trust accompanies this Executive Summary, which also contains definitions of terms, abbreviations, table and figure descriptions, targets and tolerances, and details of the main changes made to the PDA on 1 April 2013.
- The latest Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report is available at http://www.odt.nhs.uk/odt/potential-donor-audit/
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SN-OD).

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2017 based on data reported at 8 May 2017.

Complaints Annual Report

Meeting information:			
Date of Meeting:	25th July 2017	Agenda Item:	14.3
Meeting:	Trust Board	Reporting Officer:	Sharon Gardner-Blatch

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 Complaints Annual report provides an overview of progress and activity during 2016/17. This document is also required for the Quality Account process.

Significant improvements have been achieved during the year with the actual complaints process reducing the backlog of overdue complaints.
The total number of complaints reported per month has also reduced from the previous year.

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

Patient Experience Steering Group - Discussed on 11th May 2017 and sent to group for comment on Tuesday 16th May.

Approved by Quality and Safety Committee in May 17.

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

To review and approve the report.

East Sussex Healthcare NHS Trust

Complaints and Patient Advice and Liaison (PALs)

Annual Report 2016-2017

Contents

1.0 Introduction

This annual report provides an overview of the complaints and feedback the Trust received from patients, relatives, carers and service users for the period of 1st April 2016 to 31st March 2017.

Around 525,000 people live in East Sussex and we are one of the largest organisations in the country. We employ around 6,800 dedicated staff with an annual turnover of £379 million.

In 2016/17:

- Over 78,000 patients used our emergency departments.
- More than 145,000 people attended an outpatient appointment.
- 3144 women became mothers by delivering 3182 babies.
- 85.39% of the 54,422 patients undergoing elective surgery had their operations as day cases and returned home on the same day.
- In 2016/17 there were 54,422 elective primary procedures carried out. Of which, 46,470 were undertaken as day case.
- Our community nurses supported 15,870 patients.
- We performed almost 290,000 radiological examinations and therapeutic procedures.
- Nearly 6.5 million pathology tests were carried out.

We operate two district general hospitals, Conquest Hospital (the Conquest) and Eastbourne District General Hospital (EDGH), both of which have Emergency Departments and provide care 24 hours a day. At Bexhill Hospital we provide outpatients, day surgery, rehabilitation and intermediate care services. Outpatient services are also provided at Rye, Winchelsea and District Memorial Hospital. Our community staff also provides care in the patient's own home and from a number of clinics and GP surgeries.

The role of East Sussex Healthcare NHS Trust is to provide the best possible healthcare service to patients, who come first in everything the organisation does.

We work in partnership with commissioners, other providers, our staff and volunteers as part of a locally focused and integrated network of health and social care in the county.

More than ever what people tell us about the way in which we care for them and their families is crucial to ensure that we learn from our practices and continuously

improve the quality of our service provision. Patient care is at the heart of what we do and the Trust openly encourages both positive and negative feedback from our patients, their families and carers and the public.

In the vast majority of cases patients, relatives and carers are satisfied with the care, treatment and service they receive. On the occasions where a patient, relative or carer is dissatisfied, it is important that they feel comfortable in raising their concerns so that the Trust can resolve any misunderstandings or, if failings have occurred, ensure that learning and improvements take place.

A complaint may be defined as an expression of dissatisfaction with the service provided (or not provided) or the circumstances associated with its provision which requires an investigation and a formal response in order to promote resolution between parties concerned.

The Trust actively encourages staff closest to the point of care to deal with concerns and problems quickly as they arise, ensuring a professionalised response with consideration of individual needs and circumstances.

The Patient Advice and Liaison Service (PALs) is available to provide confidential advice and support to any patient, relative or carer who may not feel comfortable raising their concern with the service directly, or where they have done so but feel their concern remains unresolved. PALs aim to resolve any concerns that are raised with them quickly and informally. Such timely intervention can prevent complaints or concerns escalating, achieving a more satisfactory outcome for all involved. The Trust's approach to handling complaints is based on the "Principles of good complaints handling" published by the Parliamentary and Health Service Ombudsman in 2008.

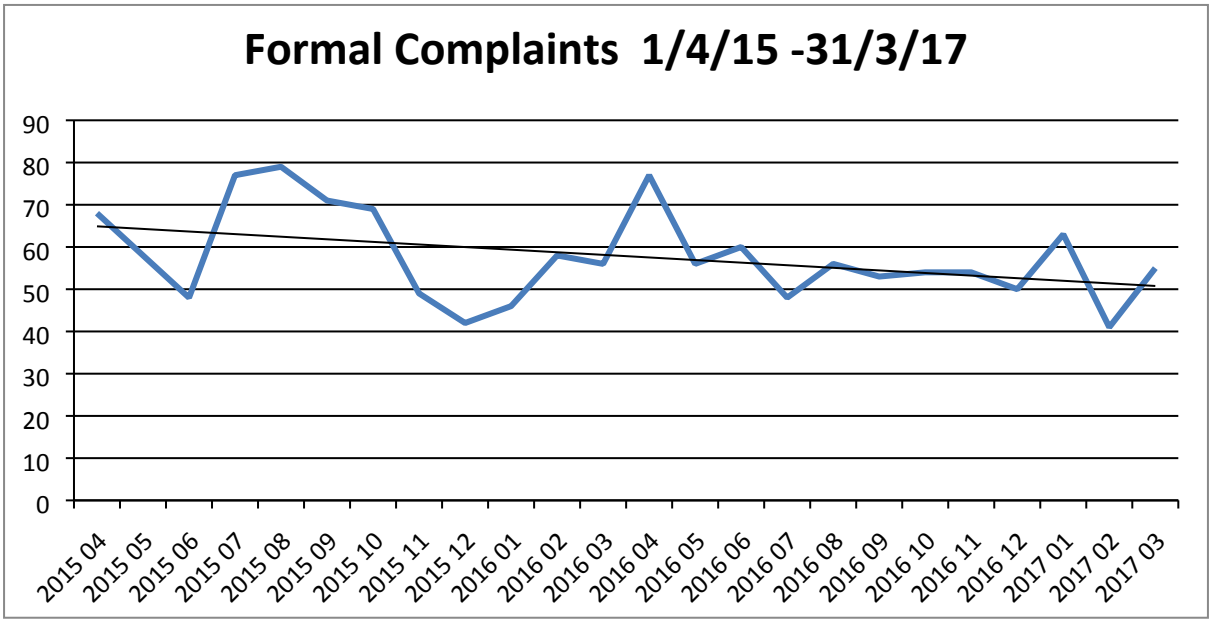
In addition to the valuable learning and improvements that result from individual concerns or complaints, complaints data is analysed to identify themes and the data generated is shared accordingly.

Regular reporting regarding complaints are shared and discussed at the Trust's Quality and Safety Committee and Patient Experience Steering Group (PESG). The purpose of this is to:

- Provide assurance to the Board and public that the Trust robustly follows its Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (4C approach).
- Demonstrate that data from complaints and lessons learnt can provide intelligence for continuously driving improvements in patient care/ experience.
- Set recommendations and devise action plans for areas requiring improvement.

2.0 Complaints

The number of formal complaints received by the Trust has reduced in 2016/17 (664) compared to 2015/16 (680) which is a 2.5% reduction. The run chart below shows a reducing trend over the last 3 years.



2.1 Complaint process

The number of overdue complaints recorded in April 2016 was 63, some nearing 100 days overdue. The complaints team reviewed and altered the complaints process to reduce the number of overdue complaints to reduce the delay in responding and achieve the agreed timescales. The revised process provides greater clarity for clinicians on investigating points raised by complainant, streamlining the investigation and drafting of the complaint response.

The complaints team now triage all complaints, request health records, identify the issues raised and forward to the Head of Nursing for each Division who identifies a lead investigator. Once the statements have been gathered and the investigation complete, it is then returned to the complaints department for drafting the response before returning to the Division for approval prior to review and signing by the Chief Executive.

There is also a clear escalation process in place if the complaints team do not get a response from the Divisions in an appropriate timescale.

To monitor progress and improvements of changes a number of Key Performance Indicators (KPI) were set for the complaints team and reported on weekly. Some of which are listed below:

KPI description	Progress
Number of formal complaints received in the month.	Showing a steady downward trend.
Total number of complaints overdue.	April 2016 total number overdue 63, March 2017 total number overdue 13.
Number of complaint responses sent for signing per month.	Apart from October 2016, every month more complaints have been sent for signing than new complaints received.
Number of re-opened complaints.	April 2016 = 5 however did spike in August 2016= 16 but has started to take a downward trend back to 6 in March 2017.
Number of open complaints.	This has reduced from 136 (April 2016) to 104 (March 2017).
Number of complaints fully upheld by PHSO.	2 cases fully upheld (4 cases partially upheld).

At the end of March 2017 the changes and improvements made by the Trust has enabled the complaints backlog to reduce to 13 overdue with 104 open complaints currently in the system at the time of writing this report.

Of the complaints received in 2016/2017, 21.1% were upheld, 37.5% partially upheld, 23.3% not upheld and 18.1% outcome not recorded. Partially upheld means that the complaint investigation identified areas for improvement, but the primary complaint was not upheld. There were 104 open complaints at the end of March 2017, this will account for the majority of the 18.1% complaints that do not have an outcome assigned to them (the investigations will not have been finalised yet). Additionally, the complaints team review those with outcomes not recorded on a monthly basis to ensure each complaint has an outcome assigned on Datix.

In 2016/17, 131 complaints were re-opened compared 106 in 2015/2016; we only re-open a complaint if the complainant is not happy with the Trust's response to their original complaint and either ask for the original issues to be re-investigated or want a meeting to seek the answers they are looking for.

The Complaints Team will continue to explore options for reducing the number of re-opened complaints; this is being explored through the post complaint survey. In the first instance we have been requesting telephone numbers from complainants so a call can be made to further clarify the concerns raised and what the complainant would like as an outcome.

2.2 Post complaint survey (feedback on our complaint service)

Following recommendations from Healthwatch East Sussex and the Trust Internal Audit Programme was to obtain feedback on the complaints process from complainants. The Complaints and PALs Manager developed a post complaints survey in consultation with the Patient Experience Steering Group (PESG).

This survey commenced in September 2016 and has a response rate of 40.3% (56 responses out of 139 surveys sent).

The top three questions we had good results on were for the following:

- I was able to communicate my concerns in the way that I wanted;
- I was satisfied with how quickly the Trust acknowledged my complaint;
- I was able to understand the response as everything was clearly explained, including names and terminology.

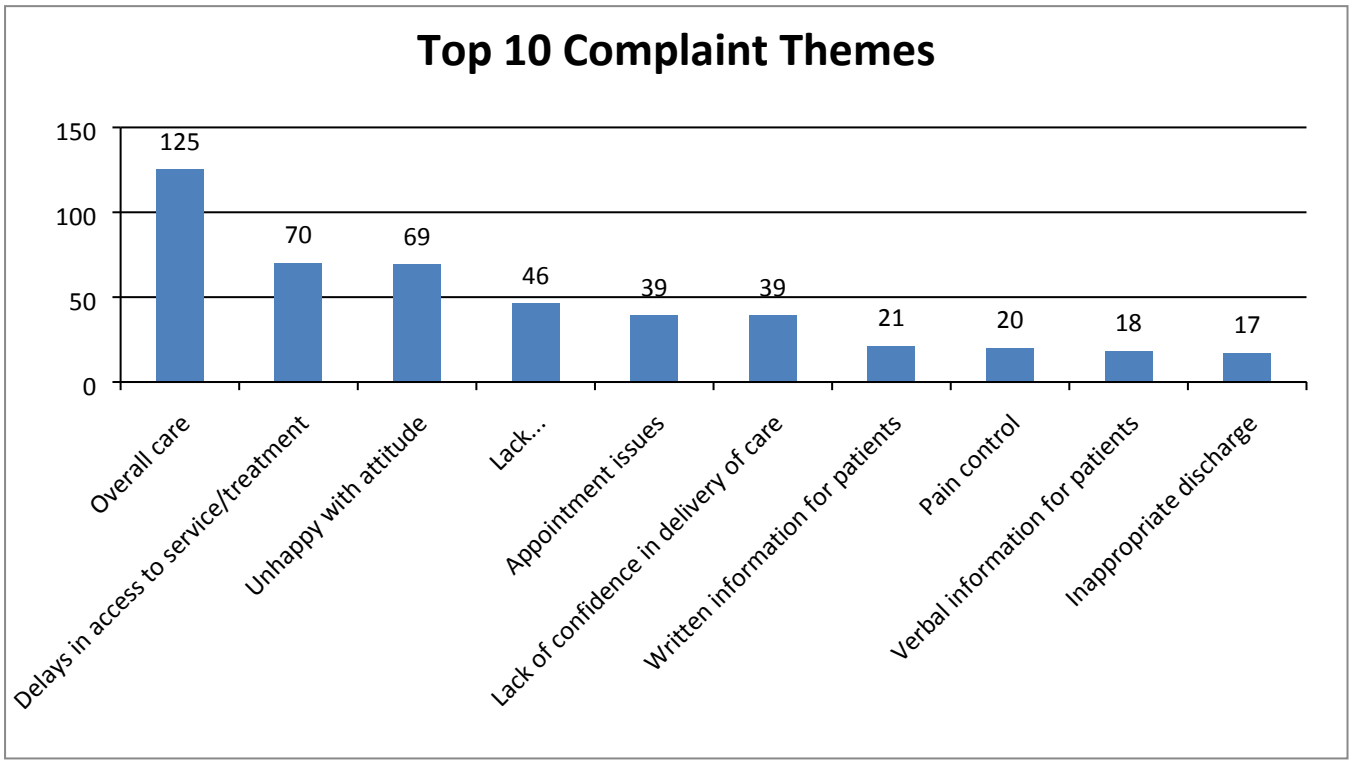
The top three questions we had poor results from are the following:

Question	Action to improve
I felt the Trust understood my concerns and what I wanted from raising a complaint.	By requesting telephone numbers from complainants we hope to be able to clarify with the complainant the concerns raised.
I felt the response answered all of the concerns I had raised.	Deep Dive sessions are being held to randomly review complaints; part of this is to ensure all points have been answered fully; also clarifying with complainants by telephone the concerns raised may help to improve this response. The number of re-opened complaints would also indicate if we are improving on this.
I felt assured that the Trust would learn from my experience.	All complaint responses are currently being reviewed by the Patient Experience Lead to ensure lessons learnt and any actions are identified, recorded and monitored. Divisions will be met with regularly to provide feedback on the learning and support them to provide better actions and learning within the complaint responses.

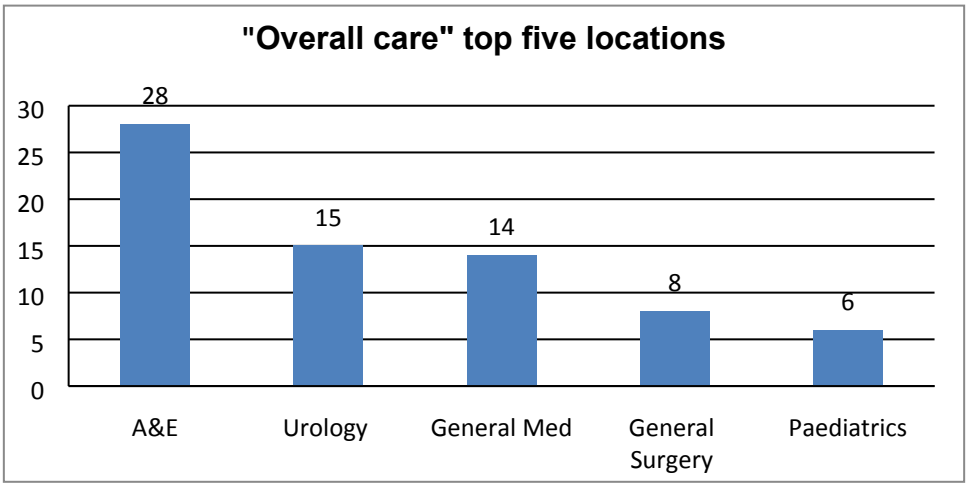
The number of complaints responded to within the locally agreed timescales has significantly improved during 2016/17 and would hope this more timely response should improve the satisfaction score.

2.3 Learning from Complaints

All complaints are assigned subjects. A single complaint can have a number of subjects assigned based on the concerns/issues raised. The chart below identifies the most common subjects assigned in 2016/17.



The most common subject assigned in 2016/17 was overall care; the table below breaks this down by area.



The complaints categorised as overall care cover a variety of issues such as patient discharge concerns, delay in referrals, communication and concerns around treatment and decisions on treatment.

2.4 Complaints actions and learning

2015/16 Communication was the highest recorded theme for complaints (total 197= 31%), this is an 18% decrease in complaints reporting “communication” as the primary subject of the complaint. During 2016/17 Duty of Candour training has taken place, patient stories via DVD have been shown at training events and Clinical Administration have revised letters patients receive and amended the appointment booking system. An automated call reminder services has been introduced for outpatient appointments, for those patients aged 70 years and older agents make the calls. The central booking team at Conquest Hospital has been designed into speciality with an increase in supervisory/ management support.

We have developed a new quality audit spot check for Accident and Emergency that includes asking the patient if they feel their pain is not being managed and allows the staff auditing to act immediately if the patient feels pain not managed effectively.

We are reviewing the information provided to patients on admission with the aim to design a standard document across the trust. This will hopefully assist in improving some of the communication issues.

During 2016/17 all identified actions from a complaint have been added to the actions system in Datix Risk Management Software to enable us to ensure the actions are tracked and subsequently completed. However further work is required to ensure these actions are robust, completed and embedded into practice. The Patient Experience Lead reviews all closed complaints to identify actions and record on Datix. These will be shared with those responsible to ensure the actions are then completed and learning recorded on Datix. Some actions will be randomly selected to ensure they are embedded in practice through closing the loop.

2016/2017 saw the first “Complaints Deep Dive” .This involved randomly selecting twenty complaints files relating to the Division, reviewing the process, looking at themes and considering how we can address these. This process enabled some rich data to be identified and shared with the Division. Attendees at the “Deep Dive” included, senior nurses from the Division, Complaints and PALs Manager, Head of Governance, Healthwatch representatives and our Patient Experience Volunteers. Two further “Deep Dives” have been planned for Urgent Care (April) and Diagnostics Anaesthetics and Surgery (May).

Themes identified from the first two sessions include; communication (between staff and patients, lack of information/ explanation about care provided or procedure), attitude of staff (staff not demonstrating respect for the patients or relatives) and standards of care (poor pain management, delay in diagnosis and dignity not maintained).

2.5 Reporting

Complaints data is reported monthly within the Patient Experience Report, which is presented and discussed at the Patient Experience Steering Group, Patient Safety and Quality Group and a summary provided every two months to the Quality and Safety Committee.

2.6 Parliamentary Health Service Ombudsman (PHSO)

The Trust recognises the value of having an independent body that patients, relatives and carers can refer their complaint should the Trust not be able to resolve their concern to their satisfaction. In such instances and in accordance with the regulatory requirements, the Trust advises the complainant of their option to refer their complaint to the PHSO. The Trust embraces the PHSO's level of scrutiny in the handling of complaints process and uses the PHSO findings as an opportunity to learn and improve our complaint processes.

In 2016/17, the Trust received 17 contacts from the PHSO. A total of 11 were notification of intent to investigate, 3 enquiries, 2 requests for further local resolution and 1 instruction to close file.

The PHSO considered and made judgement on 13 cases in 2016/2017 following PHSO investigation; it should be noted that some of these outcomes received in 2016/17 related to investigations that were started in 2015/16. The outcomes received in 2016/17 were:

Complaint Upheld (partially or in full) By PHSO = 6 (2015/2016= 7)
Complaint Not Upheld By PHSO = 7 (2015/2016= 4)
Further local resolution taken by the Trust=2 (2015/16= 2)

3.0 Patient Advice and Liaison (PALs)

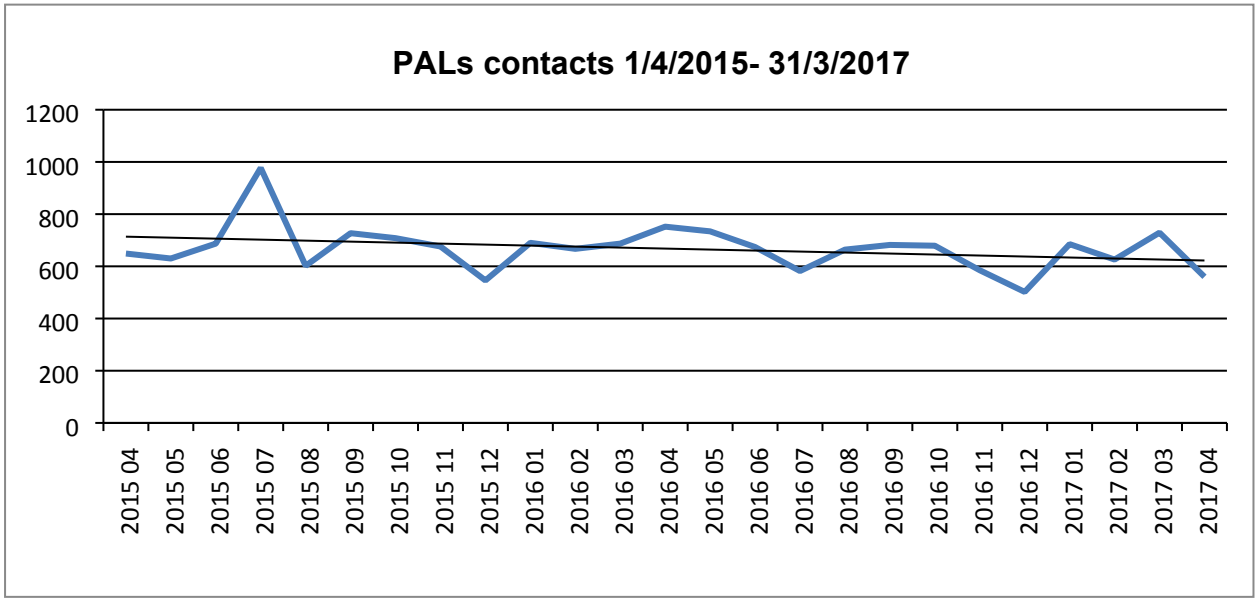
PALs is an independent and confidential advice and support service, helping resolve patients, relatives or carers concerns with the treatment, care or service being provided. PALs liaise with the service to help resolve concerns quickly and informally to the satisfaction of the enquirer. Where appropriate and necessary, PALs will direct patients, relatives or carers to the complaints department.

PALs is appropriately located in the main areas of both acute sites, making it accessible to service users. Enquiries to PALs range from questions regarding waiting times, appointments, cancellations, lost property, general services available and signposting. PALs aim to close an enquiry within three working days, PALs continue to engage with staff at all levels to ensure that learning and improvements take place to improve the service for future patients.

PALs continue to have good links with the complaints team and work collaboratively together to ensure that those concerns that need to be investigated through the complaints procedure are quickly identified and actioned by the complaint team.

3.1 PALs activity

The number of PALs contacts received by the Trust has reduced in 2016/17 (7900) compared to 2015/16 (8246) which is a 4.2% reduction. The run chart below shows a reducing trend over the last 2 years.



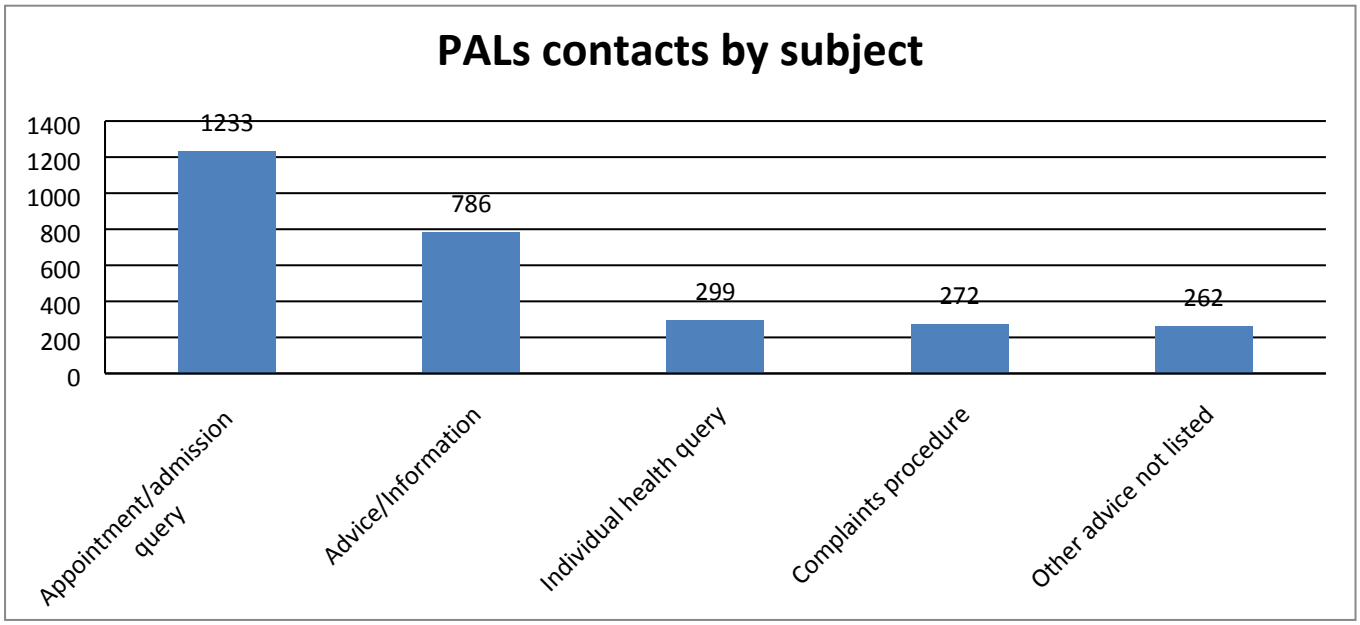
The decrease in PALs contacts mirrors that of complaints. In July- September 2015 there was a spike in PALs activity due to an Information Governance incident (353 contacts/ concerns recorded relating to this).

3.2 Levels on contact

PALS have four main categories for reporting. In 2016/17, the percentage of contacts recorded against each type was as follows:

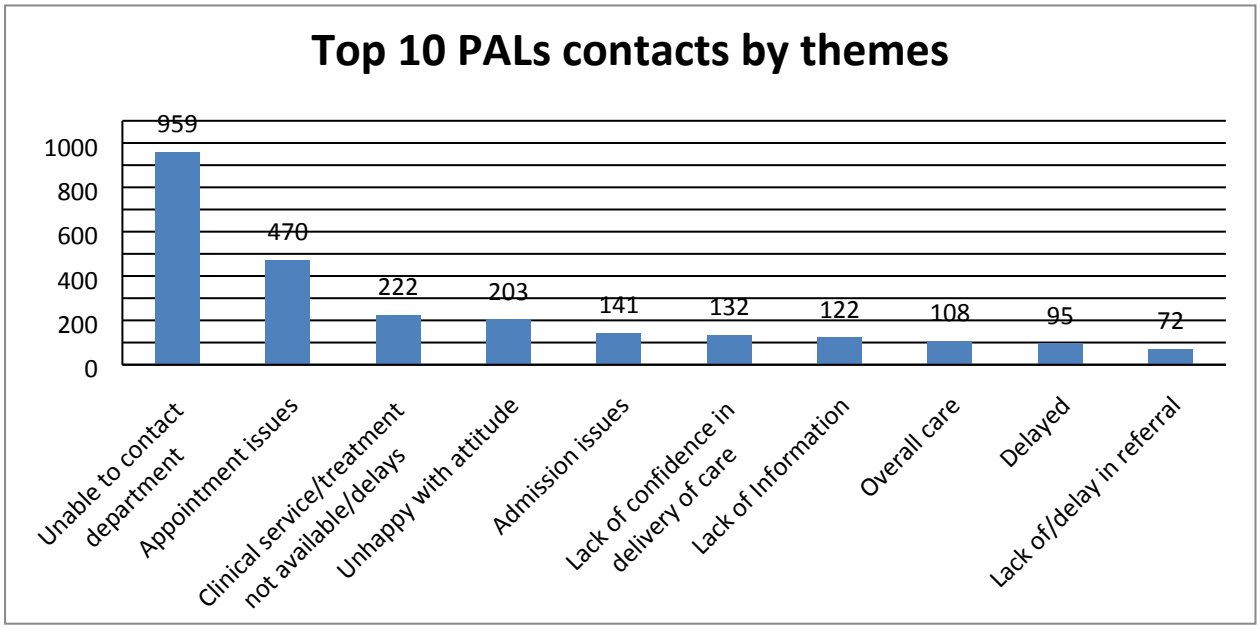
- Advice/assistance/information – 48%
- Concern/issue – 45%
- Compliment – 7%

The table below demonstrates the PALs contacts by subject in 2016/17, the number of contacts recorded against each type was as follows:



The Trust has invested in a telephone package which shows the number of calls waiting and data can be provided regarding call waiting times. However the Trust telephone system is older and therefore the number of lines coming into the Trust us restricted which impacts on the number of patients able to get through to the appointments booking team, this is currently being reviewed by the central admin team and estates department as to how improvements can be made.

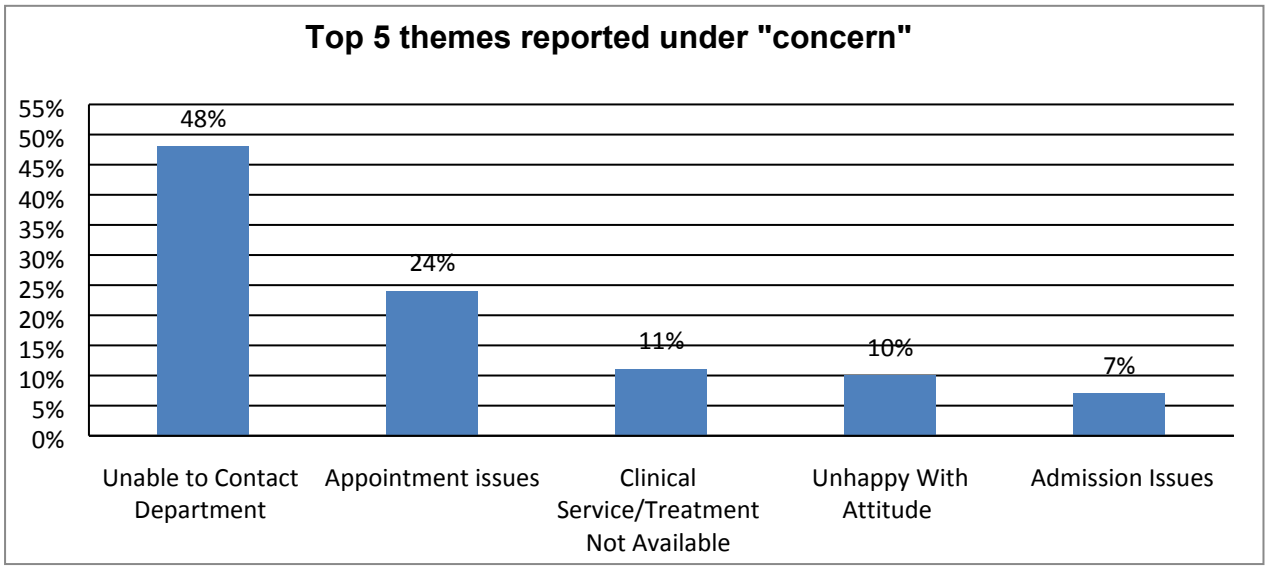
The table below demonstrates the PALs contacts by themes:



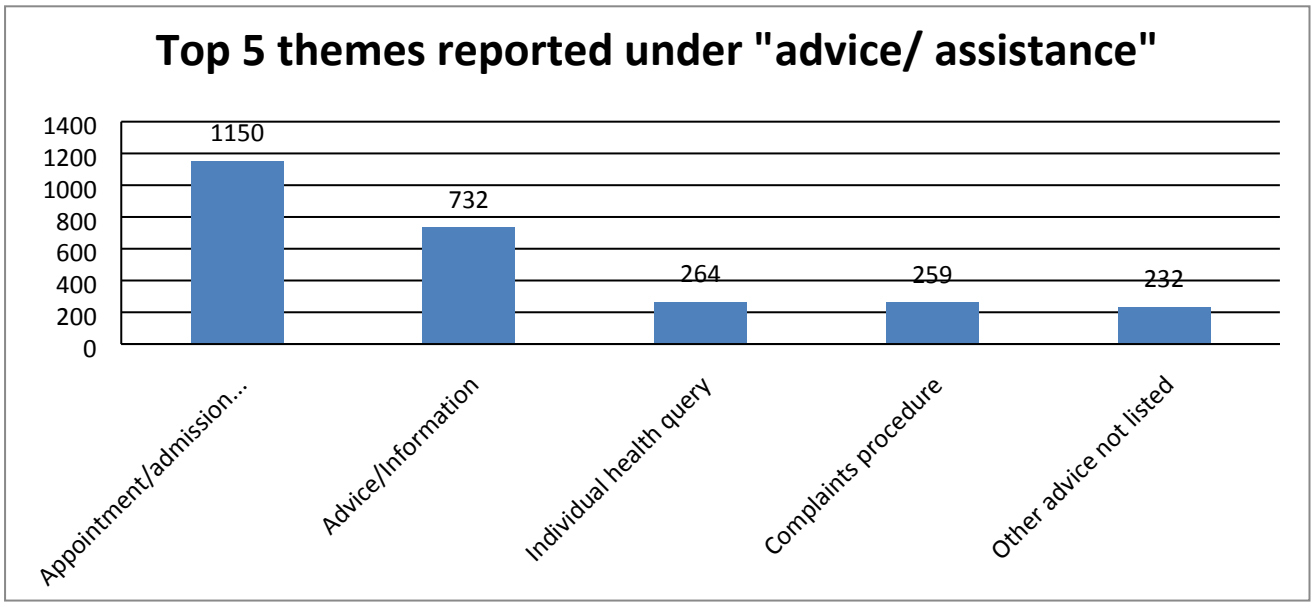
When there is a reoccurring theme such as that patients are unable to contact a certain department the team have been visiting the departments to enquire. On further investigation a phone had been put on silent and answerphone turned on. The team reported this to the Manager and it was placed on loud with the answerphone only used when needed.

Appointment issues, patients are now able to change appointments online via ESHT website, this has reduced the number of calls requiring changes to be made as the team are able to sign post where appropriate to the website.

Of the contacts recorded against the type “Concern/Issue” the top five themes in 2016/17 have been:



Of the contact recorded against the type “advice/ assistance” the top five themes in 2016/17 have been:



During 2016/17 the Complaints and PALs Manager alongside the PALs team have been working to improve the quality of data recorded regarding concerns raised. Redefining of categories and sub-categories should allow greater analysis of the PALs enquiries received. This will help to identify trends and themes under specific areas where targeted work may be required.

The PALs Team has managed to resolve many issues for patients or their next of kin/carer such as helping to re-schedule appointments, contact departments on their behalf and raise concerns with the teams caring for them.

3.3 Complaints and PALS work plan 2017/18

The Patient Experience and Engagement Strategy will be developed within quarter 1 of 2017/18. Complaints and learning from them will be incorporated into the strategy but specific complaint and PALs activity is detailed below;

	Action	Lead
1.	Track complaint actions and ensure embedded in practice	Patient Experience Lead
2.	Reduce and sustain the backlog of outstanding complaints through managing the new complaints process	Complaints Manager/ Patient Experience Lead
3.	Embed the learning from the complaints feedback process.	Complaints Manager/ Patient Experience Lead
4.	Improve Trust-wide monitoring, collecting and evaluating our changes following a complaint.	Complaints Manager/ Patient Experience Lead
5.	Continue to improve the quality of data recorded – provide /obtain more accurate data on concerns patients have in contacting departments to inform change/improvement.	PALs/ Complaints and PALs Manager
6.	Consider a way of increasing availability for PALS within current budget	PALs/ Complaints and PALs Manager

4.0 Conclusion

Complaints and concerns provide the Trust with an invaluable opportunity to make sustained and continuous improvements to patient care, safety and experience. Overall care, treatment/service provided, attitude of staff, unable to contact the department and appointment issues were the top issues raised through complaints and PALs reported in 2016-2017 and will require specific attention in the year ahead. Monthly Patient Experience Reports are reviewed and triangulated with other safety data to core groups and committees and an effective Patient Experience Steering Group is in place to analyse information and agree action for improvement. We will continue to use this information to help drive effective improvements in services across the trust.

Medical and Nursing & Midwifery Revalidation Annual Reports 2016 -2017

Meeting information:			
Date of Meeting:	25 July 2017	Agenda Item:	15
Meeting:	Trust Board	Reporting Officer:	Medical Director and 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: GMC and NMC			
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

Medical Revalidation:

1. ESHT has achieved 100% compliance for doctors who were expected to undergo a medical appraisal in 2016 – 2017

2. The report 'Taking Revalidation Forward: improving the process for relicensing doctors' by Sir Keith Pearson makes recommendations for healthcare organisations and their Boards and these are listed in this report with information about progress being made in ESHT to address them.

3. Although medical revalidation takes place over a five year cycle, revalidation was initially implemented by the GMC in 2012 in a phased approach over a three year period. In the first year of implementation (2012 – 2013), 20% of all doctors were put forward for a revalidation recommendation, followed by 40% for each of the following two years (2013 – 2015). This means that the medical revalidation workload will increase exponentially over the next few years as the full five year cycle is completed again. A plan is in place to accommodate the increased workload and ESHT but the success of revalidation compliance also depends on the number of medical appraisers required to assist with offering high quality appraisals.

4. The total number of medical appraisers has reduced in recent months due to retirement, an increased workload, or because they have left the Trust. New appraisers are being recruited and trained but the risk is that doctors may not receive quality assured medical appraisals with all the benefits they confer for their personal development in the meantime. A recruitment drive is in progress.

Nursing & Midwifery Revalidation:

1. ESHT has achieved a 99.3% compliance with completed nursing revalidation submissions in its first year 2016 – 2017.

2. The system and processes for nursing and midwifery revalidation are becoming well embedded within the organisation. There is work in progress in considering the synergy between medical and nursing & midwifery appraisals and revalidation and in developing effective methods of communication with our nursing and midwifery colleagues.

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

- Medical Revalidation – Medical Revalidation Advisory Panel 19.5.17; People and Organisational Development Committee 15.6.17

- Nursing Revalidation – Trust Nursing & Midwifery Advisory Group 19.5.17; People and Organisational Development Committee 15.6.17

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

1. The Trust Board is asked to approve both annual reports

2. The Chief Executive and Chair are asked to sign the Statement of Compliance for medical revalidation.

East Sussex Healthcare NHS
NHS Trust

MEDICAL REVALIDATION ANNUAL REPORT 2016-2017

1. Introduction

This report provides information about the medical appraisal and revalidation system and processes over the year 2016-2017, highlighting key issues and actions being taken to respond to them.

On 31st March 2017 there were 339 doctors in the Trust claiming a prescribed connection to the Responsible Officer, the Medical Director. The Trust has, for the fourth year running, achieved a very high medical appraisal compliance status for 2016-2017 as 100% of all Trust doctors, who were expected to have their medical appraisal within the required timescales, have done so.

It should be noted that, because doctors join and leave during the year, the actual number of appraisals undertaken by our appraisers is in excess of the appraisal and revalidation data relating to the 339 doctors discussed in this report and totals 373, including doctors who work for the local hospices.

ESHT's Responsible Officer offers all doctors who are employed at either St.Wilfrid's Hospice or St.Michael's Hospice a prescribed connection to ESHT as a Designated Body in support of their revalidation and appraisal. A formal Service Level Agreement is in place. Both hospices have achieved 100% compliance for the year 2016 – 2017. For the purpose of this report, however, the data refers exclusively to the medical staff in ESHT.

2. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that the Trust Board of ESHT will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

3. Governance and Quality Assurance

NHS England provides a Framework of Quality Assurance for Responsible Officers (FQA) and this has been published by the Department of Health. The framework details the

[1] 'The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

combined approaches to achieving quality assurance so that the Responsible Officer has confidence that the doctors working in ESHT are up to date and fit to practise. It comprises of the following elements:

Monthly and Quarterly information:

There is a quarterly report sent from the ESHT Responsible Officer to the 2nd Tier (higher level) Responsible Officer, to whom they are linked, which informs NHS England of ESHT's appraisal compliance data. A monthly performance report/dashboard with narrative is also provided by the revalidation team to the Trust Board so that assurance is given that the medical appraisal compliance status is steadily increasing during the year.

Annual Organisational Audit (AOA):

The AOA is a mandatory audit that all Responsible Officers are required to complete. This is a standardised return to the higher level Responsible Officer and ultimately to Ministers and the public on the status of the implementation of revalidation across England. This information forms the benchmark across the NHS region. ESHT has consistently improved its medical appraisal rates, achieving the highest compliance in the region for an acute hospital trust over the previous four years.

In the 2016 – 2017 Annual Organisational Audit (AOA), submitted in April 2017, it is reported that 339 doctors held a prescribed connection to the Responsible Officer in ESHT at 31st March 2017, of whom 250 had completed the entire medical appraisal process within the last year and a further 82 had satisfactorily completed their medical appraisal but the appraisal had received an authorised postponement or the doctors to be appraised were new starters in the Trust. The remaining seven doctors had received authorised deferrals to the following year (i.e. 2017 – 2018) as they had mitigating circumstances.

There are no doctors, with a prescribed connection to the Responsible Officer in the Trust, who should have had their appraisal and did not, or deferred their appraisal, without formal authorisation. This means that 100% of all Trust doctors with a prescribed connection to the Trust's Responsible Officer are compliant with the Trust's Medical Revalidation Policy.

Trust Board Annual Report:

Trust Boards are responsible for monitoring the organisation's progress in implementing the Responsible Officer regulations. The Trust Board annual report is one method of informing the Board of the achievements, challenges and compliance status in ESHT with regard to medical appraisals and medical revalidation

Statement of Compliance:

The Responsible Officer Regulations include the requirement of Designated Bodies such as ESHT to provide adequate support to the Responsible Officer. The Chair of the Trust Board or the Chief Executive is asked to sign a statement of the organisation's compliance with the RO Regulations. This is submitted to the higher level Responsible Officer. The statement of compliance accompanies this Trust Board annual report for signature, please.

Independent Verification:

All Designated Bodies undergo a process to validate their systems and processes at least once in each five year revalidation cycle. The last independent verification visit was held in December 2014 and was reported upon in the Trust Board Annual Report 2015 – 2016. The current Appraisal Lead for the Trust has since been invited to participate in, what is now called, the Framework of Quality Assurance – Higher Level Responsible Officer Quality Review (HLROQR) to review other organisations and will share learning across the organisations involved.

4. The 'Pearson' report

4.1 Recommendations for acute Trusts

In January 2017 and at the GMC's request, 'Taking Revalidation Forward: improving the process of relicensing for doctors', a report by Sir Keith Pearson, was published. The report reviews the progress of medical revalidation over the last five years and makes recommendations. The following recommendations have been made for healthcare organisations and their Boards, supported by others. Each recommendation is followed by a summary of the Trust status of compliance and/or any actions being taken by the Trust to ensure we can demonstrate good practice.

a) Work with patient groups to publicise and promote processes for ensuring that doctors are up to date and fit to practise.

   The Trust is fortunate to have a lay representative for medical revalidation who participates effectively in the recruitment, quality assurance processes, training and revalidation recommendation processes. However, it is recognised that more can be done to publicise the revalidation system, processes and successes of medical appraisals and revalidation in ESHT to provide the general public and patients and other colleagues in ESHT with assurance that our medical staff are working hard to ensure they remain up to date and fit to practise. This will require collaboration with our governance and communication teams and those who are involved in patient experience and involvement work in the Trust. The revalidation team is working with ESHT's lay representative for medical revalidation to develop an action plan to address this recommendation.

b) Continue work to drive up the quality and consistency of appraisal and make sure the process is properly resourced.

   Enshrined in legislation is the requirement for Responsible Officers to be properly resourced. The RO in ESHT is supported by the revalidation team which, in turn, is supported by the Deputy Responsible Officer. It is further anticipated that, following the semi-retirement of the Assistant Director – Revalidation and current Medical Appraisal Lead in August 2017, a new Medical Appraisal Lead will be in post in October 2017.

   The quality and consistency of appraisal is supported by regular medical appraiser training which is mandated at least twice per year and contributes to the medical appraiser's own Professional Development Plan. Medical appraisers are encouraged to undertake professional calibration of their medical appraisal judgements during this training. ESHT has a process of undertaking regular quality assurance checks for the first three appraisal outputs of new appraisers with constructive feedback provided. Regular quality assurance audits of all medical appraisal outputs are undertaken. The lay representative is involved in the scrutiny of both the process of quality assurance and the outputs themselves. Feedback is provided to any medical appraisers who are underperforming with support provided for improvement where required. The majority of our medical appraisers are highly rated and very effective. All medical appraisals are anonymously evaluated by the doctors being appraised after their appraisal; reports on the evaluations for each medical appraiser are provided to them on an annual basis.

c) Explore ways to make it easier for doctors to pull together and reflect upon supporting information for their appraisal. This might occur through better IT systems or investment in administrative support teams.

   ESHT is well advanced in support of the provision of supporting information for appraisals. We use Datixweb to provide information on incidents and complaints and the revalidation team automatically sends a confidential report to the doctor being appraised around two weeks ahead of their appraisal which can be included within their appraisal as part of the reflective discussion. Additionally, there is a firm process in place for the provision of multisource feedback from patients and colleagues, with doctors being offered this feedback report at least twice per revalidation cycle and on

request if it is indicated as part of a Professional Development Plan by a line manager or medical appraiser.

d) Ensure effective processes are in place for quality assurance of local appraisal and revalidation decisions, including provision for doctors to provide feedback and to challenge decisions they feel are unfair.

   As discussed in (b) above, quality assurance processes are well embedded within ESHT. The medical revalidation and medical appraisal policy offers guidance on the process for raising concerns about the appraisal and revalidation process under the section of 'Making a Complaint'. This policy is currently being revised and updated and the process for challenging a decision about revalidation recommendation will be strengthened accordingly.

e) Avoid using revalidation as a lever to achieve local objectives above and beyond the GMC's revalidation requirements.

   ESHT has introduced some elements to the appraisal process in the spirit of encouraging the personal and professional development of our doctors whilst also addressing organisational and team objectives that also benefit patient care. These elements are included to promote reflection on the support each doctor needs and can be added to the Professional Development Plan if relevant. Issues such as abandoned clinical audits and incomplete mortality reviews are examples of what might be included. The outcome of this appraisal discussion will not affect the decision about a revalidation recommendation as the focus is on reflection and not performance management, which is more the role of the doctor's line manager.

f) Boards should hear regularly about the learning coming from revalidation and how local processes are developing. They should also challenge their organisations as to how revalidation is helping to improve safety and increase assurance for patients.

   ESHT Board is provided with a RAG rated report on appraisal compliance each month. It is challenging to provide evidence of increased safety of the revalidation process and a methodology of achieving this is something that the GMC will be exploring in tandem with NHS England. Once evidence criteria are established, the revalidation team will work with clinical colleagues to develop regular reports to Trust Board. In the meantime, our medical appraisers have been asked to provide their suggestions and advice on how this might be best achieved.

4.2 Strengthening assurance around locum doctors

In sections 213 – 222 of the Pearson report, it suggests that locum doctors are generally perceived to be a greater risk to patient safety and the reputation of an organisation for a variety of reasons, many of which are often systemic rather than related to the individual practitioner. One key reason for this risk is the difficulty experienced by ROs in accessing all the information they need when they are required to provide a prescribed connection.

In ESHT we mainly divide locum doctors into two types: a) those engaged via an agency (with whom there is a contract framework that stipulates the requirement of the agency's provision of an RO and support for appraisal and revalidation) and b) those whom are directly engaged via our bank as a temporary workforce locum doctor on a non-substantive contract. In ESHT, our dilemma is how to support the potentially many locum doctors who belong to the latter group and whom we might only employ for days or weeks but who could legitimately claim a prescribed connection to our RO.

NHS England has advised all Trusts that a prescribed connection is not the choice of the RO or the individual doctor but it is enshrined in The Medical Profession (Responsible Officers) Regulations 2010 and The Medical Profession (Responsible Officers) (Amendment) Regulations 2013. NHS England has also reiterated that certain information

should be obtained before a doctor begins working in an organisation in addition to the RO Transfer of Information form content that follows post-employment. The information sought includes details of the locum doctor's previous appraisal summaries and outputs; revalidation history i.e. any deferrals, non-engagement recommendations, periods with no prescribed connection to a Responsible Officer; and a declaration that there have been no concerns raised about their practice which would lead to a probity investigation if later found to be incorrect.

However, there are challenges for our medical recruitment and temporary workforce teams in gaining sufficient information about a locum doctor's previous appraisal and revalidation history prior to their employment. Although the information is always necessary, it is particularly important if the locum doctor joins ESHT when their revalidation date is imminent. The RO needs to be provided with the relevant information so that the RO can make a revalidation recommendation regarding the locum doctor's fitness to practise.

Along with checking the revalidation history on the GMC website, gathering this information from the individual doctor *before* offering engagement or employment to *any* doctor would reduce the risk to the Trust in terms of patient safety and Trust reputation.

5. Policy and Guidance

A Medical Revalidation & Medical Appraisal Policy and a Remediation Policy have both been ratified in ESHT but are currently under review. The Medical Revalidation & Medical Appraisal Policy is being revised to reflect recent changes that the Responsible Officer is introducing regarding the even more robust method of addressing non-engagement. The policy will be ratified formally again once all revisions are completed.

6. Medical Revalidation and Medical Appraisals

Medical Revalidation

6.1 Appraisal and Revalidation Performance Data

The GMC provides web based access to ESHT revalidation data via GMC Connect. The revalidation status of all doctors who claim a prescribed connection to the Responsible Officer and ESHT as their Designated Body features on this site. The list of doctors with a prescribed connection is cross checked each month against a list provided by the Medical Recruitment team and when doctors leave or join the Trust.

6.2 Revalidation Recommendations in ESHT between 1 April 2016 – 31 March 2017

Table 1. Revalidation Recommendations in ESHT 1 April 2016 – 31 March 2017

Positive recommendations	22
Non engagement notifications	0
Recommendations completed on time	28
Recommendations completed not on time	0
Deferrals requests	6
Reasons for all missed or late recommendations	n/a

ESHT has not missed any of the deadlines for recommendation for revalidation.

Table 2. Reasons for medical revalidation deferrals 1 April 2016 – 31 March 2017

Reason for a deferral recommendation	Number of doctors
Time allowed for completion of a '360' multi-source feedback report	0
New starters - to provide them with sufficient time to have their appraisals and to prepare supporting information for their medical revalidation recommendation	5
Long term sick leave and needed more time to prepare for their medical appraisal	1
Maternity leave and needed more time to prepare for their medical appraisal	0
The doctor was on reduced hours due to serious family health issues and needed more time to prepare for their medical appraisal	0
Appraisal was submitted too close to the revalidation recommendation date and so needed more time for a full review of all supporting information to take place	0
The doctor was taking a career break due to serious family health issues	0
Further supporting information required and needed more time to gather it	0

Medical Appraisals

6.3 Table 3. Medical Appraisals in ESHT between 1 April 2016 – 31 March 2017

	Total (n)	Green	%	Amber	%	Red	%
Consultants	**215**	**215**	**100.0%**	**0**	**0.0%**	**0**	**0.0%**
SAS/Trust Grade	**82**	**82**	**100.0%**	**0**	**0.0%**	**0**	**0.0%**
LAS	**42**	**42**	**100.0%**	**0**	**0.0%**	**0**	**0.0%**
Totals	**339**	**339**	**100.0%**	**0**	**0.0%**	**0**	**0.0%**

KEY:

Total (n) Doctor Appraisal status	Total (%) Doctor Appraisal status	
339	100.0%	Doctors who **HAVE** forwarded evidence of an appraisal since April 2016 **OR** have an authorised deferral until the next year's appraisal cycle as they have either been in the Trust for less than six months OR have been on long-term sickness/maternity leave
0	0.0%	Doctors who have **NOT** had an appraisal since 1st April 2016 but are due an appraisal within their anniversary month **OR** have an authorised postponement. These doctors are expected to have an appraisal before the end of March 2017 if still with the Trust at that date
0	0.0%	Doctors who do **NOT** have an authorised postponement and have missed their scheduled month of appraisal
339	**100%**	

On 31st March 2017 there were 339 in the Trust claiming a prescribed connection to the Responsible Officer, the Medical Director.

The Trust can boast a very high medical appraisal compliance status for 2016 – 2017 with 100% (339) of all doctors with a prescribed connection abiding by the Trust's medical appraisal compliance criteria.

6.4 Methods of reporting appraisal compliance

6.4.1 NHS England/GMC method of reporting:

The method of reporting medical appraisal compliance is prescribed by NHS England/GMC as follows:

1a is a completed annual medical appraisal whereby the appraisal meeting has taken place within the three months preceding the appraisal due date, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March.

1b is a completed annual medical appraisal whereby the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply:

- a period of time of less than 9 months or greater than 12 months from the last appraisal has elapsed;
- the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting.
- The entire process did not occur between 1st April and 31 March

However, in the judgement of the Responsible Officer, the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.

Where the organisational systems of the designated body do not permit the parameters of a '*Category 1a* completed annual medical appraisal' to be confirmed with confidence, the appraisal should be counted as a '*Category 1b'.* For example, new starters in the Trust have recently been confirmed as belonging to Category 1b, by NHS England.

6.4.2 ESHT method of reporting:

In ESHT, the medical appraisal cycle runs from April to December each year. If it is agreed by the Responsible Officer that, due to exceptional circumstances, an appraisal may take place between January and March, an additional appraisal must be undertaken by the end of December in the same year. Every doctor should have an appraisal in the anniversary month, or before, of their previous appraisal. Doctors who conform to this and/or have their appraisal within 365 days of their last appraisal are reported as being compliant.

ESHT's medical revalidation team contacts all doctors joining the Trust and provides them with supporting information including the expected month of appraisal; this is particularly significant in situations where their previous appraisal took place between January and March or if they have not had an appraisal within the twelve months before joining ESHT. Training sessions are conducted at regular intervals to support doctors in developing their understanding of the expectations placed upon them for medical appraisals and medical revalidation. Help and support is also offered by the revalidation team on an ad hoc basis.

The objectives of the training sessions are for doctors to understand: the purpose of appraisal and revalidation and how the process works at ESHT; how to complete the MAG portfolio form; the supporting information they need to gather; and the importance of reflecting upon their supporting information and their practice. This enables their experienced appraiser to help them develop a personal development plan for the following year.

If doctors have had a medical appraisal within the last 12 months, and it was not conducted between January and March, the doctor will be expected to inform the Medical Revalidation team, who will then make every effort to provide a medical appraisal no later than their annual appraisal

anniversary month. Therefore, doctors are currently reported as being compliant until they have been in the Trust for six months. After this time, if the doctor has not had an appraisal, they are reported as being non-compliant.

6.5 Appraisals completed between 1 April 2016 and 31 March 2017 by Division & Specialty

Table 4. Appraisals completed between 1 April 2016 and 31 March 2017 by Division & Specialty

Division	**Number of doctors**	**Number of completed appraisals**	**Number of doctors who missed their 2016-17 appraisal**	**Number of doctors with an authorised deferred appraisal**	**Number of new starters not due an appraisal until next cycle***
Diagnostics, Anaesthetics & Surgery	190	170	0	3	17
Medicine	74	66	0	1	7
Urgent Care	24	16	0	1	7
Women & Children	51	43	0	2	6
Totals	339	295	0	7	37

* These doctors are compliant with ESHT Medical Revalidation and Medical Appraisal Policy.

6.6 Missed appraisal audit

It is felt that one of the contributing factors in the high medical appraisal compliance status in ESHT is that doctors are reminded of their annual appraisal on at least two occasions. However, some doctors do miss their appraisals and an audit is conducted for all missed appraisals, whether approved or otherwise, and the reasons for these are provided here in Table 5.

A ‘missed’ appraisal is defined as one that has not taken place within twelve months from the date of the last appraisal or one where the appraisal outputs are not signed off within 28 days from the date of the appraisal. A missed appraisal is defined as either approved or unapproved. Approved missed appraisals are where the Responsible Officer has authorised a postponed or deferred appraisal.

Continues…

Table 5. Reasons for postponed or incomplete appraisals 1st April 2016 – 31th March 2017

Doctor factors (total)	**Number**
Maternity leave during the majority of the 'appraisal due window' (authorised)	3
Sickness absence during the majority of the 'appraisal due window' (authorised)	6
Prolonged leave during the majority of the 'appraisal due window'	2
Suspension during the majority of the 'appraisal due window' (authorised)	0
New starter not due to have appraisal in current year but due within six months of joining (authorised)	37
Postponed due to incomplete portfolio/insufficient supporting information (authorised)	13
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	21
Lack of engagement of doctor (Unauthorised) All four doctors subsequently completed their appraisal within two months of their original date	4
Other doctor factors (describe) 1. Clinical emergency involving both appraiser and appraisee on the afternoon of the appraisal meeting	1
Appraiser factors	
Unplanned absence of appraiser	7
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	9
Other appraiser factors i.e lack of appraiser capacity for December 2016	1
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	6
Insufficient numbers of trained appraisers	0
Other organisational factors	0
Difficulty in arranging a mutually convenient time due to opposing timetable/clinical commitments/annual leave	9

6.7 Public and Patient Involvement

Doctors are supported in obtaining patient and public feedback, an essential component of their supporting information in preparation for their medical revalidation recommendation to the GMC by the Responsible Officer. The Trust provides this support through the Allocate Software system in order for each doctor to gather patient feedback.

In the last year which was the final year of the first five-year GMC revalidation cycle, 15 doctors received patient and colleague feedback in a report that was discussed during their appraisal with their medical appraiser. This is one of the most important elements of the appraisal and revalidation process as it provides assurances about many facets of individual character and performance and includes colleagues' and patients' views about the fitness to practise of each doctor. Occasionally, the report indicates that one or more areas of feedback warrant support to the doctor, in the form of further personal development or training. In this case, the medical appraiser and doctor being appraised are encouraged to add relevant actions to the doctor's Personal Development Plan. All 360 reports are read prior to submission of the Responsible Officer's recommendation to the GMC for medical revalidation.

A Public and Patient Involvement (PPI) representative is a full member of the Medical Revalidation Advisory Panel that provides oversight and scrutiny of medical revalidation processes. The representative is also involved in the recruitment and interview process for all medical appraisers and participates in the quality assurance audits of medical appraisal outputs.

Further work is in progress to increase the level of public and patient involvement in both medical and nursing revalidation processes; the Appraisal Lead (Assistant Director – Revalidation) and the PPI representative have participated in the Leading Together Programme and are currently working together to develop actions to address recommendations made in the Pearson Report (2017) The Assistant Director – Revalidation was recently invited to present to the NHS England (South) Region Responsible Officer Network to share our good practice regarding our current and future involvement of lay representation in the revalidation process.

6.7 Medical Appraisers

NHS England requires that the Responsible Officer ensures that the Designated Body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection. Doctors from a variety of backgrounds should be considered for the role of appraiser. This includes associate specialist doctors in secondary care settings. An appropriate specialty mix is important and it is not actively encouraged for doctors to have an appraiser from the same specialty. The recommendation for the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. ESHT attempts to have approximately 40 trained medical appraisers available each year so that each appraiser has an average of 8 – 10 appraisals to conduct in that time scale. This offers a ratio of approximately 1:9 appraisers to doctors in ESHT, taking into account locum doctors and doctors who leave and join the organisation each year.

ESHT currently has 35 trained medical appraisers and four new appraisers are in the process of being trained. Medical appraisers are provided with regular update training at least twice per year, when appraisers also have the opportunity to calibrate their professional judgements for medical appraisals. This means that medical appraisers are able to compare their appraisal decisions and outputs with other medical appraisers and align them with the NHS England and GMC requirements. Two training sessions were conducted during the medical appraisal year 2016 – 2017.

As part of the training process for medical appraisers, training needs are identified by the following methods:

1. auditing of the appraisal outputs by the medical revalidation team, particularly for new medical appraisers who receive constructive feedback by the Medical Appraisal Lead on at least their first three appraisals and doctors who are due to be reviewed for revalidation;

2. Medical appraisers adding learning objectives about their medical appraiser role to their own Personal Development Plans (PDPs); and

3. An Appraiser Review Summary provides details of the self-identified learning needs of medical appraisers to the Medical Appraisal Lead; a thematic analysis of the learning needs is undertaken; this allows these learning needs to be formally incorporated into subsequent medical appraiser update training sessions.

   Medical appraisers also identify learning needs during update training sessions so that they can be addressed within the group setting. For example, during the most recent appraiser training, it was identified that doctors required more information on managing a doctor's full scope of practice. This has now been discussed in depth and doctors can obtain further assistance and information from the Medical Revalidation team; there is a system in place which has been agreed by the revalidation team with all other local providers to support doctors in obtaining their 'Responsible Officer Transfer of Information' form.

   The update sessions are also an opportunity to discuss any challenges that are posed by being a medical appraiser and these are addressed in an open forum when possible so that all appraisers can share their experiences and work together. Where certain issues are raised that can be addressed, such as doctors not submitting their supporting evidence in good time for their appraisal. This issue is being addressed by the revalidation team who offer regular training sessions to all new doctors or those in need of a refresher of the requirements.

   The revalidation team offers advice and support to medical appraisers and both the team and medical appraisers receive very positive feedback. Tables 5, 6 and 7 display a summary of this feedback for the year 2016-17 and some free form comments are also provided.

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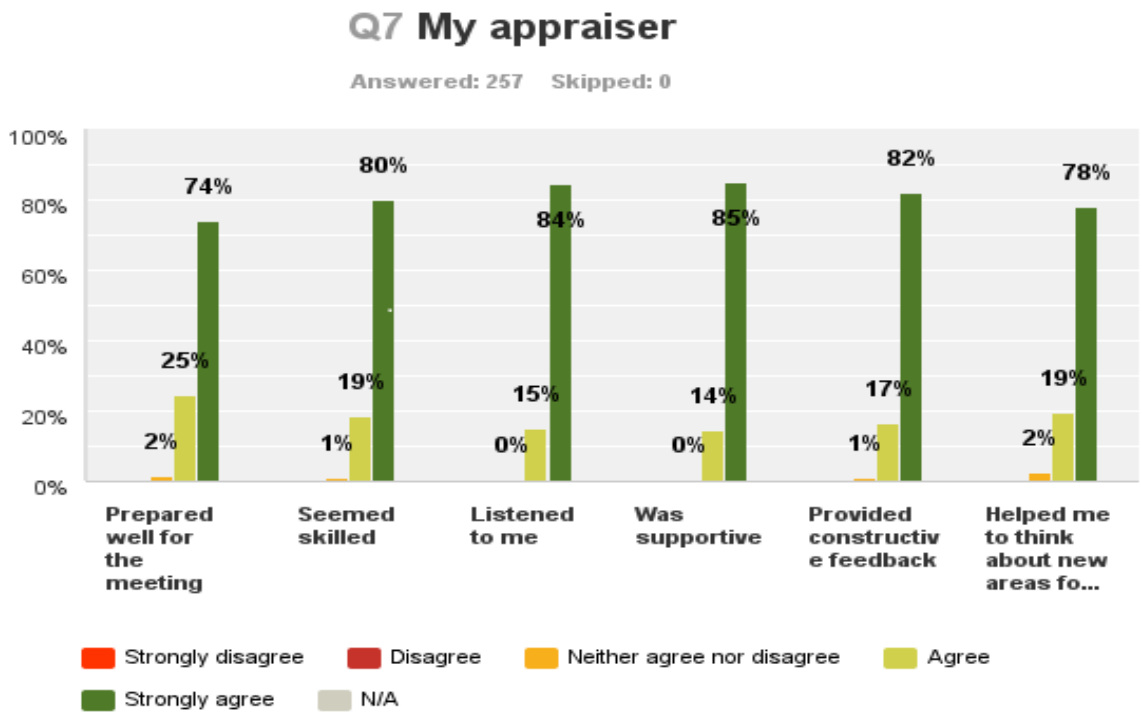
Table 6. Feedback on medical appraiser performance by 253 ESHT doctors 2016-17

Question 1 - My appraiser:



In each feedback questionnaire there is an opportunity for doctors to write comments about their appraiser. Some of these comments are included here, demonstrating the participative nature of medical appraisals in ESHT, and the general view of doctors as appraisals being a positive and constructive dialogue which encourages reflective practice. Although there are several examples provided here, which would not normally be included in an annual report, it is important to recognise the valuable contribution that medical appraisers make to quality improvement in patient care and the professional development of our highly valued medical staff:

"As this was my first appraisal, my appraisal was very good. I found him receptive and very elaborate on what should I be aiming in future and where I had shortfalls during this last seven months while I worked in the hospital. He helped me with almost everything with my appraisal from starting to the finish. I am very pleased with how my appraisal went and how well prepared and how well versed he is with the whole process. Thank you to my appraiser."

"It was my final appraisal before retirement. My appraiser clearly understood and was very empathetic re the challenges facing a doctor of 40 years who loved their job. My appraiser was very helpful at putting my career in focus, acknowledging what I felt to be my strengths and weaknesses, providing constructive feedback and looking at a way forward should I wish to continue as a doctor. She was excellently prepared, very skilled and a very good listener. I couldn't have wished for a better final appraiser."

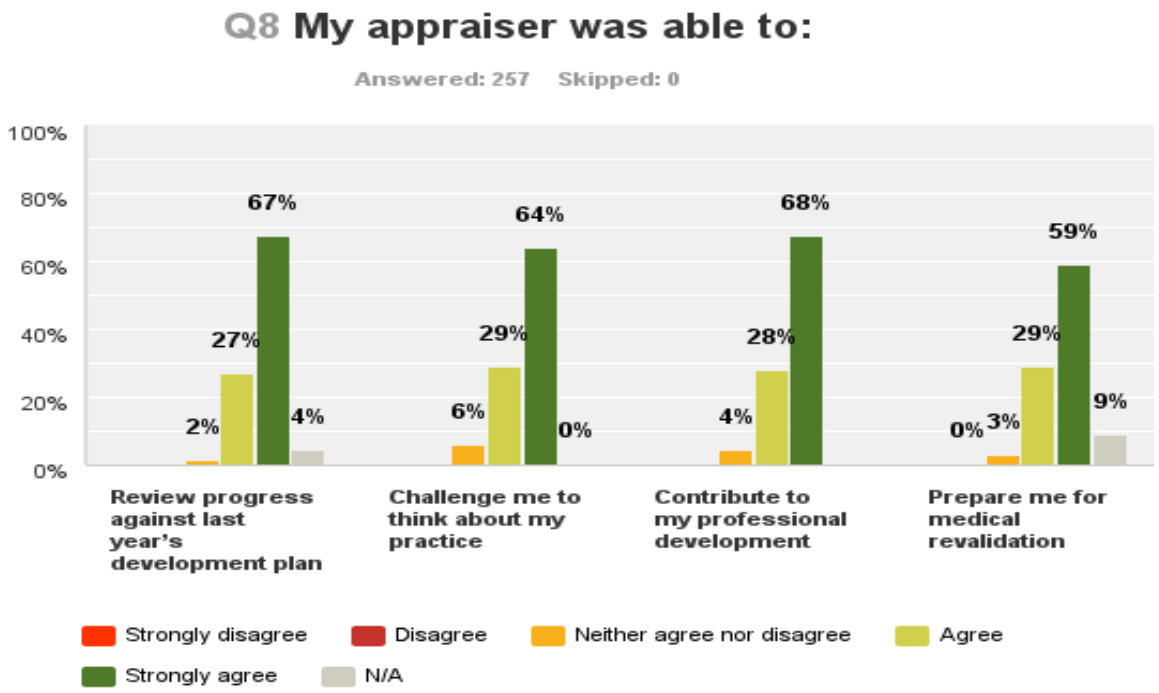
"It was my first appraisal and I was expertly guided through it by my appraiser. He helped me a great deal and introduced new ideas about potential areas for development for my career."

"My appraiser was very attentive and clearly was genuinely interested in my well being and professional development. He was approachable, friendly and provided helpful comments regarding my current situation. The meeting was very useful and felt like a very formative process which will help my professional development. My appraiser listened very carefully to the issues I discussed with him and provided very useful comments about those issues and how to deal with them. His insight is very useful and helped me to contextualise my various issues with work."

"My appraiser and I had a great conversation about areas in my practice I could further develop, gave me new inspiring ideas of ways to enhance my skills and reporting ability. He listened carefully and supported me all the way through the appraising process."

Table 7. Feedback on medical appraiser performance by 253 ESHT doctors 2016-17

Question 1 - My appraiser was able to:



Medical appraisers receive regular training on core appraisal skills but also of any GMC updates and ESHT processes. This leads appraisers to become excellent sources of knowledge and champions for medical appraisals, one of the many reasons that the appraisal compliance in ESHT is so high, particularly compared with other Trusts. Our medical appraisers are highly valued.

"He was very sure of what I needed to do achieve in next year so that I do not fall back on my required CDP points and the things I need to do to develop myself as a better medical personnel in years to come. He has challenged me with numerous courses to attend and audits to perform. I would not let him down."

"We discussed achievements over the year based on the development plan, made me reflect on my practice and where it could be better, and we discussed a way forward should I wish to continue as a doctor. She pointed out the need to continue appraisals and revalidation and to find a responsible officer. Having not been brought up on appraisals, and challenged by them, my experience could not have been better and it was a very valuable experience. My appraiser was excellent in every way and I wish she could continue to do my appraisals in my new career."

"We discussed my job in very different approaches. I was pretty surprised about my appraiser's broad knowledge in my specialty. It helped one to look at my speciality from a different angle."

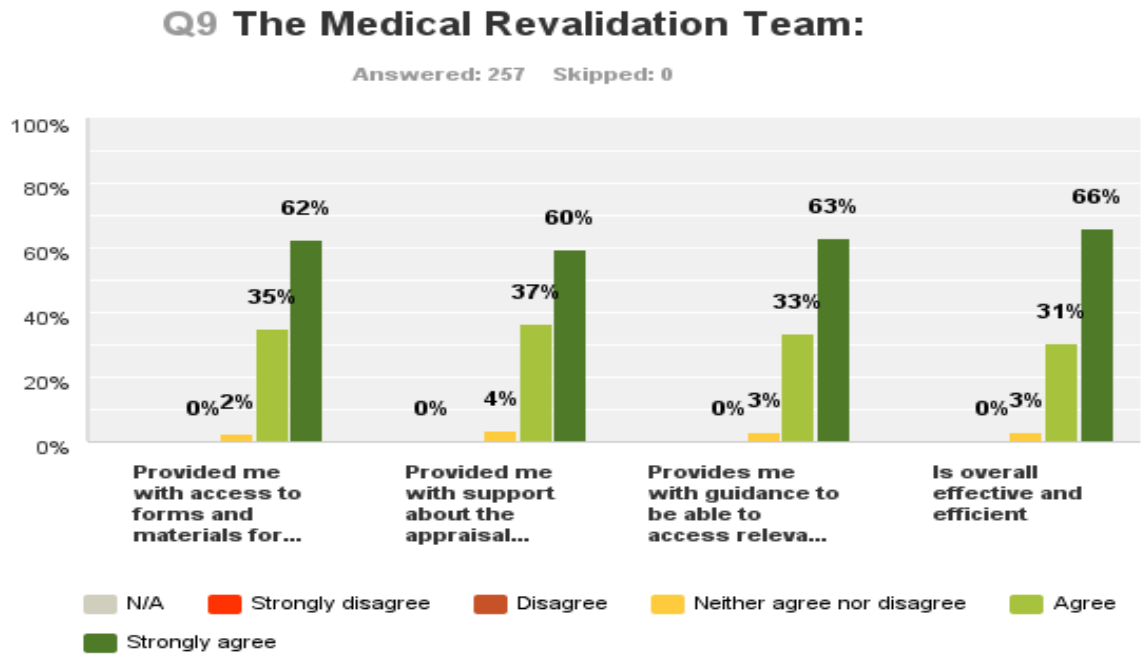
"My appraiser thoroughly reviewed last year's PDP and gave advice regarding this years. He is experienced in his specialty and was able to provide valuable advice regarding practice and professional development."

"My appraiser was quite helpful and forthright while appraising my work for the past year. He offered useful advice and challenged me to be better in my future practice."

"This was done at a very high professional level but also friendly led. Brill! Thoughtfully done. Many thanks."

Table 8. Feedback on medical revalidation team performance by doctors

The medical revalidation team organises all the associated administration for medical appraisals and medical revalidation and deals directly with all enquiries from the medical staff. Table 6 indicates that almost all doctors are satisfied with the support received by the revalidation team:



"I think the revalidation team went above and beyond what is expected of them, and I am extremely grateful for their help and support in this process."

"Good support from office team - thank-you."

"Prompt responses and helpful as always."

"Very supportive team who are available at most times with easy access. Prompt reply to email queries."

"As always, the "dream team". Professional and supportive."

"Very efficient in providing needed support."

"Best in the country by far. Thanks."

"Very supportive. The session on appraisal and revalidation support was excellent. Helped me a lot."

"The team are very helpful. They invited me to attend a lecture specifically for the appraisal and revalidation process."

7.0 Quality Assurance

The Medical Revalidation Advisory Panel regularly undertakes quality assurance exercises and 22 portfolios have been scrutinised by Panel Members over the appraisal year 2016-2017 to provide assurance regarding the following appraisal inputs:

- the pre-appraisal declarations and supporting information provided is available and appropriate - by whom and sign offs
- review of appraisal folders to provide assurance that the appraisal outputs, Personal Development Plan, summary and sign offs are complete and to an appropriate standard, by whom and sign offs

- review of appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal summary - by whom and sign offs

  During 2016-2017, only four of all Personal Development Plans (PDPs) that were audited were subsequently returned to the appraiser and to the doctor being appraised, with advice on how to amend and improve this provided by the Appraisal Lead, thus ensuring that quality assurance standards are met and to provide learning for the future.

  Continuous improvement of the quality of appraisal outputs is a common theme within all medical appraiser update training. The move away from 'tick box' appraisals is reinforced by the attention placed on the quality of the outputs and the consequent support of the individual doctor in their personal and professional development.

  Even though the Trust has been praised for its high quality of appraisal outputs by NHS England, the revalidation team strive for continued excellence.

For the individual appraiser, quality assurance is achieved by holding a review of:

- the annual record of the appraiser's reflection on appropriate continuing professional development
- the annual record of the appraiser's participation in appraisal professional calibration events such as update training sessions
- 360 feedback from doctors for each individual appraiser; this is collected through 'Survey Monkey' and it is reviewed by the Medical Revalidation Panel on at least an annual basis. Findings are presented to the medical appraisers individually, where possible, and collectively in their update training sessions. Feedback on medical appraisers is reviewed by the Trust's Appraisal Lead and individual support is provided to each medical appraiser, where appropriate and collectively all learning needs are addressed through the action learning update sessions
- Appraisal outputs and the quality of the Personal Development Plan and appraisal summary in particular.

8.0 Clinical Governance

Every doctor is required to supply an Appraisal Governance Report to their medical appraiser at least two weeks ahead of their annual appraisal; this report is obtained through the revalidation team. An Appraisal Governance Report allows doctors a formal opportunity to review and reflect upon all incidents and complaints in which they were named or involved during the previous year.

In excess of 370 Appraisal Governance Reports were generated in the year 2016-17. These reports are also generated immediately prior to the medical revalidation recommendation to the GMC so that the Responsible Officer is able to make an informed recommendation of the doctor's fitness to practise.

9.0 Challenges and Next Steps

1. Developing a robust process for pre-recruitment checks

The Responsible Officer needs to be provided with all relevant information from all doctors who can legitimately claim a prescribed connection before they begin working in the Trust. Gathering this information *before* offering engagement or employment to any doctor would reduce the risk to the Trust in terms of patient safety and Trust reputation. The RO and revalidation team are working closely with colleagues in recruitment and temporary workforce teams to address this issue and to develop a robust process for pre-recruitment checks.

2. Revalidation team restructure

The Revalidation & Job Planning team has recently undergone a restructure to ensure business continuity and succession planning in preparation for the retirement of the Assistant Director – Revalidation & Job Planning in August 2017. Although the Assistant Director plans to return part time to provide support to the Trust for overseeing the revalidation system and processes, some duties of her role have been transferred to a new Team Leader post and will be transferred to a Medical Appraisal Lead post.

3. Increased revalidation recommendation trajectory

Although medical revalidation takes place over a five year cycle, revalidation was initially implemented by the GMC in 2012 in a phased approach over a three year period. In the first year of implementation (2012 – 2013), 20% of all doctors were put forward for a revalidation recommendation, followed by 40% for each of the following two years (2013 – 2015). This means that the medical revalidation workload will increase exponentially over the next few years as the full five year cycle is completed again. The revalidation process does not just focus on appraisal and revalidation compliance but also on the quality of medical appraisals; ESHT strives for continuous improvement and excellence which additionally increases the workload of our Responsible Officer, the Medical Revalidation Advisory Panel, our medical appraisers and the revalidation team.

4. Pearson report recommendations

Previously in this annual report, actions related to the recommendations made in the Pearson Report have been identified and these will need to be addressed more thoroughly over the coming year.

10.0 Recommendations

1. The Trust Board is asked to approve this annual report, noting it will be shared, along with the annual audit, with the higher level Responsible Officer at NHS England.
2. The Trust Board is also asked to approve the ‘statement of compliance’ confirming that the organisation, as a designated body, is compliant with the regulations. The CEO and/or Chair of the Trust Board are asked to sign the statement.

Dr David Walker
Medical Director & Responsible Officer – Medical Revalidation 23.5.17

East Sussex Healthcare NHS
NHS Trust

NURSING & MIDWIFERY REVALIDATION ANNUAL REPORT 2016 - 2017

1. Executive summary

1.1 This is the second annual report for Nursing and Midwifery revalidation in ESHT. Revalidation was fully launched by the NMC in April 2016, and this report details the progress made so far in the first of the three year revalidation cycle.

1.2 This report additionally provides information about the number of nurses in the Trust and the number of completed revalidation submissions within the year 1st April 2016 and 31st March 2017. It also highlights challenges experienced by the organisation and our responses to them. For ease of reading, the report will mainly refer to nurses but the report also includes midwives within this category.

2. Background to revalidation

2.1 Nursing & Midwifery Revalidation was launched by the Nursing & Midwifery Council (NMC) on 1st April 2016 following the publication on 29 January 2015 of The Code which contains the professional standards that registered nurses and midwives must uphold. Although they do not align exactly, the Trust values also feed into the process of adhering to the Code.

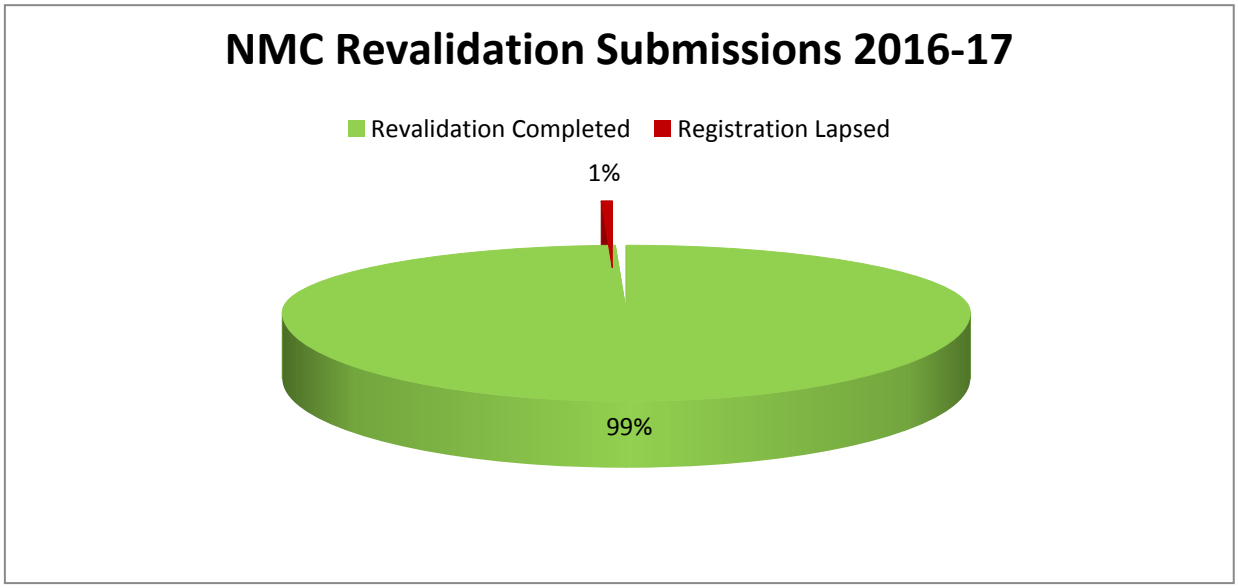
2.2. Nursing revalidation is the process that allows a nurse and/or midwife to maintain their registration with the NMC by building upon existing renewal requirements. Nurses and midwives must demonstrate their continued ability to practise safely and effectively. Revalidation is a continuous process that all nurses and midwives need to engage with throughout the year and they must meet certain requirements in order to complete their revalidation and renewal of registration every three years with the NMC.

2.3 All nurses and midwives must develop a portfolio that provides supporting information such as: a record of sufficient practice hours; continuing professional development; practice related feedback; written reflective accounts; evidence that a reflective discussion has taken place with another NMC registrant; and they must make declarations to the NMC in regard to health, character, and professional indemnity arrangements. The supporting information must be confirmed by an appropriate colleague, normally a line manager, before the revalidation submission is made to the NMC.

2.4 However, it should be noted that, unlike medical revalidation, nursing and midwifery revalidation is not an assessment of a nurse or midwife's fitness to practise. It is also not a new way of raising fitness to practise concerns as there are existing governance processes and systems to monitor the conduct and performance of nurses and midwives in ESHT and disciplinary policies and procedures are in place.

2.5 The responsibility for participating in the revalidation process lies with the nurse and midwife who are obliged to revalidate to maintain their registration. Failure to revalidate by the appointed date provided by the NMC has the consequence of being removed from the Register, meaning that it is illegal to continue to work as a Registered Nurse or Registered Midwife. It also puts the nurse or midwife at risk of being moved to a Healthcare Assistant role temporarily and of disciplinary action. Nurses and midwives who have genuine reasons for delaying their revalidation submission are asked to contact the NMC directly and complete an exceptional circumstances form. The NMC considers each case on its merits. However, the NMC do not provide employers with details of these applications, and it is the responsibility of the registrant to keep the employer up to date on any decisions or outcomes from these applications.

2.6 Between the 1st April 2016 and 31st March 2017, 736 ESHT nurses and midwives were due to revalidate, of whom 731 (99.3%) successfully revalidated, with 5 (0.7%) registrations lapsing.



Apart from one nurse who made a human error by forgetting to submit her revalidation application online in time, all the registrations that lapsed were supported by exceptional circumstances, which included:

- Maternity leave along with exceptional circumstances
- Long term sick leave
- Maternity leave

3. Governance & Quality Assurance

3.1 The Nursing & Midwifery Council provides their own system of quality assurance by contacting one per cent at random of those who have confirmed a nurse's portfolio. The NMC does not make the Trust aware of how it assesses or benchmarks the portfolio. Consequently, the Trust is unable to emulate this quality assurance process exactly and is therefore in the process of establishing its own quality assurance system.

A randomised audit of portfolios is being considered and its methodology is being reviewed by the Trust Nursing & Midwifery Action Group to ensure equity in its approach. This is particularly important because the Trust engages 2052 nurses and approximately another 86 nurses via its Temporary Workforce Services. Unlike substantive and locum doctors, whose entire suite of supporting information is scrutinised by the Responsible Officer and

the Medical Revalidation Advisory Panel prior to the revalidation recommendation, the revalidation portfolio of each nurse and midwife is only signed off by a confirmer. Nonetheless, the NMC do have the right to request further information from the nurse about their portfolio such as their evidence of practice hours and Continuing Professional Development. In these circumstances an email is also automatically sent to the nurse's confirmer and/or reflective partner.

The additional information needs to be returned within six weeks of the NMC requesting it, and the verification process will be completed within three months of the nurse's or midwife's renewal date. The registration will not be affected during this process, and it will be renewed once the verification process has been successfully completed.

Once the revalidation application has been submitted, the reflective partner and confirmer, as entered onto the nurse's or midwives revalidation application form, will be sent an email by the NMC to verify those requirements took place.

The revalidation team is not automatically made aware of the NMC's audit. However, it is possible to make an assumption that this is being carried out as, when the team checks the monthly registrations, if the expiry date of registration has not been updated – but the nurse is still classed as registered – it is evident that there is either an audit taking place or that the nurse has made an application for exceptional circumstances to be taken into account. In 2016 – 2017, one per cent (n=7) of those who were required to revalidate were asked to provide additional information by the NMC.

The revalidation team quality assures the process of support provided to nurses and midwives and this is addressed in the section on feedback that follows later in this report.

4. Training & Guidance

4.1 ESHT Nursing and Midwifery Revalidation and Appraisal Policy

The ESHT Nursing and Midwifery Revalidation and Appraisal Policy is currently being reviewed, this is to reflect the findings and processes which have been developed over the first year of revalidation. The ESHT Nursing and Midwifery Revalidation and Appraisal Policy links to the newly ratified 'ESHT Appraisal Policy' (previously 'Performance Development Review Policy'), which provides a forum to discuss revalidation and raise any concerns a nurse may have in completing the requirements.

4.2 Support for ESHT nurses and midwives and those engaged via the Temporary Workforce Service

There were 2052 nurses and midwives in the Trust at 31 March 2017 excluding those who were engaged via the Trust's Temporary Workforce Service (TWS) (n=86).

The revalidation team has been providing weekly revalidation sessions at both the Conquest and EDGH sites. The following sessions have been held up to 31st March 2017:

- 102 workshop and team sessions have been provided. The sessions have been attended by 450 attendees that included registrants, confirmers, East Sussex County Council managers, TWS members and those not working within a clinical role, but still maintaining their registration.

4.3 Workshops

Two main styles of workshop session have been developed to cover all areas of revalidation:

- NMC Revalidation Workshops provide a general overview of revalidation and how to meet the NMC requirements.

- NMC Revalidation Workshops 'The role of the confirmer' are specifically targeted to those who are providing confirmation; the session also covers each requirement of revalidation and what they are required to do as a confirmer.

- All attendees receive a workbook for them to take away, which has everything they need to get started on their revalidation journey. A follow up email is also sent after the session, providing them with a recap of the session, as well as all the documents referenced during the workshop.

4.4 Team Sessions

On request the revalidation team has been providing sessions to groups of nurses within their areas, during a team meeting or study day. This has proved popular for Practice Educators and Matrons.

4.5 Individual Sessions

Individual 1:1 sessions have been provided on request, and have supported nurses who have had exceptional circumstances to complete their revalidation submissions on time.

4.6 Reflective Writing Session delivered by the Trust's Library Service.

In partnership with the revalidation team, the library service has been providing a reflective writing session at both the Health Sciences library and Rosewell library on a monthly basis. The content of the session is to aid with the 'written reflective account' requirement of the revalidation process, and how a reflective model, such as the Gibbs' Reflective Cycle could be used to fit into the mandatory form set by the NMC. The session also encourages nurses to use the services on offer from the library and how this could support their Continuing Professional Development. So far 297 have attended, and the library service has received great feedback about their sessions.

4.7 Resource Materials

All the sessions offered on revalidation have been developed to provide all the required information and guidance needed to approach the NMC's revalidation requirements, and to help alleviate the anxiety surrounding revalidation. During the sessions, examples are given of how to complete some of the requirements and advice provided about their scope of practice. Resource materials have been developed to assist with the sessions including presentations, guidance sheets, workbooks, and completed examples. The revalidation team has been requesting feedback from the sessions and responding to comments and suggestions, some of the feedback is detailed further on in the report. All resource materials are available on the Trust's revalidation extranet page.

Looking forward to 2017-18, the revalidation team has combined the two revalidation sessions and are now offering the workshop on a monthly basis at both the Conquest and EDGH sites over the coming year.

4.8 Extranet site

An extranet site has been developed so that nurses can view details of any training and support sessions, roadshows, workshops, library sessions (such as training on reflective writing), templates for revalidation portfolios and the most up to date guidance. Comments made via our feedback form have suggested our extranet page isn't very user friendly; we plan to work with the communications team to improve this during 2017-18, and very much welcome the new website being introduced to the Trust.

4.9 Registration Dates and Reminder Emails

As part of our work in supporting the confirmer and line managers, the revalidation team has been providing team-specific lists of revalidation dates. This has proved popular, and assists line managers to plan ahead, and book the confirmation meetings in advance. It also highlights when confirmations will need to be delegated to other supervising staff. This is an ongoing service, as the teams are ever evolving.

The revalidation team has been sending out reminder emails to all nurses and midwives who are due to revalidate. Where an email address is not located, correspondence has been sent to either the Matron or to the nurse or midwife's home address. The reminders are sent to them approximately 10-12 weeks prior to their revalidation date and then again approximately 4 weeks ahead of their revalidation due date.

The reminder emails provide an opportunity for the nurse or midwife to contact the revalidation team if they have any concerns about revalidation, as well advertising the revalidation team support sessions.

Recent improvements within the ESR system have meant an automated reminder email is sent to named supervisors within ESR for those registrants who are due to revalidate in the next 6 months.

4.10 Text Messaging

As part of our engagement work with TWS, the revalidation team has started to use the text messaging facility to send revalidation reminders. This has proved very useful when requesting information from members.

4.11 Developing learning needs assessments

The revalidation outputs of confirmers, and the nurses' and midwives' revalidation portfolios, will be quality assured by randomised auditing during the year. The findings of these audits will be reported to the Heads of Nursing and Governance, the Assistant Directors of Nursing and the Director of Nursing through the Trust Nursing & Midwifery Action Group for any action deemed necessary. Any learning will also be applied to training and support sessions provided by the revalidation team. The audit findings, and the application of any learning, can be included in future annual Trust Board reports on nursing and midwifery revalidation.

4.12 Feedback on the organisational support provided by the revalidation team

In order to quality assure the revalidation and appraisal process, a Nursing & Midwifery Appraisal Colleague Feedback form has been included in the Nursing & Midwifery Revalidation and Appraisal Policy. This form can be retained by the confirmer and/or appraiser for use as colleague feedback for their own portfolio.

During our support sessions a feedback form is provided. Tables 1 and 2 show the feedback about the information and support provided by the revalidation team; 425 feedback forms were returned by nurses and midwives during 2016 – 2017.

Table 1. Feedback on information provided by the revalidation team

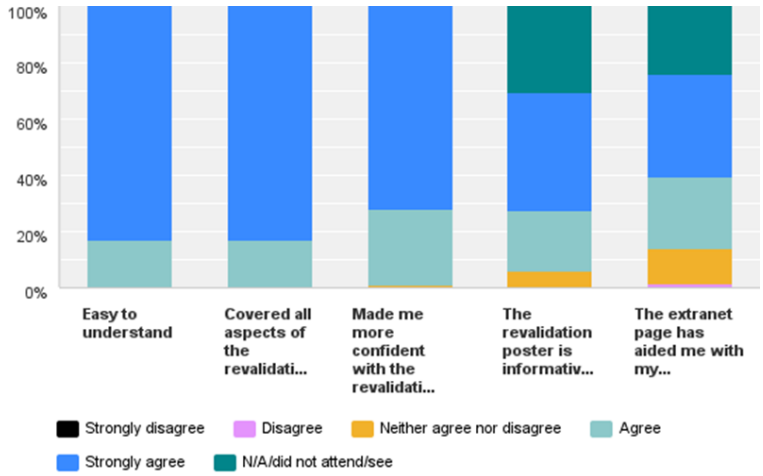
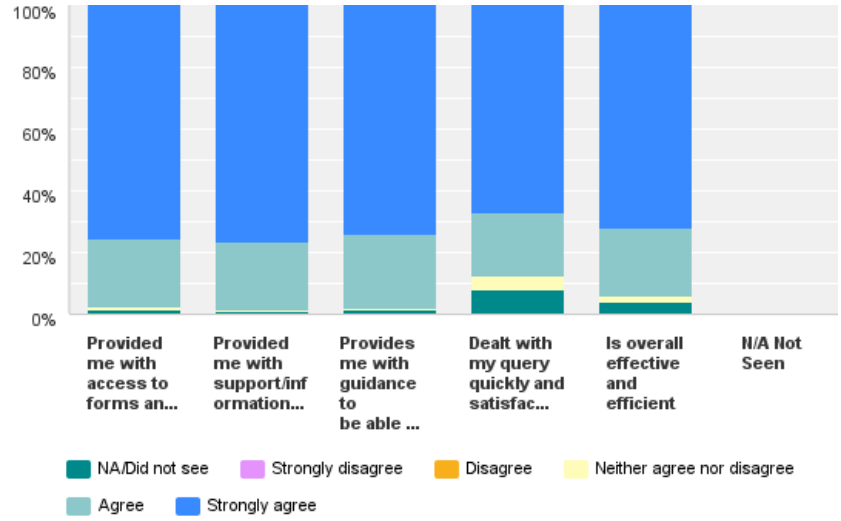


Table 2: Feedback on the support provided by the revalidation team



Comments received from attendees:

- *'The 1:1 has been an enormous boost to my wellbeing and mental state. I was very nervous but Jo and Agheta have been brilliant - 6* service. They gave me a lot of advice and kept me informed of what to do. They even took the time to look at my portfolio and gave advice. The sample booklet is a great help too. It enabled me to read, reflect, digest and write my Revalidations the correct way.'*

- *'I feel able to help & support staff going through revalidation. You gave me the confidence to do this on my own and to help others.'*

- *'Made process very clear- far less stressed about amount of work to submit. Very useful. Excellent/ clear presentation, thank you.'*

- *'Very helpful to learn about all aspects of revalidation and my role as a confirmer.'*

- *'First of all thank you very much for a very good, informative and re-assuring session. I had heard positive feedback from staff regarding the high quality of the sessions that the Revalidation Team provided and your session supported this.'*

5. Clinical Governance

One of the most important elements of any appraisal is the opportunity of reflection on what has gone well and also on what has been learned. The revalidation team now supplies every nurse and midwife with an appraisal governance report for their annual appraisal. This report contains information spanning over the previous 12 months and includes information about any complaints or incidents in which the nurse and midwife has been directly or indirectly involved. This means that the nurse can reflect upon what they have learned and how they have shared their learning and applied it to their clinical practice. It is this reflection and learning that promotes continuous improvement in the quality of our patient care.

Between 1st April 2016 and 31st March 2017, the team has provided 1277 appraisal governance reports (AGRs) to nurses and midwives. The revalidation team undertook an evaluation of the effectiveness of the AGRs over the past year by sending a survey to over a 1000 nurses on two separate occasions. The response rate was very poor as only 42 nurses completed the survey. The findings, therefore, are unrepresentative as the sample size is too small to be significant. The revalidation team asked nurses how they used the AGRs as a reflective tool as part of their appraisal and revalidation preparation. The revalidation team will be consulting the Trust Nursing and Midwifery Group on how best to receive this feedback in future.

6. Challenges and Next Steps

6.1 Shared learning and reflective practice by medical and nursing colleagues

Nursing revalidation was implemented in April 2016, and this has offered many opportunities to the Trust. We have the potential of integrating certain aspects of medical and nursing appraiser/appraisal training such as shared learning, reflective practice, quality improvement and patient and public engagement. Nurses and doctors have the additional opportunity of learning from the others' knowledge, skills and experience. The revalidation team plans to hold a focus group and invite medical appraisers and confirmers to explore the benefits and opportunities that might arise from joint working and shared learning. This activity will thoroughly support all the Trust Values.

6.2 Increased methods of communications with nurses

Increasing communications with nurses and midwives who do not have ready access to emails has been a challenge and so the revalidation team has recently implemented a text message system which will be reviewed over the coming year.

7. Recommendation

The Trust Board is asked to approve this annual report.

Alice Webster, Director of Nursing 02/05/17

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

NB: The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Designated Body Statement of Compliance

The Trust Board of East Sussex Healthcare NHS Trust can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   YES. The Medical Director acts as the Responsible Officer. An Assistant Medical Director has been appointed as the Deputy Responsible Officer.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   YES. The revalidation team maintains an accurate record of all licensed medical practitioners with a prescribed connection to ESHT.

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   YES. There are also new appraisers being appointed and trained to mitigate against any risk of the numbers of medical appraisers reducing.

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   YES. Medical appraisers are required to undergo two medical appraiser update training sessions each year. These sessions always include opportunities for professional calibration.

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   YES. The compliance rating in ESHT for medical appraisals is extremely high and a record is maintained of the reasons for any missed or deferred appraisals. An effective non-engagement process is additionally employed, supported by Trust policy.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

YES. Clinical governance and monitoring of conduct and performance is undertaken by individual Divisions with the support of senior medical leaders.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

YES. The Trust has a formal process for responding to concerns and a ratified remediation policy is in place.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

YES. A formal transfer of information system is overseen by the Revalidation Team, working closely with the Medical Staffing team.

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

YES. Human Resources' Recruitment Team and the Medical Staffing Team are required to undertake all appropriate pre-employment checks.

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

YES. The Medical Revalidation Advisory Panel oversees the actions for continual improvement of all areas in the system of medical revalidation.

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: EAST SUSSEX HEALTHCARE NHS TRUST

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Thursday 23rd March 2017 at 10.00am in Committee Room, Conquest

Present: Mr Mike Stevens, Non-Executive Director (Chair)
Mrs Sue Bernhauser, Non-Executive Director

In attendance
Mr Chris Lovegrove, Counterfraud Manager, TIAA
Mr Adrian Mills, Audit Manager, TIAA
Ms Janine Combrink, Director, BDO
Mr Stephen Hoaen, Head of Financial Services
Mrs Emma Moore, Clinical Effectiveness Lead
Mr Jonathan Reid, Director of Finance
Mr Mike Townsend, Regional Managing Director, TIAA
Mrs Lynette Wells, Director of Corporate Affairs (item 21/17 onwards)
Dr James Wilkinson, Assistant Medical Director
Mrs Hilary White, Head of Compliance
Mr Andy Bissenden, Associate Director, ESHT Digital
Mr Chris Hodgson, Associate Director, Estates
Ms Fran Edmunds, Head of Nursing, Women and Children

Mr Pete Palmer, Assistant Company Secretary (minutes)

Action

014/17 Welcome and Apologies for Absence

Mr Stevens opened the meeting and introductions were made.

Apologies for absence were received from:

Mr Barry Nealon, Non-Executive Director
Dr David Walker, Medical Director
Mr Jody Etherington, Audit Manager, BDO
Mrs Alice Webster, Director of Nursing

015/17 Minutes of the meeting held on 19th January 2017

i) The minutes of the meeting held on 19th January 2017 were reviewed and approved as an accurate record.
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ii) Matters Arising

The following verbal updates were provided:

National Adult Diabetes Audit

Mr Wilkinson explained that the Trust was unable to participate in the main adult part of the audit as there was an issue with the cost of purchasing the necessary software. He explained that PMO had taken on the task of resolving the issue and had identified a software suite that would enable participation, alongside wider management of diabetes within the Trust, at a cost of £84k.

Mr Stevens asked that the production of a business case for the software be prioritised as the Board had made it clear that they wanted the issue to be resolved. Mr Reid noted that funding for the software had been allocated from the 2017/18 budget and agreed to prioritise the production of the business case.

Pharmaceutical Write Offs

Mr Hoaen explained that he had requested comparative data on pharmaceutical write offs from other organisations, but had not received any. He asked that the item be added to July's agenda. **PP**

Chemocare Administrator

Mr Reid reported that a business case had been completed and was being processed. Three Trusts would share the funding for the position, and it was proposed that ESHT would employ the member of staff.

TIAA IT Audit Recommendations Update

Mr Bissenden explained that a concerted effort had been made to improve communication with TIAA and to provide updates on audit recommendations in a timely manner. He reported that the IT department had reduced the number of outstanding recommendations from 82 to 14 and reviewed the progress on a monthly basis. He asked for access to the web based tracker and Mr Palmer agreed to arrange this. **PP**

016/17 Board Assurance Framework and High Level Risk Register

Mrs White presented the Board Assurance Framework (BAF) and High Level Risk Register, explaining that the paper had been discussed at both the Trust Board meeting and the Quality and Safety Committee earlier in the week. She noted that the number of high level risks had been reduced to 47, and not 26 as detailed on the front sheet.

Mr Stevens noted that the BAF and Risk Register were lengthy

documents and explained that he was concerned that the Committee might miss important information. He asked if a digested register could be presented to the Committee in future, focussing on the issues that most needed the Committee's attention. Mrs Bernhauser agreed that the Quality and Safety Committee should review the full documents and would share appropriate risks with other committees.

The Committee reviewed and noted the revised High Level Risk Register and Board Assurance Framework and were of the view that the main inherent/residual risks had been identified and that actions were appropriate to manage the risks.

The Committee supported the recommendation to the Board to reduce the rating associated with Clinical Administration from amber to green.

017/17 Women and Children Clinical Audit & Risk Register

Ms Edmunds explained that the division held monthly risk meetings within the women's and children's departments, and met on a daily basis within maternity. Identified risks were escalated to a divisional accountability meeting. Well attended quarterly clinical audit meetings took place, and a new clinical effectiveness co-ordinator was in post.

Ms Edmunds reported that 13 risks were on the division's risk register, the highest of which was rated as 16 and related to the inappropriate admission of children with mental health issues to paediatric wards. Work was being undertaken with Sussex Partnership Trust to address the issue which resulted in young patients staying in hospital for longer than was ideal. Sussex Child and Adult Mental Health Service (CAMHS) were developing a transformation plan to resolve the issue and had seconded a CAMHS nurse into the organisation.

Ms Edmunds noted that there were only 10-12 tier 4 beds for children with mental health issues, the nearest of which was in Haywards Heath, and they were regularly fully occupied. The beds were assigned based on an assessment of the level of need of the patient and was not controlled by the Trust. Mr Reid noted that no additional funding was realised for the care of these patients, although the costs of special care would be recharged to Sussex Partnership Trust in the future. Ms Edmunds reported that a practice educator would look to develop training for staff during the summer to improve the care given to these vulnerable patients.

Ms Edmunds reported that the division had completed 19 clinical audits during the previous two years. 15 audits were outstanding

and work was being undertaken to engage with clinicians to encourage them to complete audits in a timely manner. Dr Wilkinson noted that there had been issues with ensuring medical attendance at the divisional audit meeting, and hoped that a recent change in leadership would address the issue.

Mr Stevens thanked Ms Edmunds for the clear presentation of the issues facing the division.

018/17 Estates & Facilities Risk Register

Mr Hodgson reported that the Estates and Facilities division were reporting a much improved position with 43 open risks, 11 of which were rated as extreme. The risks were reviewed on a monthly basis. Many of the risks related to the Trust's maintenance backlog, and would require continued investment over 4-5 years before they could be removed from the register. Work had been started on a maintenance backlog programme, and this would continue in future years which would reduce risks in the long term.

Mr Hodgson reported that the risk relating to asbestos was difficult to address as the asbestos was above the ceilings of wards at EDGH and it was not possible due to organisational pressures to empty wards. He noted that it was possible that East Sussex Fire & Rescue would issue the Trust a warning notice. A related issue concerned compartmentation in the ceilings, and fully resolving the issues would take between 3-6 months.

Mr Reid asked if the work could be undertaken in a phased fashion and Mr Hodgson explained that it was possible but would reduce capacity by 50-60 beds while it was undertaken. Mr Reid noted that work was being undertaken to devise a bed plan which accurately matched the Trust's capacity based on demand and Mr Hodgson agreed to ensure that the issue was incorporated within these plans.

In response to a query from Mr Stevens about risk 1389, Mr Hodgson explained that the risk relating to the failure of sewage disposal systems could not be eliminated, and careful consideration had been given to ensure that it was appropriately managed and rated.

Mr Townsend asked whether risk 1823 concerning potholes and the condition of roads within the Trust was correctly rated. Mr Hodgson explained that the rating was being reviewed, noting that the number of claims received by the Trust was significant and that the issues had not been resolved.

019/17 ESHT Digital Strategy

Mr Bissenden presented an update on ESHT's Digital Strategy, explaining that the next step in the process would be to create a website to form a 'living strategy'.

Mr Stevens asked whether learning was being shared with other Trusts to fully understand what would constitute an effective digital strategy. Mr Bissenden reported that he had liaised closely with other Trusts via East Sussex Better Together and the STP. Issues with disparate systems across the Trust had been identified and work was underway to ensure that all systems were compatible in the future.

Mr Reid explained that some of the proposed IT projects would be self-financing, with straight forward business cases due to savings that would be realised in time, finances and in staff in the long term.

020/17 Clinical Audit Update

Mrs Moore reported that TIAA had recommended the development of a grading system of audits which would be implemented in April. Highly rated risks reviewed by the clinical audit team to act as an early warning system, and would be escalated appropriately.

She reported that audits were now being marked abandoned when staff had left the Trust prior to finishing them. Data on audits would be provided for annual appraisals from April 2017 so that these could be discussed and Trust policies would be updated to reflect this. Mr Stevens noted that recognition for the completion of audits needed to be fully incorporated into the appraisal process. Dr Wilkinson explained that the revised appraisal process would provide an opportunity to discuss any reasons for audit abandonment, noting that the recent high abandonment rate had been due to the rationalising of the Trusts' backlog of audits.

Mrs Moore reported that the clinical audit work plan for 2017/18 was due to be finalised during the following week, and that it would be circulated to the Committee once it was completed. She reported that 53 national audits had been mandated, an increase on the number for the current year. Divisions would be provided with support to undertake these audits, but she anticipated a reduction in the number of local audits being undertaken due to the significant amount of time needed to undertake the mandatory work.

Mr Stevens reported that he felt reassured about the good progress that was being made, and thanked Mrs Moore for the excellent presentation of her paper.

021/17 Internal Audit Progress Report

Progress Report

Mr Mills reported that nine final audit reports had been issued since the last meeting of the Audit Committee. Two had given substantial assurance, three reasonable assurance and one limited assurance. Three operational reviews has been issued which didn't carry an opinion.

Mr Stevens asked whether the pay review had improved the Trust's processes, and Mr Reid explained that he felt that the processes in place were robust, and that issues raised by the audit had been implemented appropriately.

Mr Reid reported that the operational review of budget maturity had provided a lot of useful information and that planning sessions had been convened to ensure that the information was used to improve working practices.

Mr Mills reported that progress against the audit plan for the year had been updated. He noted that the review of telephone usage had shown a large number of unused mobiles which were still being paid for and that this was being investigated more fully. A program of follow up work, to review audits which had received limited assurance, was being undertaken and would help to form the overall audit opinion for the year.

Audit Tracker

Mr Mills reported that 76 recommendations relating to IT had been cleared since the last meeting of the audit committee, but that 70 still remained on the tracker, which were being followed up.

Work Plan

Mr Mills reported that the work plan had been developed in conjunction with the Trust. The auditors had met with divisions and senior management and hoped that their work would link with projects being undertaken by the Trust during the year. He noted that findings and recommendations from the CQC's reports into the Trust had been incorporated into the work plan.

Mr Stevens asked whether work the auditors undertook with other organisations influenced the work plan for ESHT. Mr Townsend explained that cybersecurity had been identified as an emerging risk in other Trusts and had been included as a result.

Mr Reid reported that the work plan had been presented to Trust executives who had felt that the plan was well aligned with Trust plans and had suggested minor changes. He noted that additional

work would be added as the year progressed and issues were identified.

022/17 Local Counter Fraud Service Progress Report

Mr Lovegrove reported that the Local Counterfraud Service (LCFS) work plan for 2017/18 was being presented in a new style from previous years as a risk based plan incorporating local and national risks. It was a live document that could be updated as required. Mr Reid noted that the plan would be reviewed at an upcoming executive's meeting, but anticipated that it would remain largely unchanged.

Mr Stevens noted that he was pleased to see that shared learning was incorporated within the work plan.

Mr Lovegrove explained that restrictions had been introduced regarding overpayments of salary which meant that LCFS could no longer become involved with cases where existing members of staff had received communication from the Trust but had not made any payment. Mr Hoaen explained that in some cases these were written off as bad debt, but that processes would be reviewed in light of the new guidance to take civil action.

Mr Lovegrove reported that LCFS would be undertaking a review of items that had been loaned to patients by the Trust and not returned during 2017/18. Items were sometimes being sold on or thrown away. Mrs Bernhauser noted that wards labelled and numbered crutches and zimmer frames and were clear about how they should be returned, requiring patients to sign a contract for the loaned items.

Mr Lovegrove reported that the Trust's self-review tool had been completed and would be submitted following review by Mr Reid at the end of March. The self-review tool acted as a counterfraud healthcheck for the organisation.

He reported that a newly referred piece of work was being carried out jointly by LCFS and internal audit to review contractors and invoicing processes. Deep dives would be undertaken to see if there were areas of weakness that needed to be addressed.

Mr Lovegrove reported that a review of declarations of interest had been undertaken. He noted that the forms provided by staff had been simplified and complete however, there were some concerns about the process for following up staff who did not complete the forms. Mrs Wells reported that 16 members of staff had been identified as failing to make a positive declaration. They had been followed up but only five had since completed appropriate declarations.

Mrs Wells reported that the declarations process had been changed for the upcoming year, with private practice needing to be declared for the first time. Mr Lovegrove explained that he would like deterrents for not declaring to be made clearer and Mr Stevens agreed that this should be done. Mr Wilkinson asked that a list of non-compliant doctors be sent to him so that it could be followed up appropriately. **PP**

The Committee noted the Local Counter Fraud Service Progress Report

023/17 External Audit Progress Report

Ms Combrink explained that a final onsite visit was due to be carried out for 2016/17's audit, but that no significant issues had been identified during pre-planning. Payroll processes have been identified as an issue and would be reviewed during the final audit visit, which was anticipated to begin at the end of April.

She reported that the Audit Plan 2016/17 had set the Trust's materiality level at 1.75%, and that this figure would be revisited when the draft accounts were issued. She explained that the level would be adjusted if necessary.

Mr Stevens questioned why the audit plan was being presented at such a late stage, and Mr Reid explained that the plan being presented was a focussed version of previously agreed plans. It had been discussed and agreed with the finance teams.

Ms Combrink reported on a number of issues that had been identified and would be scrutinised in detail during the audit process. Mr Stevens noted that he had found the plan to be very clear.

The Committee noted the External Audit Progress Report

024/17 Information Governance Toolkit Report

Mrs White reported that the Trust anticipated submitting the Information Governance Toolkit (IGT) at the end of March with all areas scoring two or above. A recent tiaa audit had provided a good outcome. Mr Reid noted that the Trust was exploring the additional resources that would be needed for compliance with the introduction of the General Data Protection Regulation (GDPR) which would generate a large amount of mandatory work.

Mr Bissenden noted that submission of the IGT would alter from an annual submission to a continual cycle of submission in 2017/18, and Mr Reid agreed to provide assurance to the Committee about plans to meet the new requirements.

Mr Stevens asked how many staff in the organisation required smartcards. Mr Bissenden explained that the cards were being used to access a large variety of systems across the Trust and anticipated that 100% of staff would need to be issued with smartcards.

The Committee noted the Information Governance Update Report.

025/17 Changes in Accounting Policies

Mr Hoaen reported that very few changes in accounting policy were included with the Group Accounting Manual 2016/17. Mr Stevens said that he had been surprised by the bad debt rules that had been implemented. Mr Reid explained that the rules had been changed to encourage a realistic local assessment of bad debt and that the Trust would look at information from previous years in order to make a realistic assessment.

026/17 Draft Annual Governance Statement 2016/17

Mrs Wells presented the first draft of the Annual Governance Statement, noting that the document was owned by the Chief Executive and reviewed the effectiveness of the Trust's internal systems of control. She asked Committee members to contact her with any revisions they might want.

027/17 Annual Review of Effectiveness Checklist

Mr Stevens asked that Non-Executive colleagues, Mr Reid, and internal and external audit completed the annual review of effectiveness. The documents would be circulated following the meeting. **PP**

028/17 Date of Next Meeting

The next meeting of the Audit Committee will be held on:

Wednesday 31st May 2017 at 1000 in Room 5, Education Centre, Conquest.

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on
Wednesday 26th April 2017 at 9am – 11.30am
In St Mary's Board Room, Eastbourne DGH

Present: Mr David Clayton-Smith, Chairman (Chair) for Mr Barry Nealon
Mr Mike Stevens, Non-Executive Director
Mrs Jackie Churchward-Cardiff, Non-Executive Director (part)
Dr Adrian Bull, Chief Executive
Mr Jonathan Reid, Director of Finance
Mr Ian Miller, Director of Financial Improvement
Mrs Lynette Wells, Director of Corporate Affairs

In attendance: Mr Dan Bourdon, Interim Deputy Director of Finance
Mrs Jenny Darwood, General Manager, Transformation
Miss Chris Kyprianou, PA to Director of Finance (minutes)

056/17	**Welcome and Apologies for Absence** Mr Clayton-Smith welcomed Dan Bourdon, Interim Deputy Director of Finance and Jenny Darwood, General Manager for Transformation to the Finance & Investment Committee and introductions were made. Apologies were received from Barry Nealon, Joe Chadwick-Bell and Tracey Rose (on behalf of Catherine Ashton).	**Action**
057/17	**Minutes of the Meeting of 29 March 2017** The minutes of the meeting held on 29 March 2017 were agreed as an accurate record.	
058/17	**Action Log** <u>(i) Cashflow – monthly review</u> At the last meeting, the Committee had requested a paper on how NHSLA works. Mrs Wells reported that she will present a paper to the May meeting. <u>(ii) Review of Committee Governance</u> This was included is section 063/17 below. <u>(iii) Draft 17/1Work Programme</u> It was noted that Mr Nealon would review the draft Work Programme	**LW** **JR/BN**

	with Mr Reid on his return from annual leave.	
059/17	**Integrated Performance Report/Finance Report – Month 12** Mr Reid presented the month 12 Finance Report and highlighted the key issues. It was noted that the full Integrated Performance Report was not included in the pack as this was still in draft. The Trust performance in month 12 was a run-rate deficit of £1.5m with an adverse variance against the original plan of £0.9m. At year end, the deficit stands at £43.9m, which is £12.6m worse than plan. Mr Reid reported that the Trust ended the year meeting its CRL limit. It was noted that some of the expenditure was deferred into the 17/18 capital year. The cash position remained extremely challenging. However the Trust met the £2.1m balance at 31 March 2017. This has led to a significant growth in the creditors. Mr Reid reported that the report will be slightly more streamlined for the next financial year. **Action** **The Committee noted the financial performance for Month 12 and noted the current and projected risks associated with the current projected financial position and the steps being taken to mitigate the risks as far as possible.**	
060/17	**Contracts – Monthly Review** The Committee received a paper providing an update on the 2016/17 contract income position, identifying any risks in the reported year end position and describing steps being taken to mitigate the risks. The Trust had set an ambitious income plan for the year. M12 final accounts had reported actual income exceeding plan. Levels of activity growth in the year were significant and this had been 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 were identified in the work the Trust had undertaken and these schemes were detailed in the FRP. **Action** **The Committee notes the current position regarding NHS income and the steps being taken to ensure the best outcome for the year.**	
061/17	**Cashflow – Monthly Review**	

	Mr Reid presented a paper setting out the cashflow plan for the next 12 months and highlighting the risks and pressures to those plans. The Trust continues to apply on a monthly basis for additional cash to match the monthly planned deficit; As the Trust is in Financial Special Measures (FSM) all loans from the Department of Health are at 6%. The Capital programme is planned to be funded from internally generated depreciation and additional loans from DoH. Failure to secure these loans will result in the capital spend being reduced. It was noted that 2017/18 looks to be even more challenging than the previous year as the Trust starts the year with a significant value of aged creditors, strained trading relationships and a CIP target that could quickly generate pressure on financial performance against plan. Mr Reid reported that the Trust had anticipated getting £2.3m worth of Education Funding the previous week, which did not materialise resulting in the Trust being £494k overdrawn. However the affects of the risks were mitigated. **Action** **The Committee noted the ongoing management of cash and capital within the Trust.**	
062/17	**Capital Programme – monthly review** The Committee noted that the capital resource limit (CRL) for 2016/17 was £11.5m and is internally generated by the Trust's level of depreciation. The plan excludes any on-going bids for additional capital resource whilst business cases are developed. At the end of month 12, the year to date capital expenditure was on plan. The Capital Approvals Group reviews and monitors the capital programme on a monthly basis and ensures that the Trust does not exceed the capital resource limit. **Action** **The Committee noted the current performance of the capital programme and the risks associated with limited capital.**	
063/17	**Financial Plan/FSM Update** At the last Finance and Investment Committee, the Committee had asked for a refreshed financial plan to meet the control total. The Trust had also met the Financial Special Measures team in March and agreed to refresh the financial plan, testing the key assumptions and	

	establishing how it is was going to deliver the control total of £36.5m. Mr Reid presented a paper highlighting the refreshed key components of the financial plan and the process for the delivery of the control total. It was noted that the Trust delivered an outturn deficit of £46.5m (before STF funding) in 2016/17. This was £4.8m behind the initial plan, however this is in line with the revised forecast submitted to NHSI in month 10. The Committee reviewed the table showing the breakdown of the £4.8m variance and the run rate for the year. It was noted that whilst some of the M12 position includes non recurrent items, there has been a significant reduction in the run rate from the start of the year. The specific increase in CIP of £6m from previous iterations, £1.7m from additional FSM interest charged on all borrowing, and £4.2m to reflect contract risks/challenges. This drives a £28.7m efficiency requirement. The Committee were advised that while the Trust is in FSM all loans are charged at 6%. The Trust had not anticipated the increase in interest charges on the submission of the previous plan. Mr Reid summarised the key components of the refreshed plan. The efficiency requirement is a £28.7m improvement, this is required in the position to meet the control total. It was noted that the margin on new non-ESBT work is minimal, reflecting capacity and temporary workforce challenges. The Trust will work with the CCG to manage demand. The Committee noted that there were significant opportunities to reduce additional spend against run-rate. This will be a key focus within the efficiency plan, alongside productivity and efficiency savings Mr Reid highlighted the bridge charts which explained the movements in income and expenditure for 2017/18. An update was given on the actions in train to improve the position and the further work required, including a Capacity, Demand and Bed Review, New Medical Model, New Urgent Care Model, and other Business cases and pressures. Mr Clayton-Smith queried how long it would take for the further work to be carried out. Mr Reid confirmed that the diagnostic analysis on the bed review had already been done. This requires further discussion at the Executive Director's meeting and will be presented to the F&I Committee in May. The Medical Model may well happen as the Trust firms up the rest of the components of the efficiency plan. The Committee received an update on the 2017/18 Efficiency Programme (Financial Improvement Programme). It was noted that the Trust had made good progress in 2016/17, setting	**JC-B**

up a financial arm to the PMO, and developing an FRP in October and November which delivered a substantial reduction in run-rate and savings of £12.45m against a target of £16.1m. A number of key lessons had been learned, including the need for strengthened governance and focus on delivery, the need for rapid escalation and greater resources and support, both within central teams and the Clinical Units tasked with delivery.

Mr Reid presented an updated version of the Financial Improvement Process (FIP) noting that governance, leadership and administration of the programme had been refreshed under the FIP. The Committee reviewed a diagram showing the overall approach with three key components:

- Improved financial management
- Integrated business planning
- A more robust delivery approach

The Committee noted the changes to the governance structure. Mr Reid reported that a refreshed paper which described the new governance architecture was considered at the FISC Committee on 25 April 2017. The strengthened governance process and new gateway process was noted. New escalation and QIA arrangements have been implemented and a quality control checklist has been developed. Mrs Churchward-Cardiff queried whether the various levels of approval was slowing down the process. Mr Reid explained that the schemes would go through a more rigorous process but that this should not delay the implementation.

Mr Stevens queried how the governance worked at a clinical unit level as it was absolutely essential that this is monitored and is part of the process. He queried what they would do if they were adrift after a few months and did they have any capacity to make changes and also have they got ownership of their overall target. Mr Miller explained that meetings were taking place with the divisions to see how they were managing this on a week to week/monthly basis.

It was noted that one of the key components of getting approval to go into the green 'Approval of PID gateway' box is that there is a robust timetable with milestones.

The range and focus of the CIP programme had been extended and more clarified with more systematic reporting, support and challenge to each workstream.

The Trust had identified £46.6m of opportunities as at 23 April 2017. There was a much more robust process in place for turning these opportunities into signed off cases.

The Financial Improvement & Sustainability Committee had signed off projects for £9.7m at their meeting on 25 April 2017 and there were a series of projects for £14m were due to be signed off over the next 6 –

	8 weeks. Mr Reid reported that the Grip and Control measures were being reviewed to ensure that they were robust, and he gave an overview of the work that was going on to re-test the budgets to make sure they were understood and signed off. The Committee noted that there were a number of specific measures in train to try and bring down the costs around corporate costs, operational management structure and investment decisions. Mr Stevens asked whether Mr Miller was comfortable with where the Trust was now and where it was going. Mr Miller said he was very comfortable that over the next few months the Trust will be able to demonstrate that all those things are working effectively. The Committee noted that progress against the financial plan is monitored on a weekly basis through the Programme Management Office, and by the Executive Directors. The overarching programme is formally reviewed on a monthly basis through the Financial Improvement and Sustainability Committee, and by the Finance and Investment Committee on behalf of the Trust Board. Support and challenge is provided by the NHSI Financial Special Measures Team. The next formal progress review is on 4th May 2017, where the Trust will be re-tested on the commitment to the control total. Mr Reid presented the Committee with information on the East Sussex Better Together (ESBT) System Financial Plans and the Capped Expenditure Process (CEP). It was noted that within ESBT, the Trust, CCGs and East Sussex County Council have developed a shared Strategic Investment Plan (SIP). The SIP detailed the commissioning investments and savings required to ensure system financial balance, and was being extended to include the ESHT financial position. This had been developed on a collaborative basis, with inputs from all members of the ESBT accountable care system, and reflected the priorities and plans of all partners. The Committee reviewed a table setting out the key headlines from v5.4 of the Strategic Investment Plan. It was noted that at a high level there was a financial shortfall of £10m across the ESBT plan. Planned investment in primary care and HH of c£10m are being held as a non-recurrent reserve to mitigate this gap as agreed by the ESBT Integrated Management Team. Nationally, NHSI and NHSE have agreed a process for financially challenged health economies called the 'Capped Expenditure Process.' This is being managed through STP groupings and is aimed at ensuring delivery of services within the overall available financial envelope. The process is new, and untested, and information is just being made available to Trusts and CCGs.	

	The CEP requires that STPs deliver within the available resources the aggregate control total, which comprises the sum of control totals for each of the constituent organisations. The Committee noted that there were two components to the gap to be addressed: - Planning Risk - Operational Risk The Trust and the CCGs have been requested to join NHSI/NHSE on 2 May 2017. A planning submission is due on 4 May 2017 from the STP setting our steps to bridge the gap. Mr Reid reported that a further iteration on the position of the financial plan will be presented to the May F&I Committee together with a more detailed update on the governance structure. It was agreed that Mr Reid would brief Mr Nealon prior to the next meeting. **Action** **The Committee noted the refreshed key components of the financial plan and the process for the delivery of the control total.**	**JR** **JR**
064/17	**Review of Financial Governance** This was discussed in section 063/17 above. **Action** **The Committee noted the proposed options to strengthen FISC governance and the further changes required.**	
065/17	**Business Planning Update 2017/18** The Committee received an update on the progress with the business planning process. It was noted that the Business Planning and Development Team had been supporting the development of the divisional business plans. Although good progress has been made, further work is required including development of detailed plans and timelines for delivery of the divisional financial control totals. Further work is also required to identify the interdependencies between divisional plans, workforce requirements, and plans to address the financial challenges. The work is expected to be completed within the next 3 weeks, with continued support from the Business Planning and Development team. The Committee noted the following summary risks: • The potential impact of the ESBT financial plan and schemes which	

	have not been incorporated into the plans for 2017/18. • Delay to the finalised financial plans being signed off by divisions which have a direct impact on the business plans. • Operational challenges may result in limited engagement from divisional leads and their teams with the business planning process and in particular, with finalising the timescales for delivery. The strategy, planning and finance teams are actively supporting the process to mitigate this risk and good engagement has taken place to date. **Action.** **The Committee noted the progress of the business planning round for 017/18.**	
066/17	**ESBT/ Alliance Executive Financial Plan 2017-18** The Committee noted that the Trust, working within East Sussex Better Together, is aware of and supporting the broader system efficiency programme, which has estimated savings of £50m in the 2017/18 financial year. The Committee received a schedule setting out the schemes which were anticipated to impact on the Trust's activity, cost and income. The Trust has not yet reflected full delivery of these schemes in its financial plans for 2017/18, as the level of evidence around income and activity reduction was not yet sufficiently robust, and a risk-share agreement has not yet been put in place. As the Trust gains confidence in delivery, and understands the implications for the cost base, these schemes will be reflected in the financial position and plans for the Trust. The schemes are a subsection of the broader East Sussex Better Together Strategic Investment Plan – which is monitored through the East Sussex Alliance Governing Body and Alliance Executive. The Trust PMO is working alongside the CCG PMO to develop a single PMO reporting function and approach, supporting both the Trust, the Governing Body and the Alliance Executive in monitoring and tracking progress. The Alliance Executive is working to develop a single financial framework across the shadow Accountable Care Organisation, aimed at supporting both the Executive and the Governing body in managing the budgets for the system. The difference between the Trust and CCGs individual entity organisations is current £38m, plus £12 differential baseline. This is reflected in contractual agreements and financial plans, and the Trust alongside the CCG is working to agree a refreshed approach to the system control total by agreement with NHSI/NHSE. **Action.** **The Committee noted the update on the ESHT/Alliance Executive Financial Plan 2017/18**	
067/17	**Sussex and East Surrey STP Financial Plans**	

	The Committee noted that the Sussex and East Surrey STP continues to work across local health economies to develop the financial plans for 201718-2020/21. The latest financial planning position for the STP was provided which showed a significant financial challenge across the STP and within each of the localities. The STP Finance group continues to work with key workstreams across the STP to support the development of financial improvements, and the Trust is fully participating in this process. The STP has been notified by NHSI and NHSE that it needs to work to a 'financial envelope' approach, although the implementation of this approach remains unclear. The Trust has secured a copy of the letter which was sent out to some parts of the STP, and a meeting with NHSI/NHSE has been arranged for early May 2017, alongside a meeting with the CCG/County Council and Trust in late April 2017. **Action** **The Committee noted the position of the Sussex and East Surrey STP Financial Plans**	
068/17	**Board Approval for Annual Cost Collection submissions: Costing Transformation Programme, Integrated Reference Costs, Education & Training Collection** The Finance & Investment Committee is required to confirm in advance of the 2016/17 Costing Transformation Programme Patient Level Costing, Reference Costs, and Education & Training Cost Collection submissions that it is satisfied with the Trust's costing processes and systems, and that the Trust will submit its returns in accordance with the guidance. Mr Reid presented a paper providing assurance to the Committee (acting on behalf of the Trust Board) as mandated by NHSI, to ensure that it is satisfied with the Trust's costing process and systems and that the Trust will submit its Combined Costs Collection 2016/17 in accordance with NHSI guidance. For 2016/17, the Reference Costs and Education & Training collection process have been amalgamated into a Combined Costs Collection and should be signed off by both the Finance Director and the Education Lead for the Trust, in addition to a new submission under the NHSI Costing Transformation Programme (CTP). For the 2016/17 Combined Costs Collection, there is an additional requirement for Trust Boards (or other appropriate Board sub-committees) to approve the costing process that supports the Combined Costs submission. This Board confirmation needs to be obtained in advance of the Combined Costs submission and should be subjected to the same scrutiny and diligence as any other financial return submitted by the Trust.	

	As part of its assurance, the Trust Board (via the Finance & Investment) is specifically required to confirm that: i. The Finance Director and Education Lead have, on behalf of the board, approved the final combined costs collection return before submission; ii. The return has been prepared in accordance with the approved costing guidance, which includes the Combined Costs collection guidance; iii. Information, data and systems underpinning the Reference Cost return are reliable and accurate; iv. There are proper internal controls over the collection and reporting of the information included in the Reference Costs, and these controls are subject to review to confirm that they are working effectively in practice; and v. Costing and Education & Training teams are appropriately resourced to complete the combined costs collection return, including the self-assessment quality checklist and validations, accurately within the timescales set out in the guidance. The Committee noted the revised timescale for completion of the combined costs collection. Mr Reid assured the Committee that the process had previously been audited and the results of the audit were very positive. There had been a recent audit and the Trust was awaiting the results. Mr Reid confirmed that he was very comfortable that the process that was in place was robust, transparent and rigorous. **Action** **The Committee confirmed in advance of the 2016/17 Costing Transformation Programme Patient Level Costing, Reference Costs, and Education & Training Cost Collection submissions that it was satisfied with the Trust's costing processes and systems, and that the Trust will submit its returns in accordance with the guidance.**	
069/17	**Operational Productivity Programme (Lord Carter)** Mr Reid presented a brief update outlining the progress to date in response to the NHSI Operational Productivity Programme from a local perspective, describing the Trust's continuing engagement in the project and the steps being taken to ensure that the Trust validates and exploits the true potential efficiency improvement opportunities that are identified. The Committee noted that the current gaps highlighted in the report were being considered through the FISC and being acted on. **Action**	

	The Committee noted the progress to date in response to the NHSI Operational Productivity Programme.	
070/17	**Commercial Strategy and Market Developments** The Committee received an update on the current status of business cases and tenders. When agreed these cases and tenders will be incorporated within the annual business planning process. It was noted that 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. Business cases and tenders are currently monitored by the Business Case Approvals Group (BCAG) on a monthly basis and from May the work will be monitored by the Business Development Group (BDG). Mr Reid reported that there was now increased resource within the Business Planning and Development Team to enable the Trust to look out for the bids that are coming up to enable the Trust to position itself early. Mr Reid reported that the Trust had not yet signed off the contract for the iMSK contract and was in extensive dialogue with the CCG about the financial responsibility for the backlog. It was noted that the Trust had developed a really good implementation plan. Mr Stevens said it would be helpful on the tenders section to include an additional column showing the value. Mrs Wells asked whether the title of this report could be reviewed to reflect what the paper contained. It was noted that while this was a useful and valuable paper its title was a little misleading and in future should be entitled simply "Market Developments" **Action** **The Committee noted the update on tenders and service developments.**	**TR** **TR**
071/17	**Leasing of IM&T Equipment** Mr Reid reported that there was a significant shortfall in the number of computers and laptops across the organisation, and a number of those that exist are now obsolete. It was noted that the Trust had been out to market to explore the pricing opportunities but this has not yet been discussed at the Executive Directors meeting.	

	Mr Reid reported that the Trust had a price and a potential contract offer for replacement of the equipment and this would be discussed at next week's Executive Directors meeting before bringing it back to the F&I Committee. **Action** **The Committee noted the position of the leasing of IM&T Equipment.**	**JR**
072/17	**Draft 2017/18 Work Programme** The draft work programme for 2017/18 will be reviewed by Mr Nealon on his return from leave. **Action** **To be reviewed by Mr Nealon on his return from leave.**	**BN**
073/17	**Minutes to note – for information only** The Committee received the minutes of the following meetings for assurance and information: • Financial Improvement & Sustainability Committee – 28.3.17 • Digital Steering Group – 6.4.17 **Action** **The Committee noted the above minutes.**	
074/17	**Date of Next Meeting** The next meeting will take place on Wednesday 31 May 2017 at 9am – 11.30am, Committee Room, Conquest	

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on
Wednesday 31st May 2017 at 9am – 11.30am
In the Committee Room, Conquest

Present:	Mr Barry Nealon, No-Executive Director, Chair Mr Mike Stevens, Non-Executive Director Mrs Jackie Churchward-Cardiff, Non-Executive Director (part) Dr Adrian Bull, Chief Executive Mrs Joe Chadwick-Bell, Chief Operating Officer Mr David Clayton-Smith, Trust Chairman Mr Jonathan Reid, Director of Finance Mr Ian Miller, Director of Financial Improvement Mrs Lynette Wells, Director of Corporate Affairs Mr Dan Bourdon, Interim Deputy Director of Finance Miss Tracey Rose, Associate Director of Planning & Business Development (representing Catherine Ashton)
In attendance:	Mr Chris Hodgson, Associate Director for Estates & Facilities Miss Chris Kyprianou, PA to Director of Finance (minutes)

075/17	**Welcome and Apologies for Absence** Mr Nealon welcomed members to the Finance & Investment Committee meeting. No apologies had been received	**Action**
076/17	**Minutes of the Meeting of 26 April 2017** The minutes of the meeting held on 26 April 2017 were agreed as an accurate record.	
077/17	**Action Log** (i) Cashflow – monthly review A paper on how NHSLA works was discussed under minute item 085/17. (ii) Draft 17/1Work Programme Mr Nealon reported that he had met with Mr Reid to review the draft work programme. (iii) Diagnostic Analysis on the Bed Review	

	Mr Reid reported that the work on this has been accelerated, and this should be completed within the next week or so. (iv) Financial Plan/FSM Update This item was on the agenda and discussed under minute item 082/17. below. Mr Reid had met with Mr Nealon to brief him on the financial position following the last Committee meeting. (v) Commercial Strategy and Market Developments Item renamed 'Market Developments'. (v) Leasing of IT Equipment Discussed under minute item 088/17 below.	
078/17	**Integrated Performance Report/Finance Report – Month 1** The Committee received the full Integrated Performance Report for Month 1 and noted that the Trust remains challenged against the key constitutional targets and trajectories. All four of the key performance indicators (A&E, RTT, Diagnostics and Cancer 62 days) failed to meet the national targets. RTT met the planned trajectory figure and is on track for achievement Mrs Chadwick-Bell reported that A&E continues to remain a challenge and the biggest risk was with medical staffing within the Department. Discussion took place on what was being done to try and address this issue, and the Committee noted that all options were currently being explored. Mr Nealon queried whether there was a clear strategy the Trust should be having around merging the two Emergency Departments. Dr Bull reported that the Trust has not developed a proposal to change the functions of the two Emergency departments. Mr Clayton-Smith stressed that the Trust has a responsibility to provide safe care. The Committee agreed that discussion on the Emergency Departments was a Board issue, and not an issue for the Finance & Investment Committee. Mr Miller reported that as a required service, the Trust has an obligation to explain to its commissions how much it is costing to provide that service. Mrs Churchward-Cardiff queried why some of the information had dropped off the report such as the number of outliers. Mrs Chadwick-Bell explained that the information had not been included as this was	

	not accurate but that she will be happy to bring this information back to the Board. Mr Stevens queried the 'overall care' category in the complaints section of the report. Dr Bull said he would raise this with the Complaints Lead. Mr Stevens queried the A&E trajectory which he felt looked unrealistic. Mrs Chadwick-Bell reported that there were plans to deliver that. It was acknowledged that describing the trajectory as a plan would be more accurate. Mr Reid presented the month 1 finance report and highlighted the key issues. The finance report had been streamlined this month and Mr Reid welcomed comments from the Committee on how the report could be strengthened. The Committee noted that the Trust delivered to plan at month 1, however this was particularly challenging. Although activity levels were below that forecast for RTT and activity growth, expenditure was also lower than expected. Mr Read stated that during month 1 the Trust had used £0.5m of its £3.1m winter pressures money to fund escalation capacity. It was noted that the Trust was working with NHSI and the Financial Improvement Director to strengthen the existing financial plan. The Trust has a £28.7m CIP target for 2017/18 which is heavily phased towards the latter part of the year. Mr Reid reported that the Trust had delivered the CIPs for April. This is partially due to delivery of planned schemes and partially from enhanced grip and control measures which has mitigated the slippage in Elective Pathways and other schemes. It was noted that the Trust had met its plan for workforce and, in particular, temporary staffing spend. Mr Reid drew the attention of the Committee to a chart which clearly showed a reduction in temporary workforce spend from its peak in 2016/17. **Action** **The Committee noted the performance for Month 1 and noted the current and projected risks associated with the current projected financial position and the steps being taken to mitigate the risks as far as possible.**	**JC-B** **AB**
079/17	**Contract Income – Monthly Review** The Committee noted that the month 1 position was slightly below plan. This was due to - Tariff exclusions being £400k below plan (offset by reduction in spend)	

	- Impact of Easter higher than planned. The plan accounted for the April Bank Holidays but did not take into account the variance in performance due to a high number of annual leave. - RTT income was anticipated to grow at higher levels across the year. Early indicators are that this has not taken place. Mr Reid reported that there were no new contractual issues emerging in month 1. **Action** **The Committee notes the update on Contract Income.**	
080/17	**Cashflow – Monthly Review** Mr Reid gave a brief update on the Trust cash position. It was noted that the rolling cashflow forecast for the next 12 months was consistent with the financial plan. However, the cash position of the Trust remains extremely challenging. It was noted that cash is carefully managed with two weekly detailed cash meetings and a further cash overview meeting. Payment runs are carefully calibrated to try and prioritise smaller non NHS suppliers. Mr Reid reported that the Head of Financial Services was in dialogue with NHSI about the potential for an exceptional working capital loan this year to try and bridge the underlying cash gap. **Action** **The Committee noted the ongoing management of cash within the Trust.**	
081/17	**Capital Programme – monthly review** Mr Reid reported that the Trust had a capital plan for the year. It was noted that there was a refreshed Capital Review Group and Mr Bourdon was working on refreshing the Terms of Reference which will be presented to the Executive Directors and to the Finance & Investment Committee. Dr Bull reported that the Trust had received the capital bid for the primary care co-location on site. It was noted that there was £100m external capital centrally identified to ensure that the Trust could co-locate primary care. The Trust had received £950k for EDGH and £700k for Conquest which will support the relocation of various services and should release some capital. With regard to the capital bid for the ambulatory care areas of the acute medical units at Eastbourne, it was reported that this had not yet been received; However the Trust had been given very good assurance and this was supported by NHSI.	

	Action **The Committee noted the current performance of the capital programme.**	
082/17	**Financial Plan/FSM Update including review of Financial Recovery Governance** Mr Reid presented the Committee with an update paper on 2017/18 FSM/Planning. He reported that the Trust Board and Finance & Investment Committee had formally approved the 17/18 financial plan. The Trust financial challenge remains at £28.7m efficiency requirement for 2017/18. It was noted that work is in train to reduce this ask, through review of all budgets, corporate costs review, and business case re-evaluation, but the Trust is focusing on identifying and delivering the required efficiencies. NHSI have requested a resubmission of the Trust financial plans by 9th June 2017. Work is in train to refresh the financial plans by 6th June 2017. Mr Reid reported that for efficiency savings the Trust had a new, more rigorous, approval process in place. As at 30 May, the Trust had identified, and approved through the Financial Improvement & Sustainability Committee (FISC) £15.9m of efficiencies, and had a pipeline of schemes for the remaining £12.8m of efficiencies. The key areas of focus for the Committee and the NHSI team were: - The arrangements for delivering a fully-phased financial plan, - the plans for the remaining savings, - adequate resourcing and support to deliver the plan - adequate financial management and 'grip and control' arrangements. Mr Reid explained what was being done to secure the balance of CIPs (£12.8m). This included: - Moving opportunities into savings (£7m list value) - Developing the CSR programme (£6.3m initial value, discounted from £10m) - Developing the workforce programme (unvalued opportunity, but new team in place) It was noted that the priority was to have key components of the remaining programme in place for 9th June, and an agreed trajectory for finalisation. Mr Clayton-Smith reported that the Trust is aiming to get the finances stable and be out of special measures by Christmas. With regards to resourcing and support, it was noted that the Director of Financial Improvement had undertaken a review of capacity based	

	on self-assessment with rigorous challenge. This suggested a need for significant step-change in capacity and this aligns with the NHSI view that the Trust has the commitment but not the capacity. The FISC Committee had recommended securing additional capacity (external support). The F&I Committee reviewed the extra capability that had been brought in since January 2017 and the additional requirement to get the Trust to a higher degree of certainty on delivering the plan. It was noted that the cost of this was currently not in the financial plan. The finance team were reviewing output of Financial Improvement Director review to cost up requirement. It was noted that Mr Reid will be developing a paper by 6th June, and the Finance Director and Financial Improvement Director would review market opportunities. Mr Nealon asked if the Trust was getting to a position where divisions were signing up to delivery and understand that that delivery is part of their job spec and they are accountable. Dr Bull explained that through the year, they have been emphasising to the divisions that the numbers from April have to be numbers that they agree and understand as there will be increasing rigour around the numbers. Mr Clayton-Smith gave an update on his conversation with NHSI. They advised that the control total 'is' the control total and there is no negotiation. However they realise there may be risks around that. The Trust needs to produce a complete plan and must demonstrate that it has the mechanisms and governance and the engagement to deliver. Mr Clayton-Smith re-iterated that the Trust, as an organisation, needs to get to the very best place to get out of financial special measures. He also reported that NHSI had said that the Trust was developing a very comprehensive plan with caveats that it can delivery it, and queried whether the Trust had the capacity to be able to ensure that the management team who were delivering had all the information they needed. Mr Clayton-Smith confirmed that a really detailed capacity review had been undertaken the Trust will need more financial capacity to meet the target. Mr Stevens reported that he was not confident that the Trust would achieve £36m deficit and was not satisfied that this was linked in properly with the divisions, or that the divisions understood that if they miss their target in one month that they have to make this up in the rest of the year. Mrs Chadwick-Bell confirmed that the General Managers are very clear what is expected of them and they understand they will need to find additional savings if they miss their target in one month. Mr Nealon reported that the Committee needed greater assurance.	

	Dr Bull reported that it might be helpful to show the progress on the work that has been going on with the Clinical Services Review to the Finance & Investment Committee. Mr Miller reported that it is going to be a very challenging plan and the Trust needs to have processes and procedures in place that will enable the Trust to identify when things are not going to plan, and to have in place a governance process, to show what additional actions are being taken so that the Trust can show that it is doing everything possible. Mrs Churchward-Cardiff reported that she felt re-assured by Mrs Chadwick-Bell's comments about ownership by the divisions. However she expressed her concerns over the level of cash owed to suppliers, the inability to invest, particularly in IT and capital to the level required in order to drive change, and the impact on the CQC inspection if everyone's attention is focused FSM, Dr Bull reported that the key issue to address are to sort: - Performance, - FSM - Quality Special Measures. Dr Bull reported that he will bring a paper to the next Board Seminar on how the objectives of the team have been prioritised against the three key targets of the organisation and the Trust will seek to ensure than it maintains the balance against the three. **Action** **The Committee noted the financial plan/FSM update.**	TR AB
083/17	**ESBT/ Alliance Executive Financial Plan 2017-18** Mr Reid reported that ESBT was continuing to go well to balance the tension between contractual arguments and working together as an ACO. It was noted that there was a collective financial challenge that the Trust was participating in. The Trust was running a joint PMO through the ACO and trying to look at the overall financial position of the East Sussex locality. **Action.** **The Committee noted the update on the ESHT/Alliance Executive Financial Plan 2017/18**	
084/17	**Sussex and East Surrey STP Financial Plans** Mr Reid reported that the Sussex and East Surrey STP continues to work across local health economies to develop the financial plans for	

	201718-2020/21. It was noted that the STP has a financial gap facing it, predominantly sat with the CCGs. Mr Reid reported that they were collectively working on a recovery plan. The STP had submitted an initial capital expenditure plan to national regulators and good feedback had been received. **Action** **The Committee noted the position of the Sussex and East Surrey STP Financial Plans**	
085/17	**Understanding NHSLA Costs** The Committee had requested a paper to support their understanding of the NHS Litigation Authority negligence scheme. Mrs Wells presented a paper which provided an overview of the scheme and explaining how the Trust's contribution is calculated. The Committee also received a copy of the Trust's Scorecard which provided an analysis of the claims profile focusing on areas of high cost and/or volume. After discussion about the ability for the Trust to reduce its cost in this areas it was agreed that there was little that could be achieved in the short-term and the main driver for future reductions would be a reduction in the number and value of claims, **Action** **The Committee noted the paper on NHSLA costs.**	
086/17	**Market Developments** Miss Rose presented the Committee with a summary of tenders in the pipeline and business cases. These are monitored by the Business Development Group. It was noted that some of this links in with the financial recovery plan eg. Audiology which links in to the work the Head of Planning and performance is undertaking, and the financial viability of the service was being assessed. Miss Rose reported that the total value of business cases is £2.8m and the Planning and Business Development team are challenging each business case owner as to how the business cases will be funded. **Action**	

	The Committee noted the update on market developments.	
087/17	**NHS Radiology Services in East Sussex** Mr Reid presented a paper on NHS Radiology Services in East Sussex. It was noted that the Trust was commencing a procurement exercise to select a strategic commercial partner, to help deliver a range of radiology services at a pace and level of quality that the Trust could not achieve on its own. The process will take several months to complete, and the Director of Corporate Affairs was engaged to support and advise on governance and legal matters to ensure an appropriate level of awareness and approval within and without the Trust. The appointment of a strategic partner is an important step, requiring careful selection and contractual agreement. After appointment, the selected partner will be able to work closely with the Trust to develop specific proposals and cases, which will form the basis of substantial contracts under the initial agreement. Although the initial contract was not expected to expose the Trust to any substantial outlay, it has potential to be one of the most important agreements. The Trust is acting in good faith with a view to entering into substantial contracts for a period expected to exceed thirty years. Dr Bull explained that the plan will be to get this partnership in place by the end of the calendar year and will help to address issues around the MRI scanners that previously have been funded by appeal. Mr Nealon reported that he had been invited by the Project Director, for the Sustainability Programme, to become more closely involved with the project. Given the potential conflict of interest, Mr Nealon reported that he would like to meet with Justin Harris first to ensure that he is comfortable with this. **Action** **The Committee noted the paper on NHS Radiology Services in East Sussex**	
088/17	**Leasing of IT Equipment** Mr Reid presented a paper that had been shared with the Executive Directors on the Leasing of IT Equipment. The Committee noted that the Trust's IT infrastructure was underdeveloped, with many computers – desktop and laptop alike – out of warranty and delivering poor performance, following a number of years of underinvestment. The Trust has a constrained capital budget. The Head of Digital has identified the 'minimum ask' for upgrade of computer hardware, and the Head of Procurement has undertaken a	

	tender exercise, using Leaseguard, the Trust's retained advisers on leasing. The cost of the new equipment will create a revenue pressure for the Trust, but will be an enabler for the pending SystmOne business case. Efficiencies identified through the SystmOne case will create the funding available to support the lease. The Executive team considered this report and were happy with the proposal. However, they needed to be convinced that this demonstrated value for money and asked for the IT requirements for the next 6 years to be mapped out. This work is underway and will be completed in June and will be re-presented to the Executive Team. The Finance & Investment Committee, on behalf of the Trust Board, approved the proposal in principle, subject to this being approved by the Executive Team. **Action** **The Committee noted the proposal in principle, subject to agreement with the Executive Team.**	
089/17	**Energy Performance Contract (EPC)** Mr Hodgson was welcomed to the F&I Committee to present a paper on the Energy Performance Contract. It was noted that there is a business and sustainability (carbon emissions) rationale for operating a Combined Heat and Power (CHP) at the Conquest, as already demonstrated by the Trust owned and operated CHP at Eastbourne. PDC funding for new capital for CHP and other environment initiatives is however restricted given the Trust commitment to its existing 5 year 2016-2021 capital programme. Mr Hodgson gave an update on the other opportunities via third party contracts such as Energy Performance Contract (EPC) to bring in further investment in CHP, LED lighting, more efficient fans and drives etc. to reduce the Trust energy expenditure and carbon emissions. Following approval at the Estates and Facilities IPR, the Trust became a member of the Carbon Energy Fund in February 2017. The Trust is actively engaged through the Carbon Energy Fund in sourcing an EPC for both Conquest and Eastbourne sites. The Committee noted the direction of travel and will await to see the business case. **Action** **The Committee noted the direction of travel and the draft timetable for approvals.**	
090/17	**Draft 2017/18 Work Programme**	

	The Committee received a copy of the updated 2017/18 work programme. **Action** **The Work Programme was noted**	
091/17	**Minutes to note – for information only** The Committee received the minutes of the following meetings for assurance and information: • Financial Improvement & Sustainability Committee – 25.4.17 • Capital Approvals Group – 20.4.17 (now Capital Resources) • Capital Resources Group – 24.5.17 • Business Development Group – 24.5.17 • Digital Steering Group – 12.5.17 The Committee felt it was very helpful to receive these. **Action** **The Committee noted the above minutes.**	
092/17	**Date of Next Meeting** The next meeting will take place on Wednesday 28 June 2017 at 9am – 11.30am, in St Mary's Board Room, Eastbourne DGH	

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

Minutes of the People and Organisational Development (POD) Committee meeting held on Thursday 30 March 2017, 11.00am – 1.00pm Room 3, Education Centre, Conquest v/c to Princess Alice Room, EDGH

Present: Mrs Miranda Kavanagh, Non-Executive Director (MK) – Chair
Mrs Jackie Churchward-Cardiff, Non-Executive Director (JCC)
Ms Monica Green, Director of HR (MG)
Mrs Kim Novis, Equality & Human Rights Lead (KN)
Mrs Moira Tenney, Deputy Director of HR (MT)
Dr David Walker, Medical Director (DW) from 12.00pm
Mr Jamal Zaidi, Associate Medical Director – Workforce (JZ)
Mr Salim Shubber, Director of Medical Education (SS) from 11.40am

In attendance: Dr Adrian Bull, Chief Executive (AB)
Mr Mike Dickens, Medical Education Manager (MD) - for item 5
Mrs Lorraine Mason, Head of Staff Engagement & Wellbeing (LM)
Dr Barry Phillips, GOSWH (BP) – for item 6
Mr Waleed Yousef, GOSWH (WY) – for item 6
Mrs Ruth Merrick, Workforce Projects Manager (RM) – for item 10
Miss Sarah Gilbert, PA to Director of HR (SG) - Minutes

No.	Item	Action
1)	**Welcome, introductions and apologies for absence** The Chair welcomed all to the meeting and noted a quorum was present. Apologies for absence were received from: Mrs Joe Chadwick-Bell, Chief Operating Officer (JCB) Dr Louise Christou, ST3 (LC) Mrs Edel Cousins, Asst. Director of HR – Workforce Development (EC) Mrs Jan Humber, Staff Side Chair (JH) Mrs Alice Webster, Director of Nursing (AW)	
2)	**2.1 Minutes of the last meeting held on 15 December 2016** The minutes were reviewed and agreed as an accurate reflection of the meeting.	

2.2 Review of Action Tracker:
The outstanding items on the Action Tracker were reviewed and the following noted:

Recruitment hotspots: nurse vacancies – MG advised EC was currently on sick leave, however, MT and the recruitment team would be picking up work relating to new roles and would update further at the next meeting.

HR metrics – The Chair advised that the monthly divisional IPR reports were not appropriate to be reviewed at this committee as they were too detailed.

Long Term Sickness
MT presented the report regarding long term sickness following a request at the December POD Committee meeting for further information. MT commented that the number of staff under the long term sickness procedure was reducing. Work was being undertaken to encourage getting staff back to work as soon as possible. MT noted that Additional Clinical Services, Nursing & Midwifery and Admin & Clerical were the staff groups with the highest numbers of long term sickness. The main reasons for long term sickness were noted to be musculoskeletal and stress/anxiety.

JCC commented that a third of the total number of staff off sick are long-term sick and asked whether line managers felt competent to address this. MT advised that the Operational HR team provide support to line managers and also hold case conferences with the Occupational Health team once a member of staff triggers long term sickness. For short term sickness episodes managers were expected to undertake early stage meetings themselves and HR would be involved in later stages if required.

The Committee noted the report.

BME Recruitment
MT outlined the paper relating to BME recruitment. MT noted that on reviewing data of BME staff appointments at band 8a and above for Agenda for Change posts, figures were lower than expected for numbers of applicants and appointments and confirmed that further analysis for the reasons why applicants were unsuccessful would be undertaken. The Committee felt it would be important to embed having BME reps on interview panels where possible and engage the BME network in relation to this. KN confirmed the Trust do aim to have a BME rep on interview panels and, on occasions where this might not be possible, KN has offered to attend.

JCC asked whether offering interview skills to candidates would help.

	KN advised the BME network was taking this forward for internal candidates. MK raised whether unconscious bias training is offered to staff, LM/KN agreed to look into this to see if funding is available. KN to undertake further analysis for the whole previous 12 months and provide a further report at the September 2017 meeting. The Committee noted the report. <u>Recruitment</u> MT presented a paper on recruitment. MT highlighted that there are now more doctors, nurses and HCAs in the Trust compared to 12 months ago and that vacancy rates have reduced across a number of staff groups including nursing, HCAs and AHPs. International recruitment campaigns would be continued for nursing and an increase in recruiting UK nurses had been noted. MT advised that retention of staff would now be a key focus for the Trust. BP asked whether the impact of Brexit would have a detrimental impact on recruitment from overseas. MT advised NHS employers would be taking this forward and negotiating whether visas will be required. Further updates to the Committee would be provided via the Workforce Resourcing Group quarterly summary. The Committee noted the report.	**LM/KN** **KN** **MT**
	Feedback from sub-groups of HR Senior Leaders Meeting: **3.1 – Engagement & OD Ops Group** LM advised a new action plan would be published in April 2017 incorporating the corporate priorities agreed for the staff survey. LM agreed to summarise the progress made to date and how this would be taken forward over the next year. The Committee noted the report. **3.2 – Education Steering Group** MG highlighted the apprenticeship update and integrated education updates within the report. The Committee noted the report. **3.3 – Workforce Resourcing Group** MT advised the resourcing group had not met although confirmed the terms of reference and membership were to be reviewed shortly. MT outlined work around new roles which had been commissioned with South Central Commissioning Support Unit (CSU). This work would be looking at A&E and other areas to determine what the Trust requires in terms of new roles that would reduce vacancies in hard to fill posts. JCC asked for a review of all different new roles to be included in this report. The Committee noted the report. **3.4 – HR Quality & Standards Group** The Committee noted the report.	**LM** **MT**

4)	**Staff Survey Briefing and Actions** LM summarised the corporate priorities that were agreed at the Trust Board earlier this month: • **Continue to develop ESHT as a good place to work and ensure patient care is our organisation's top priority** • **Further reduce the number of staff experiencing bullying and harassment from colleagues, patients and public** • **Improve good communication between managers and staff** MG highlighted the importance of "You Said We Did" and promoting actions that have been undertaken to staff. The Committee noted the report and agreed actions.	
5)	**GMC Visit and medical engagement** MD presented the report on the GMC visit undertaken at the end of last year. Issues were highlighted in several areas including medicine. Following this an action plan had been produced and is reviewed on an ongoing basis. SS advised the three key priorities for action were; 1) improvement of incident reporting and ensuring junior doctors report incidents and view this as a learning opportunity, 2) filling gaps within rotas, and 3) exception reports which has highlighted areas with recruitment and retention issues. DW also commented that the impact of escalation wards opened at EDGH at peak times is a concern amongst trainees. AB summarised the discussions held at the Education Steering Group and advised the three key priorities ought to be the main focus for the action plan and regular review. The chair suggested adding the risk of removal of training posts to the risk register. MT/MD agreed to add this to the Workforce risk register. JCC asked whether there was a strategy for junior doctors that encompassed all of the work in this area. It was agreed MT, SS & DW would work to develop a strategy to be reviewed by the Committee at a future meeting. MD reported that the GMC survey for 2017 has now commenced and a report would be received later this year. The committee noted the report and requested a further progress report for the three key priorities to be provided at the September meeting.	**MT/MD** **MT/SS/ DW** **SS/MD**
6)	**Guardian of Safe Working Hours report** BP & WY were welcomed to the meeting and provided a background to the work being undertaken following introduction of the new junior doctors' contract. BP highlighted the new exception reporting process	

	now in place to ensure safe working hours of junior doctors and noted that challenges have been highlighted within medicine, Orthogeriatrics, A&E and urology at night, resulting in a higher number of exception reports for those exceeding 48 hours. Work is being undertaken to look at managing rotas on a 45-46 hour week to reduce the requirement to exception report. JCC noted the recommendations made at the end of the paper and particularly the requirement for dealing with exception reports in a timely fashion. AB confirmed the Chiefs of Division and Specialty Leads are aware of this and this is being looked at in conjunction of HR. MT noted that the cost of implementing the contract at present is less than the cost for implementing the 2002 contract although advised there are still some doctors to be transferred onto the new contract and this may be offset by vacancies. The committee noted the recommendations made in the report and it was agreed that a brief summary report with an action plan would be presented to Trust board on 9 May 2017. The committee thanked BP & WY for attending the meeting and for the significant amount of work being undertaken with this.	**BP/WY**
7)	**Leadership Strategy & Leading Excellence Programme** LM updated the committee following comments fed back from members and the Executive Team and asked the committee to consider whether this is now ready to be presented at Trust Board on 9 May 2017. It was agreed this strategy would be forwarded to the BME network for review/comment. The strategy would also be presented to Trust Board on 9 May 2017. <u>Leading Excellence Programme</u> MG outlined the background to the programme. JCC raised whether the role of the committee would be to review progress with this or if this would be monitored by another group. It was agreed that this would be reviewed by the Engagement & OD Group and that this paper had been provided for information only to the Committee.	**KN/LM MG**
8)	**OD Strategy and feedback** LM updated the committee following comments fed back from members and the Executive Team and asked the committee to consider whether this is now ready to be presented at Trust Board on 9 May 2017. The Committee agreed that this strategy was ready to be presented at Trust Board on 9 May 2017.	**MG/MK**

9)	**Workforce assurance tool** MG outlined the tool and advised this is for information and asked whether the committee should see this once populated. It was agreed the populated workforce assurance tool should be circulated to the Committee for information once available.	**MG**
10)	**Healthroster – Safecare update** RM was welcomed to the meeting and provided an update on the Safecare module which has been added to Healthroster. This has been rolled out successfully across four wards and is now being rolled out to other areas. The module enables review of staffing levels on wards and acuity of patients in areas to be available in real time via iPads on wards allowing for informed decisions to be made regarding moving of staff. The Committee noted the report and thanked RM for attending.	
11)	**Items for information** **11.1 – workforce report** The Committee noted the report.	
12)	**Items for the future meetings** The Committee noted the items to be added to the agenda for the next meeting in June 2017. The Chair requested to meet with MG to review and shape the agenda for future meetings to ensure it met the remit of the Committee.	**MG/MK**
13)	**AOB** <u>Lord Carter report</u> DW updated regarding a meeting that had taken place reviewing work the Trust has undertaken to date in relation to the Lord Carter review. DW/MK to look at this work more closely with a view to this being reviewed at a future POD Committee meeting.	**DW/MK**
14)	**The next meeting of the Committee will take place on:** Thursday 15 June 2017, 3.00 – 5.00pm in the Princess Alice Room, EDGH with v/c to Committee Room, Conquest	

Minutes of the Quality and Safety Committee Meeting

Wednesday 22 March 2017
St Mary's Board Room, EDGH

Present:
Sue Bernhauser, Chair
Jackie Churchward-Cardiff, Non- Executive Director
Adrian Bull, Chief Executive
Alice Webster, Director of Nursing
Catherine Ashton, Director of Strategy
James Wilkinson, Assistant Medical Director, Quality
Lynette Wells, Executive Director, Corporate
Ashley Parrott, Associate Director of Governance
Joe Chadwick-Bell, Chief Operating Officer
Lesley Smith, Head of Infection Control

In attendance:
Tracy Peters, Speech and Language Team
Karen Salt (notes)

1.0 Welcome and Apologies for Absence

Sue Bernhauser welcomed everyone to the Quality and Safety Committee meeting and introductions were made.

Apologies for absence were noted from:

Monica Green, Director HR
Janet Colvert, Ex-Officio Committee Member
David Walker, Medical Director
David Clayton-Smith, Chair, ESHT
Anne Wilson, Director of Infection Prevention and Control

Report from the Chair and Chair's Actions

Sue Bernhauser reported that two Chair's Actions had been taken since the last meeting on 18 January 2017:

1 – Approval of Trust Mixed Sex Accommodation Compliance Statement. This had been required for the Trust Board meeting on 21 March, hence the Chair's Action to approve. It was noted that the Quality and Safety Committee was sighted on Single Sex Accommodation breaches through the Quality section of the Integrated Performance Report. Copies of the paper that had gone to Trust Board were made available at the meeting.

2 – Approval of amendments to the Terms of Reference of the Quality and Safety Committee. Following a Governance Review recommendation a sentence had been added to the Terms of Reference reflecting the relationship between the Quality and Safety Committee and the Finance and Investment Committee. Some other minor amendments were also made including one to reflect the name change of the Improvement Sub Committee to Quality Improvement Steering Group. Copies of the revised Terms of Reference were made available to those attending.

The Chair further introduced the new Improvement Group which was to be chaired by Catherine Ashton, Director of Strategy. Catherine Ashton outlined to members the purpose of the new group which would report into the Quality and Safety Committee. The aim was to have oversight of projects in the Trust, making sure that they were aligned with each other, that improvements were being prioritised and best use of resources was being made. In addition the forum would ensure the development of improvement expertise across the organization. A short monthly report would be submitted to the Quality and Safety Committee highlighting exceptions and issues.

2.0 Patient Story

Tracey Peters introduced her role which was a new initiative and explained that a mouthcare pilot was just about to start on 6 wards. Tracey introduced two patient stories (Florence and Peter) where improved mouthcare had proven to be very beneficial for them. Both patients had had a level of cognitive impairment and it was known that this could affect patients' ability to attend to mouth care resulting in health issues. The health of the mouth was important for dignity, and for functional reasons.

The longer term aim was to roll out the pilot to other areas and to train staff on the wards, in the community and to introduce ward packs. There had been interaction with the community Speech and Language Team and Dementia Links and the Council had expressed an interest in the pilot for their care homes. This bode well for gaining accreditation. An audit of paperwork would ensure compliance.

There was a plan to develop a competency and training in suction for Healthcare Assistants.

Sue Bernhauser thanked Tracey for her presentation which had been received with interest by the Committee.

3.0 Minutes of the Previous Meeting

The minutes of the 18 January 2017 meeting were agreed to be an accurate record of the meeting.

Jackie Churchward-Cardiff noted that papers for the current meeting had been distributed late which had restricted the time available to review them. It was noted that this had been due to administrative issues which were being addressed.

3.1 Matters Arising

There were no matters arising.

3.2 Action Log

QSC 57 - TIAA Audit and Actions item was on the agenda. Action closed.
QSC 58 – Action completed and closed.
QSC 59 – Chemotherapy System issues confirmed added to the risk register on 13 Dec 16 as risk 1581. Action closed.
QSC 60 – Sue Bernhauser reported that this had been raised at the Audit Committee meeting on 19 Jan 17. Funding had been found to proceed with the audit work and a business case was being worked on by the new service manager. As this had been a long

standing issue it was agreed that should be an update at the next meeting to confirm that the audit had been done. Action closed.

Action – Update to the next meeting to confirm that funding was in place to proceed with National Adult Diabetes Audit work.

QSC 61 – It was noted that End of Life Care was due to be the Deep Dive topic at the next meeting. Action remained open.

4.0 Compliance and Risk

4.1 Patient Safety and Quality – Board Assurance Framework

Lynette Wells presented the Board Assurance Framework noting that due to the timings of meetings the paper had already been presented to Trust Board on 21 March. She reported that the gap in assurance regarding Infection Control had moved to 'business as usual' and the Tenders and Capacity to Respond had been removed from the BAF.

It was noted that there was an error in the narrative of the cover sheet for this agenda item and that high level risks had reduced to 47 (not 26).

There was one addition to the Board Assurance Framework (2.7) relating to a gap in control for the monitoring of appointments but this was being addressed.

There were three areas showing red
- Emergency Department reconfiguration/patient flow
- Patient Flow
- Finance

All had been discussed at the Trust Board meeting on 21 March 2017.

There was a discussion about risk 2.1.2 – Emergency Department reconfiguration. It was agreed that there was a mix of two issues - physical changes to the Department and the impact of patient flow on the Emergency Department. Joe Chadwick-Bell reported that an issue at EDGH caused by the repurposing of a dedicated room for Mental Health Assessments was being addressed.

It was agreed that Lynette Wells and Joe Chadwick Bell would discuss the risk and split it into two.

Action – Lynette Wells to discuss with Joe Chadwick-Bell and arrange to split the risks.

4.2 Patient Safety and Quality – High Level Risk Register

Ashley Parrott presented the High Level Risk Register noting the newest high level risk - Winter Pressures - which had been added due to concerns regarding patient flow and safety. (Page 2). It was agreed to change the title of the risk to reflect that it related to the management of seasonal surge activity and demand.

Action – Ashley Parrott to change the risk title and to check that the Executive Team has had sight of it over the December 16/January 17 period.

Other key highlights were:

Risk 1603 - reduced medicine supply was rated high at 16. This had been noted at the IPR meeting and related to cash flow issues but would be revised.

There was still some duplication around patient flow but the register had improved on the previous year.

All risks had been assigned to monitoring committees and the Patient Safety and Quality Group and Clinical Effectiveness Group were already monitoring their own risks. In addition Division IPR meetings discussed their own risks. Following a discussion it was agreed that oversight of all the high scoring risks by the Quality and Safety Committee was essential. It was agreed that a revised cover sheet should be developed to flag all new areas, important issues or those risks that had been on the register for a lengthy period of time so that the Committee could decide areas of focus.

There was a discussion about poor attendance of senior staff (clinical lead/General Manager) at the Divisional governance meetings where risks should be followed up. The Intergrated Performance Report meetings were only picking up the higher level risks.

Jackie Churchward Cardiff stated that as a Non-Executive Director she would want to be confident that risks identified were being followed up.

Ashley Parrott outlined the process of entering risks on to the Risk Register and noted that all risks scoring over 15 had to have formal sign off. Division Governance facilitators followed up the risks at governance meetings. It was noted that the process had ween improvements on the previous year and continued to improve. There had been some issues over ownership of risks at Divisional meetings.

It was noted that the Quality and Safety Committee did not own the risks on the register but provided assurance to the Trust Board that the risk register was being managed well.

Action – Ashley Parrott to develop cover sheet ready for the next meeting, to raise issues by exception, assuring the Quality and Safety Committee that all other risks were being monitored/addressed in a robust way.

4.3 External Visits and Reviews

Lynette Wells presented the External Visits and Reviews Report which aimed to avoid duplication of visits and reviews and to provide reporting on outcomes. The report for the next meeting would be slightly different as it was being split into externally arranged Visits and Reviews, and those reviews by external agencies that had been commissioned by ESHT.

Members were advised that if they wished to see more in depth reports on the visits these could be made available.

4.4 Quality Account Report

Ashley Parrott presented the 2017/18 Quality Account Report noting that the priorities had been agreed at the Trust Board meeting on 21 March 2017.

A review of the Trust's Quality Account 2016/17 had been completed and Quality

Improvement Projects had been partially achieved with one exception – Priority 5.

It was noted that to meet submission deadlines the latest draft of the Quality Account would need to be submitted for approval to the Quality and Safety Committee meeting (22 May 2017) while it was also out to the CCG and the Health and Overview Scrutiny Committee for comment.

Priority 5 – Reduce the transfer of patients for non-clinical reasons between our wards. Data was available but narrative was needed.

Action – Alice Webster to produce a narrative for Priority 5 with emphasis on Out of Hours.

Confirmation of owners of the new priorities for 2017/18 was needed. Many were existing initiatives with leads in place.

Action – Ashley Parrott to contact leads and update to the next meeting.

4.5 ESHT 2020 Improvement Programme

Alice Webster presented the ESHT 2020 Improvement Programme paper noting that Urgency and Emergency Care remained at red. Significant work was being done to address this. It was agreed that the minutes of the Quality Improvement Steering Group should be submitted to future meetings along with the ESHT 2020 Improvement Programme item.

Action – Karen Salt to arrange for the minutes of the Quality Improvement Steering Group to be submitted with the ESHT 2020 Improvement Programme item at future meetings.

Key highlights were:
- Mortality showed continued improvement.
- Lack of compliance regarding Sepsis, VTE and AKI but this was being monitored by the Quality Improvement Steering Group.
- Requirement from 1 April 2017 to report on all deaths including up to 30 days post-discharge. This would involve closer monitoring of community deaths.

Safety and Quality

5.1 TIAA Audits and Actions

Ashley Parrott presented the TIAA Audits and Actions Report noting that TIAA kept a track of actions and these were being presented to the Audit Committee in March 2017. TIAA had been asked to ensure that the Committees assigned to the actions were noted.

Ashley Parrott reported that most of the actions had been completed. All would be tracked by the Audit Committee.

5.2 Governance Quality Report

Ashley Parrott presented the Governance Quality Report noting the following key points:

- Progress with complaints backlog.

- Significant improvement in Duty of Candour compliance due to efforts by the team.
- Improvement to the Amber incident process although timeliness of replies remained an issue. Support was being provided.
- Improved in-patient Friends and Family Test response rate which was due to a reconfigured system and ongoing work with the Divisions to support.

There was a discussion about the 12 statements in the post-complaint survey and the somewhat disappointing response rates and scores. Darren Langridge-Kemp would be producing a breakdown report for the Patient Experience Steering Group.

Action – Post-complaint Survey Report to be sent to Lynette Wells once available.

It was noted that for reviews of deaths where the death was avoidable (SI or Amber) families were invited to participate and to present their concerns.

Patient Safety and Quality Group Report

Ashley Parrott presented a statement of activity regarding key areas for the year and updated on progress. There were no further comments. It was noted that NHS Choices contained a couple of negative reviews relating to neurology – these would be monitored
5.3 through the Patient Experience Group and the Patient Safety and Quality Group.

Back to Green

Joe Chadwick-Bell presented the Back to Green Update noting that a similar version had been presented to the Urgent and Emergency Care Board.

5.4 There had been well attended review session, cross site, to reflect on the Christmas period and Back to Green.

It was reported that there had been a significant improvement (10%) in Back to Green week compared to the week before.

ECIP had completed a review/learning day and it was feedback had been positive.

Key highlights were:

- Feedback from staff had been positive
- The focus was on the Easter Back to Green
- There had been weight bearing pathway issues but these were being tracked weekly.
- Further work was needed regarding access to equipment.
- Sharon Gardner-Blatch, Deputy Director of Nursing was meeting with the Continuing Healthcare Team and the CCG to address issues.
- Paediatric streaming was being reviewed.
- Professional standards had not been circulated adequately but this had now been done.
- Wards had been supplied with laminated ‘how to’ documents to highlight alternative services and a Grand Round was planned.

Two model wards were trialling named therapists and social workers visiting on a daily basis to see if that resulted in improvements. It was noted that there was no resource to roll this out across the Trust

A Back to Green week was planned for the week after Easter and a week-long discharge event was planned for before Easter to bring occupancy down.

It was reported that the withdrawal of physiotherapists from the wards a number of years ago had impaired relationships and a return to ward based therapy was being looked at

There was a discussion about whether the pre-Christmas 25% spike. It was noted that it was difficult to obtain data regarding nursing homes but that there had been some feedback that relatives had been resistant to having patients return home. The CCG was working with nursing homes to address inappropriate referrals in.

On page 4 of the report, under A & E Activity it was noted that the first bullet point should read '6 week average attendance…….'

Jackie Churchward-Cardiff commended the initiative. Joe Chadwick-Bell said that staff had found the exercise helpful, giving them a chance to focus on patient flow. There had been important learning regarding communications and this would go into the Easter plan.

5.5 Nursing Establishment Review

Alice Webster explained that post 2014 (Francis Report) the Trust was required to conduct an annual establishment review. The reviews had been gone through with all the matrons and the aim was to make this business as usual in the Divisions.

The paper presented findings from the review and made recommendations to increase the establishment. The increased levels were expected to impact on the Trust's reliance on agency staff.

The Quality and Safety Committee noted the report and approved the recommendations. It was agreed that any workforce issues should be addressed by the People and Organisational Development Committee.

6.0 Deep Dive – Falls

Ashley Parrott presented the Falls Deep Dive.

Key points were noted as follows:

- Much progress had been made with the rate of patient falls at 6 per 1000 bed days for all falls and 0.1 falls per 1000 bed days rated severe.
- Work resulting from a fishbone analysis had been done with the wards.

With the support of the ward matrons and Deputy Head of Nursing an innovative approach was being tried on Tressell Ward where there was an assumption of high risk of falls. Weekly run charts would identify any issues. The aim was to change the culture.

Jackie Churchward-Cardiff remarked that the performance against annual objectives for falls that resulted in serious harm (a reduction from 29 falls to 24) didn't feel ambitious. Ashley Parrott reported that a new objective had been developed, with an expectation of no falls and seeking a reduction from 1.9 to 1.6 per 1000 bed days for falls resulting in harm. A target had been required by the CCG.

7.0 Any other business and Deep Dive for the next meeting

Deep Dive - It was agreed that the Deep Dive for the next meeting would be End of Life.

Quality Strategy – It was agreed that this would be circulated by email for approval by Committee members.

Action – Karen Salt to circulate latest draft of the Quality Strategy for approval.

Date of Next Meeting

24 May 2017.