EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 9th May 2017, commencing at 09:30 in the St Mary's Boardroom, EDGH

	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 21st March 2017	A	Chair	
4.	Matters arising	B		
5	Quality Walks		Chair	
6	Board Committee Feedback	C	Comm Chairs	
7	Board Assurance Framework	D	DCA	
8	Chief Executive's Report	E	CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
9	Integrated Performance Report Month 12 (March) 1. Performance (including plan and recovery trajectories for statutory targets) 2. Workforce 3. Finance	Assurance	F	DN/MD COO HRD DF	1015 - 1110
10	Guardian Of Safe Working Hours Report	Assurance	G	MD	

STRATEGY

					Time:
11	ESBT	Assurance	H	DS	1120 - 1205
12	Quality Strategy	Assurance	I	DN	

13	Leadership & Talent Management Strategy (for approval)	Approval	J	HRD	
14	Organisational Development Strategy (for approval)	Approval	K	HRD	

GOVERNANCE AND ASSURANCE

					Time:
15	Delegation of approval of Annual Report and Accounts 2016/17 and Draft Quality Account 2016/17	Assurance		DCA	1205 - 1215
16	Board sub-committee minutes: 1 Audit Committee 2 Finance & Investment Committee 3 People and Organisational Development Committee 4 Quality & Safety Committee	Assurance	L	Comm Chairs	

ITEMS FOR INFORMATION

				Time:
17	Annual Self Certification	M	DCA	1215 - 1230
18	Use of Trust Seal	N	Chair	
19	Questions from members of the public (15 minutes maximum)		Chair	
20	Date of Next Meeting: Tuesday 25th July 2017, Uckfield Civic Centre		Chair	

David Clayton-Smith

Chairman

7th April 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, 22nd March 2017 at 09:30 in the Strand Room, Cooden Beach Hotel.

Present: Mr David Clayton-Smith, Chairman
Mr Barry Nealon, Vice Chairman
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Ms Miranda Kavanagh, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Miss Catherine Ashton, Director of Strategy
Dr Adrian Bull, Chief Executive
Mrs Joanne Chadwick-Bell, Chief Operating Officer
Ms Monica Green, Director of Human Resources
Mr Jonathan Reid, Director of Finance
Mrs Alice Webster, Director of Nursing
Mrs Lynette Wells, Director of Corporate Affairs

In attendance:
Miss Jan Humber, Joint Staff Committee Chairman
Dr James Wilkinson, Associate Medical Director
Ms Ruth Agg, Speak Up Guardian (for item 022/2017 only)
Mr Pete Palmer, Assistant Company Secretary (minutes)

Welcome and Apologies for Absence

016/2017 Chair's Opening Remarks

Mr Clayton-Smith welcomed everyone to the meeting of the Trust Board held in public. He noted that the meeting was the first anniversary of his tenure as Chair of the Trust and highlighted the changes he had seen within the organisation during the year. He explained that despite the great progress, the Trust were not yet where they aspired to be and a huge amount of work was taking place to continue to improve.

Apologies for Absence

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

Mrs Sue Bernhauser, Non-Executive Director
Dr David Walker, Medical Director

Monthly Award Winners

Mr Clayton-Smith reported that the monthly award winner for January was Christopher Laney who worked as Health Visiting Team Administrator. He was nominated for his work in supporting the Health Visiting team.

There were two winners of February's monthly award. Linda Upton, who works for the Safeguarding Children team won the award for her work in highlighting a case of domestic abuse which ensured a mother and her children received the support they required.

Senior Medical Secretary Patricia Cole was the second winner who had worked tirelessly during an extremely difficult couple of months whilst her colleague had been on long-term sick leave

017/2017 **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.

018/2017 **Minutes**

The minutes of the Trust Board meeting held on 24th January 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.

019/2017 **Matters Arising**

008/2017 – NED Capacity

Mrs Wells reported that she had discussed the potential for appointing an additional Non-Executive Director (NED) designate with Mr Clayton-Smith and that they had agreed to revisit this in six months' times due to the ongoing work in forming an Accountable Care Organisation (ACO).

020/2017 **Speak Up Guardian's Report**

Ms Agg reported that she had been in post for a year, and that during that time she had been contacted by nearly 300 staff. She explained that staff now felt reassured about the independence of her role, resulting in an increase in reporting of issues. Improving links with HR and with Trust management had been established and Trust leaders had taken strong action in addressing behavioural issues across the organisation. Ms Agg reported that she had recently been appointed Vice-Chair of the South Coast Speak Up Guardian Network, noting that a national Speak Up Guardian had also recently been appointed.

Mr Stevens asked about how the national whistleblowing policy would be delivered within the Trust. Ms Agg explained that the Freedom to Speak

Up/Raising Concerns policy would be made into a condensed, simpler local policy. Roadshows would take place to promote the policy, and it would be incorporated into mandatory training alongside information delivered through Trust communications, on the Trust website and via the 'Theme of the Week'.

Miss Green noted that the progress that Ms Agg had made was reflected in the improved Staff Survey results. She reported that a management essentials programme was being introduced to further improve communication with staff.

In response to a question from a member of the public, Mr Campbell, Ms Agg confirmed that subcontracted staff within the Trust were included within the policy, noting that she also had contact with patients and relatives.

Dr Bull praised the contribution Ms Agg had made, noting the importance of educating staff that other channels for raising concerns were also available to them. He hoped that an environment was being created where staff were happy to raise any concerns they had in confidence that they would be listened to and responded to appropriately.

021/2017 **Feedback from Quality Walks**

Mrs Churchward-Cardiff reported that she had recently undertaken four Quality Walks and had seen improved clinical ownership among staff. She had been particularly impressed by Chris Powell on Gardner Ward. Matron assistants had been introduced and were seen to relieve the pressure on matrons and had been greatly appreciated. The overriding concern reported to her by staff was about having the wrong patient on the wrong ward. The Trust's limited capital restricted environmental improvements on wards, but staff were more confident in their roles, and no longer feel isolated.

Ms Kavanagh reported that during a recent walk she had spoken to patients about the impact on them of a delayed transfer of care. Mrs Webster noted that a 'red to green' initiative had been launched where staff were trying to remove 'red' days that added no value to patients' care.

In response to a query from Mr Nealon, Mrs Chadwick-Bell explained that the Trust had a programme in place that tried to ensure that patients with no medical need for admission were not admitted to hospital. Unfortunately admission was not always avoidable as appropriate care in other settings was not always available.

The Board noted the feedback on Quality Walks.

022/2017 **Board Committees Feedback**

Audit Committee

Mr Stevens reported an improved grip on Clinical Audit, noting that clinicians were being encouraged to complete audits to a high standard. IT security had been discussed, and the Trust would be making use of the knowledge of the Internal Audit team to strengthen processes. Procurement processes had been strengthened with the aim of ensuring better value for purchases made by the Trust.

Finance and Investment Committee

Mr Nealon reported that the Trust was forecasting a final deficit for the year of £46.5million, £1.5million better than the budget set at the start of the year but short of the control total deficit of £41million. £16million of potential savings had been identified in month 6 and the Trust was likely to realise £12.5million of this total. He explained that the Finance and Investment Committee had oversight of the budget for 2017/18 which included a further £20million challenge. Grip and control was expected to be greater during 2017/18 and conversations continued with the CCG about proposals to allocate funds from the Trust's budget to the community.

Quality and Safety Committee

Mrs Churchward-Cardiff reported that the Committee had received assurance that processes concerning feedback from risks and incidents were increasingly robust. The Urgent Care pathway remained a concern, but the Committee was otherwise assured that the Trust had introduced strong initiatives to identify and manage risks.

Mrs Chadwick-Bell reported that a consolidated system-wide Urgent Care plan was being produced which would complement the Trust's existing internal plan and was expected to be presented to the next Quality and Safety Committee. Mr Clayton-Smith noted that he would like an opportunity to discuss the issues faced across the system with the Board and it was agreed to add this to the agenda of an upcoming Board Seminar. Dr Bull reported that a number of system-wide initiatives had been introduced which had received support from both County Council and Primary Care colleagues through East Sussex Better Together (ESBT). **PP**

Mr Clayton-Smith praised the work carried out by the Committees and explained that Committee Chairs were always welcome to raise significant issues of concern for discussion by the Board if they felt this was necessary.

The Board noted the Committee Reports.

023/2017 **Board Assurance Framework**

Mrs Wells explained that the Board Assurance Framework (BAF) would normally have been reviewed by both the Quality and Safety and Audit Committees prior to coming to the Board, but as the Board meeting had been rescheduled to avoid a clash with the ACO Governing meeting this had not been possible on this occasion.

She reported that an additional gap in control concerning electronic reporting for follow-up appointments had been added to the BAF. Three areas rated red remained on the BAF. It was hoped that the issues with patient transport would be resolved, as a new provider was due to take over the service from April 2017.

Mrs Wells proposed that the gap in control relating to the management of infection control incidents should be removed from the BAF, as good progress had been made and this had now become business as usual for the organisation. She also proposed the removal of the issue relating to support Any Qualified Provider (AQP) and tendering exercises by commissioners as this was now controlled with a team in place. The Board agreed to the removal of these items from the BAF.

The Board confirmed that the main inherent/residual risks and gaps in assurance or controls had been identified in the Board Assurance Framework and actions were appropriate to manage the risks, and approved the removal of the gaps in control relating to infection control incidents and capacity for tender and AQP.

024/2017 **Chief Executive's Report**

Dr Bull reported that the Staff Survey results had been published and were publically available. The survey had been carried out in the autumn of 2016 and reflected the views of almost half of the Trust's employees. There were a number of very significant improvements and no measures where results had deteriorated; work would continue with the ambition of improving results further in 2017.

The Trust's performance against the four hour A&E target illustrated the pressure that the organisation had experienced and a number of plans had been introduced to improve performance. All of the Trust's escalation capacity had been open throughout winter with greater than 99% occupancy, with the hard work of staff maintaining safe care for patients. Elective work had been maintained during the period and an improvement in 18 week waits was realised, with a reduction in cancelled operations compared to previous year.

Dr Bull reported that the Trust's mortality ratios had returned to within the expected range and focussed work continued to improve these further. The new contract for junior doctors had been introduced throughout the organisation. Dr Bull explained that that he felt the introduction of the

new contracts had been effectively managed and that teams had responded well to issues that had been raised. He hoped that the upcoming junior doctors survey would reflect the improvements made within the organisation.

Dr Bull reported that, since the last Trust Board meeting, the CQC had published their reports of the Trust's inspection in October 2016 and had given an overall rating to the Trust of 'Requires Improvement'. The surgical division had moved from being rated as 'Inadequate' at the previous inspection to a 'Good' rating, putting them alongside the Medical and Out of Hospital divisions. The report noted significant improvements within the Trust including a transformed culture and areas of outstanding practice.

Dr Bull reported that safety within the A&E departments had been rated as 'Inadequate' and improvement work was ongoing. The Trust would remain in Special Measures until the CQC and NHSI were assured that the improvements seen were fully embedded.

Dr Bull reported that the Trust had won a substantial contract for the provision of MSK services in Hastings and Rother.

The Trust's financial position remained challenging with a forecast deficit for 2016/17 of £46.5million and significant financial controls had been introduced. Additional support was being introduced to the Trust with the appointment of Ian Miller as Financial Improvement Director for six months from April, who would be working with the executive team on the Trust's sustainable recovery plans. Significant work was being undertaken to reduce the Trust's dependency on agency and locum staff.

Ms Kavanagh asked when A&E four hour wait targets were anticipated to be met and Mrs Chadwick-Bell explained that this was still to be determined as she believed that, while the Trust had the correct plans in place to achieve the target, the problem would need to be resolved on a system-wide basis.

QUALITY, SAFETY AND PERFORMANCE

025/2017 **Integrated Performance Report Month 10 (February)**

Performance

Mrs Webster reported that work to improve a number of Quality and Safety issues was ongoing. An increased number of mixed sex breaches had been reported in January, relating to the high level of activity within the Trust. Patients affected by January's breaches had been spoken to and breaches had since reduced to zero with compliance monitored on a daily basis.

Methods of increasing response rates to Friend and Family Tests continued to be explored and other Trusts had been contacted for advice. Healthwatch had been very supportive in asking patients how they would like to be contacted. The number of open complaints had remained the same since the previous month, but numbers of overdue complaints had significantly reduced.

Dr Wilkinson reported that mortality indicators had improved significantly during the previous 12 months, with the SHMI remaining within the expected range during the previous three 3 quarters. RAMI and HSMR had also improved and continued to do so. A robust system for tracking issues had been introduced within the mortality review group and a rigorous programme of M&M review meetings alongside initial consultant review of deaths was in place.

Mrs Webster noted that safer staffing levels reported as over 100% reflected the fact that additional capacity had been opened or 1:1 nursing care was being provided for patients requiring additional support, and that staffing levels were monitored on a daily basis.

In response to a query from Mr Stevens about increased medication administration incidents, Dr Wilkinson explained that the increase reflected that the Trust had become better at reporting errors.

Access

Mrs Chadwick-Bell reported that the Trust had seen an improvement of over 3% in 18 week performance during January to 88.9%. The backlog of patients waiting 18 weeks had significantly reduced, with a validation exercise contributing to this reduction. She expected to see further improvements as a result of an additional validation exercise being carried out with NHSI.

She noted that one patient who had waited for more than 52 weeks had been identified during the validation exercise. The patient had been treated swiftly following identification, and the incident had been declared to NHSI with no clinical harm found to have occurred. The wait had been due to an administration error, and additional training had been given to staff.

Diagnostic targets had been achieved during January but a continued risk concerning equipment failure in Radiology had been identified and a plan had been completed to address this over the coming months. Cancer targets continued to be met with the exception of the 62 day target.

Mrs Chadwick-Bell reported that the Trust had performed at 73.4% against the 4 hour A&E target during January, but that March's performance had significantly improved to 81.1%. Streaming pathways had been further embedded and investment in clinical site teams continued with additional recruitment to support 24 hour cover. A new

discharge work stream had been launched with an integrated discharge team and work on the revised medical model continued to progress.

Community teams continued to support patient flow from the acute hospitals and a hospital intervention team were supporting patient discharge.

In response to a query from Mrs Churchward-Cardiff, Mrs Chadwick-Bell explained that processes for approving outpatient clinical cancellations were being revised to ensure that the experience of patients was improved. She noted that medical and surgical clinics ran at less than 70% utilisation against an expectation of 90% utilisation. Dr Bull reported that work was being undertaken on both outpatient and theatre utilisation in order to improve this against national bench marks. Mrs Chadwick-Bell agreed to share utilisation information with Mrs Churchward-Cardiff and would look at the possibility of introducing a summary of this information into the IPR. **JCB**

Finance

Mr Reid explained that he had produced two financial reports for the Board which reported on the same information. He planned to incorporate the financial update into the IPR for future meetings to avoid duplication.

He explained that the Trust had been offered £10.4m of Sustainability and Transformation funding (STF) at the start of the year, linked to achieving financial targets and that £2.8m of this had been realised. The Trust was forecasting a £46.5m deficit for the year which included the unrealised STF funding.

Mr Reid praised the achievement of staff in delivering £12.5m of identified savings in a short period of time. He noted that the range of risk to achieving financial savings had been reduced from £16million in November to £2-3million for the end of year. Key areas of risk had been identified around year end accounting transactions and around securing agreement with commissioning colleagues about income received at the end of the year.

The Trust's cash and capital position remained challenging. The capital budget for 2016/17 was £11million and £9m of this had been spent by the end of month 10. The Trust maintained good control over the capital budget, but had been challenged in ensuring that constraints on capital did not impact on safety and the quality of care.

Mr Clayton-Smith noted that the reduction in the risk to achieving financial saving had been impressive. He asked what work would be undertaken to further reduce costs during 2017/18. Mr Reid explained that work was being undertaken to understand very clearly where money moved out of the organisation. The number of staff who were able to approve expenditure had been greatly reduced which had resulted in

increased grip and control. Improvements to non-pay controls were in place, and further improvements would be made in this area as a fully substantive procurement team had now been employed by the Trust. Control on agency expenditure was improving but it was hoped that greater improvement would be realised in 2017/18 as this was an area where significant improvements in the underlying deficit could be realised. Services were being reviewed using benchmarking and Lord Carter data in order to ascertain how efficient and cost effective they were, and it was hoped that this work would feed into strategic planning and realise further cost reductions.

Mrs Churchward-Cardiff asked what percentage of the temporary workforce costs was spent on escalation staffing and Mr Reid explained that work was being undertaken to look at the original assumptions made within the Trust's Financial Recovery Plan to ensure that they were accurate. A process of redefining the Trust's, and the system's, bed base was taking place and this would allow for escalation capacity to be accurately planned. Mrs Churchward-Cardiff noted that if the Trust no longer had to open escalation areas then a significant reduction in costs would be realised. Mr Reid agreed, explaining that any decisions taken that would affect the whole healthcare system would have to be taken in conjunction with partner organisations.

Workforce

Ms Green reported that workforce indicators had remained relatively static during January. Integrated support workers who followed patients from the acute setting into health and social care had been introduced. An A&E consultant had recently been recruited at the Conquest. Work was being undertaken with divisions to identify innovative roles to help with the difficulty in recruiting to some roles, and doctors assistants, nurse associates and nurse practitioners had already been identified.

Pulse surveys of staff were carried out throughout the year and the recent survey showed continuing improvement in engagement, relations with managers and the Trust as a place to work. Ms Green noted that focused work had been undertaken to realise improvements in these areas. A development programme for the top 50 leaders in the Trust was being designed. Flu vaccination uptake amongst staff was 53%, which was an improvement on previous years.

Mr Clayton-Smith noted that there had been many positives during the previous 12 months and asked if the Trust was now in a position, with a capable, willing, motivated workforce, to support teams to improve performance. Dr Bull explained that a number of initiatives were in place across the organisation using Carter comparisons about the cost effectiveness of services. Teams were being brought together to explore new ways of working and new collaborations with other services, with a good response from staff. He hoped that this work would be reflected in improved performance over the coming year.

Ms Ashton reported that over 100 members of staff had undergone clinical pathway design training during February, including commissioners and community nurses. The training would enable staff to support and embed improvements and changes within the organisation.

Mr Stevens explained that he was very impressed with the work that HR were undertaking, but was concerned about appraisal rates which he felt should be above 90%. Miss Green explained that the issue was discussed with clinical units during IPR meetings, and that alternative approaches to improving appraisal compliance were being explored in low performing areas.

Mr Stevens explained that he was reassured about grip on payments but had concerns about the organisation's cash flow. Mr Reid explained that issues with cash flow were causing some delays in making payments to suppliers but that plans were in place to improve this situation, as well as to provide robust plans for 2017/18.

Mr Stevens expressed concerns about the £33m of bids for capital funding that had been made against a budget of £11m. He noted that 2016/17's capital budget had not been fully spent and asked if a larger budget should be set for 2017/18 to ensure that it was fully utilised. Mr Reid explained that the full capital budget for 2016/17 would be spent by the end of the financial year, and that capital spending for 2017/18 would undergo rigorous scrutiny due to the constraints that existed.

The Board noted the IPR Report for Month 10.

026/2017 **Financial Update Month 10**
Covered under item 025/2017 above.

027/2017 **ESHT 2020 Improvement Programme**
Mrs Webster noted that progress on the 2020 Improvement Programme was reviewed by the Quality and Safety Committee and by the Quality Improvement Steering Group. She explained that the Urgent Care project was currently rated as red, and that it was felt that this may need breaking down into component parts as the rating currently only looked at progress against the four hour A&E standard rather than reflecting the large amount of positive work that was being undertaken.

She explained that multidisciplinary ward rounds were being carried out once a day to pick up potential issues, including patient and staff experience and ward productivity. End of Life Care and mortality projects would soon be removed from the programme as they became business as usual for the Trust.

Mr Clayton-Smith asked how the adult sepsis screen had been introduced and Mrs Webster explained that the sepsis tool had launched

in September 2016. This had resulted in improvements in the management of sepsis in some areas, particularly in A&E. Work was being undertaken to improve the capture of data and support was being offered to staff to do this.

Mrs Webster reported that the red to green initiative had been launched in two initial areas to ensure that it was effective and could be embedded and would then be rolled out across Trust.

Mr Stevens asked about governance changes that had taken place under the Chief Operating Officer and Mrs Chadwick-Bell explained that the 2020 Programme had previously covered improvements in a number of different areas and had now been refocussed on to five key areas to ensure that they were looked at in greater detail.

The Board noted the ESHT 2020 Programme Update.

028/2017 **Quality Account Improvement Priorities 2017/18**

Mrs Webster presented the priorities that had been identified for 2017/18 Quality Account, explaining that these built upon the work reported on in the 2016/17 Quality Account. She noted that the priorities had previously been discussed and agreed by the Executive Team.

The Quality Account Improvement Priorities 2017/18 were approved.

STRATEGY

029/2017 **ESBT**

Ms Ashton provided an update on progress in developing the East Sussex Better Together (ESBT) Alliance model moving towards a test bed year in 2017/18. She explained that during this period the Alliance would have a notional pooled budget, Alliance Boards and governance arrangements would be reviewed and developed to ensure that they were correct.

Mr Clayton-Smith updated that the Alliance Governing Body had met the previous day, advising that he was Chairman of the Body. The meeting had explored how elements of the governing body would work together while continuing to comply with the statutory obligations of each organisation. Mrs Churchward-Cardiff had joined the Alliance Governing Body as ESHT's Non-Executive Director representative. Meetings of the governing body would be held in public every two months, and lay representation would be arranged.

Ms Ashton noted that every member of ESHT's Executive team was involved in at least one of the Alliance meetings, ensuring engagement at every level. She said that every effort was being made to ensure correct levels of engagement were maintained to ensure that the Board,

patients and the public were involved and informed about progress.

The Board noted the update on ESBT.

030/2017 **Delivering Same Sex Accommodation Annual Declaration of Compliance**

Mrs Webster explained that the Trust was required to annually declare compliance with the national definition to eliminate mixed sex accommodation, except when it was in the overall best interests of the patient, or reflected patient choice. She asked the Board for approval of the declaration, explaining that it would be displayed on the Trust's website.

Mrs Chadwick-Bell noted that the declaration was heavily caveated due to the Trust's estate and that further work would have to be undertaken to improve facilities in order to deliver full compliance. Dr Bull noted that the Trust only deviated from the compliance in very carefully controlled circumstances.

Mr Stevens noted that describing the exceptions that had taken place during the previous year would strengthen the declaration by providing context to the included caveats. Mrs Webster agreed to amend the document to incorporate this suggestion.

The Board approved delegated authority to Mr Clayton-Smith to approve the final wording of the delegation.

031/2017 **Organ Donation Annual Report**

Dr Wilkinson reported that the Trust had a well developed system for assessing and supporting potential organ donors and their families. A Clinical Lead and Specialist Nurse provided support and education for staff and patients about organ donation.

He explained that during the reporting period, seven potential donors with neurological conditions had been identified but only one had proceeded and of 21 potential donors with cardiac conditions, only three had 3 donated. While specific areas within the Trust, such as ITU, Theatres and A&E had good knowledge of donation processes, there was a lack of knowledge elsewhere which had led to numbers of donations at a slightly lower level than the previous year. Education for staff about how to recognise appropriate patients was due to be carried out.

Dr Wilkinson noted that the Organ Donation Committee had no senior Trust membership, and Dr Bull agreed to meet with him to discuss potential representation. Plans to establish link nurses on wards were being developed, and a biannual organ donation forum was being organised to heighten the profile of organ donation within the Trust. He reported that the embedded specialist nurse for organ donation had left **JW/AB**

the Trust and had been backfilled by two specialist nurses from Brighton, one of whom had also recently left. The organisation now had a single specialist nurse who also had duties in Brighton, and it was hoped to address this issue via recruitment.

Mrs Churchward-Cardiff asked whether, with the limited staff available, initial contacts made on wards were appropriately followed up. Dr Wilkinson explained that performance in following up contacts had improved during the previous four months, but a reduction in staff education had been made in order to accommodate this.

Mr Clayton-Smith thanked Dr Goswami on behalf of the Board for the huge amount of work he did on Organ Donation.

The Board noted the Organ Donation Annual Report.

032/2017 **Board Sub-Committee Minutes**

i. Finance & Investment
Noted

ii. Quality and Safety
Noted

ITEMS FOR INFORMATION

033/2017 **Use of Trust Seal**
A single use of Trust seal in February was noted.

034/2017 **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, explaining that these had already been answered in writing by the Trust.

Transport between EDGH and Conquest
Mr Hardwick explained that he had received a copy of the review of the study looking at the feasibility of providing transport between the acute hospital sites, and asked if this had been reviewed by a Trust Committee. Dr Bull confirmed that the paper had been reviewed during the Estates and Facilities Performance meeting, as well as at the Joint Staff Committee and input from these meetings would be included in the final version of the report. He expected the final version to be completed within the next 2-3 months.

Maternity Services
Ms Walker noted that she continued to Chair the Save the DGH campaign, who were continuing their campaign to bring maternity

services back to the DGH. She explained that she had received feedback about babies who had been born in transit from Eastbourne to Conquest Hospital and asked whether consideration had been given to asking Brighton Hospital for investment into maternity services at EDGH.

Mr Clayton-Smith reported that a review of acute provision across Sussex was being carried out. Dr Bull explained that he felt that investment into maternity services by Brighton was unlikely, noting that the Trust was working in partnership with them to provide radiotherapy services at EDGH. He explained that he was keen to continue dialogue with the Save the DGH campaign, noting that a meeting was scheduled in April.

Dr Bull advised that a significant majority of babies born prior to arrival in hospital were from the Hastings area rather than from Eastbourne, noting that a midwife led unit operated within EDGH. In 2017 eight babies had been born prior to arrival in hospital, all due to unavoidable circumstances. Six of the babies were from the Hastings area, and two from Eastbourne. Both babies born prior to arrival at Eastbourne had been due to be delivered at Brighton Hospital.

Bed Occupancy

Ms Walke reported that her nephew had recently undergone an operation at EDGH and had experienced issues when being discharged from theatre recovery due to the lack of an available bed, leading to another patient having their operation cancelled. Dr Bull agreed that running the hospital at 100% occupancy was inefficient, explaining that planning work was being undertaken in order to maintain 85-90% occupancy during the summer months. Operating systems were in place, and investment in the site management team ensured that every opportunity was made to create bed space.

Eligibility for Patient Transport Services

Mr Campbell asked if a link to information about eligibility for patient transport services could be added to the Trust's website. Dr Bull agreed to ensure that this was done. **AB**

Public Board Meetings

Mr Campbell asked whether, given the Accountable Care Organisation activity, public engagement events would be reinstated, as there were questions he would like to ask Board that he couldn't during the meetings in Public. It was advised that this was being reviewed and some joint events with ACO partners would be organised.

035/2017 **Date of Next Meeting**

Tuesday, 9th May 2017, in the St Mary's Boardroom, EDGH

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 21st March 2017 Trust Board Meeting

Agenda item	Action	Lead	Progress
022/2017 – Board Committee Feedback	Urgent Care to be discussed in detail during April's Board Seminar	Pete Palmer	Complete
025/2017 – IPR Month 10	Theatre Utilisation Data to be sent to Ms Churchward-Cardiff	Joe Chadwick-Bell	Complete.
031/2017 – Organ Donation Annual Report	Dr Wilkinson and Dr Bull to meet to discuss senior Trust representation on the Organ Donation Committee.	Adrian Bull	Meeting Arranged
034/2017 – Questions from members of the public	Patient transport eligibility criteria to be added to the Trust's website	Adrian Bull	Complete

East Sussex Healthcare NHS Trust

Audit Committee

1. Introduction
An Audit Committee was held on 23rd March 2017, but as the final minutes have not yet been approved a summary of the items discussed at the meeting is set out below.

2. Matters Arising
An update on progress in recruiting a regional Chemocare administrator was provided. An update on progress against IT audit recommendations was also given.

3. Board Assurance Framework and High Level Risk Register
The Board Assurance Framework and High Level Risk Register were presented. One new risk had been added to the Risk Register since January 2017, concerning the Trust's ability to monitor and formally report on follow up appointments in order to ensure that there was no clinical risk to patients suffering a delay. Three areas on the BAF, relating to emergency department reconfiguration/patient flow, patient transport and finance were rated as red. The Committee supported a recommendation to be made to the Board to remove risks concerning management of infection control incidents and capacity to tender.

4. Clinical Audit Update
A system for grading clinical audit actions had been developed and will be rolled out in April 2017. Trust Clinical Audit Awards will be held on 29th June 2017. The Clinical Audit work plan for 2017/18 was discussed.

5. Internal Audit Progress Report and Recommendation Tracker
The Committee received an update on internal audit progress. Nine final audit reports had been issued – one gave "Limited" assurance, three gave "Reasonable" assurance, two gave "Substantial" assurance and three were operational reviews and carried no opinion. Good progress was being made against the 2016/17 internal audit plan, with all reported work finalised with the exception of one review at a draft stage.

The Internal Audit work plan for 2017/18 was discussed and approved,

6. Local Counter Fraud Service
The Committee received the Counter Fraud progress report and noted actions that were being taken. The LCFS work plan for 2017/18 was reviewed and approved.

7. External Audit
External Audit provided an update on their progress to date, presenting their progress to date on their audit for the year ending 31st March 2017.,

8. Information Governance Report
A total of 75 IG incidents were reported between April-December 2016, with none needing to be raised with the Information Commissioner's Office.

9. Draft Annual Governance Statement
The first draft of the Annual Governance Statement was presented and reviewed by the Committee. The final version will be included in the Trust's annual report and accounts.

Mike Stevens
Chair of Audit Committee

2nd May 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 30th March 2017. A summary of the items discussed at the meeting is set out below.

2. Review of Action tracker

The Committee noted the progress with outstanding actions. Following requests made at the previous meeting, the Committee received reports regarding long-term sickness, BME recruitment and vacancies and noted the actions being taken to address these matters.

3. Updates from Committee 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.

4. Staff Survey Briefing and Actions

The corporate priorities for 2017/18 agreed following the staff survey presentation to the Board on 21 March 2017 were noted by the Committee;

- Improving communication between managers and staff
- Reducing bullying and harassment with a particular emphasis on raising concerns
- Health and Wellbeing of staff, including making ESHT a good place to work
- Improving the number of staff who would recommend the trust for care and treatment

5. GMC Visit and medical engagement

The Director of Medical Education and Medical Education Manager presented the findings of the recent GMC visit to the Committee and summarised the three key areas of focus for action; 1) Improvement of incident reporting and learning from incidents, 2) Filling of gaps in rotas and 3) Exception reports. The Committee agreed to receive a further update on progress to address these areas at the next meeting in June.

It was also raised whether the Trust has an overarching strategy for junior doctors that would encompass all of the work being undertaken. It was agreed that a strategy would be drafted and presented at a future meeting.

6. Guardian of Safe Working Hours report

The two Guardians of Safe Working Hours were in attendance and presented their first quarterly report to the Committee following implementation of the new junior doctors' contract. The new exception reporting process was reviewed in detail and noted by the Committee. The Committee recommended a summary report and action plan based on recommendations outlined in the report to be presented to Trust Board on 9 May 2017.

7. Leadership Strategy & Leading Excellence Programme

The Committee approved the updated leadership strategy and this would be presented to Trust Board for final approval on 9 May 2017. The Committee noted the Leading Excellence Programme outline and this would be monitored under the OD and engagement sub-group.

8. OD Strategy

The Committee approved the updated OD Strategy and noted this would be presented to Trust Board for final approval on 9 May 2017.

9. Workforce assurance tool

The workforce assurance tool template was circulated for information and the final populated version would be presented at the next meeting in June.

10. Healthroster – Safecare module

The Workforce Systems Manager was in attendance and presented an update to the Committee regarding the Safecare staffing module of Healthroster being successfully rolled out across the Trust. This module allows a real time view of staffing levels on wards and acuity of patients to enable decisions to be made regarding staffing. The Committee noted the report.

11. Future agenda items

The committee agreed the following items would be added to the agenda of the next meeting:

- Workforce vacancies
- Development of new roles
- HR Incident Report 2016-17

The Chair agreed to meet with the Director of HR and Director of Corporate Affairs prior to the next meeting to review and shape the agenda for future meetings and create a work plan for the Committee.

Approved minutes of the meeting held on 15 December 2016 are attached for the Board's information.

Miranda Kavanagh
Chair of POD Committee

25 April 2017

East Sussex Healthcare NHS Trust - Quality and Safety Committee

1. Introduction
Since the Board last met a Quality & Safety Committee meeting was held on 22 March 2017. The minutes of that meeting are due to be approved at the next meeting on 24 May 2017. A summary of the items discussed at the meeting is set out below.

2. Patient Story
Two patient stories (Florence and Peter) were introduced outlining how improved mouth care had proven very beneficial to both patients.

3. Board Assurance Framework and High Level Risk Register
Due to the timings of meetings the Board Assurance Framework and High Level Risk register had already been presented at Trust Board on 21 March 2017.

4. External Visits and Reviews
Going forward the report would be split into two types of visit, with those that had been commissioned by ESHT being reported on separately.

5. Quality Account Report
The 2017/18 Quality Account Report was presented. Priorities had been agreed at the Trust Board meeting the previous day.

6. ESHT 2020 Improvement Programme
Urgent and Emergency Care remained at red but significant work was being done to address this. Mortality showed continuing improvement.

7. TIAA Audits/Actions
Most actions had been completed and all actions would be tracked by the Audit Committee.

8. Governance Quality Report
Complaints backlog and Duty of Candour compliance was improving. Inpatient Friends and Family Test response rates were better.

9. Patient Safety and Quality Group Report
Established work plans in place for all the main groups. Governance system established. Top 3 patient safety risks were: winter pressures: consultant vacancies: non-compliance with NICE guidance on the Diabetic Foot Pathway.

10. Back to Green Update
Review sessions had taken place and learning was being cascaded. Next Back to Green was scheduled for April.

11. Nursing Establishment Review
Report on the findings and proposed establishment changes from the October 2016 Nursing Establishment Review. Committee asked to agree priorities for the following six months.

12. Deep Dive – Falls
Fishbone analysis had taken place and a focus was on the wards where the most impact could be had. An innovative approach was being tried on Tressell Ward.

Sue Bernhauser
Chair, Quality and Safety Committee
24 April 2016

Board Assurance Framework

Meeting information:			
Date of Meeting: 9 May 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 (BAF). Following agreement at the last Board meeting the Urgent Care and patient flow gap in controls have been divided (see 2.1.2 and 2.1.3). These areas are rated red along with 3 areas rated red along with 4.1.1 Finance

Assurance has increased in respect of patient transport (3.3.1) and this has moved to Amber as the new service is being successfully implemented and embedded.

There is a proposal to remove two items from the BAF:

1.1.2 health records as effective controls are in place and EDM is being rolled out.
3.3.2 centralised reception/outpatients as service is stable, good feedback received from staff and CQC and is no longer an outlier.

And to amalgamate the gap in control under 5.1.3 with 5.1.1 as the two relating to recruitment are covered by the same actions.

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

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

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

The Trust Board is asked to review and note the revised Board Assurance Framework and consider whether the main inherent/residual risks have been identified and that actions are appropriate to manage the risks. The Board is requested to note the increased assurance around patient transport and agree the removal of the two gaps in control in respect of health records and clinical administration and the amalgamation of the two HR recruitment gaps in control.

Assurance Framework - Key

RAG RATING:

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

Status:

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

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

C indicated Gap in control
A indicates Gap in assurance

	Strategic Objectives:
1.	Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.
2.	All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.
3.	We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.
4.	We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.
5.	We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable.
	Risks:
1.1	We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies.
2.1	We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.
2.2	There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.
3.1	We are unable to develop and maintain collaborative relationships based on shared aims, objectives and timescales with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.
3.2	We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.
3.3	We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we may not be the provider of choice for our local population or commissioners
4.1	We are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.
4.2	In running a significant deficit budget we are unable to invest in delivering and improving quality of care and patient outcomes. This could compromise our ability to invest in our ability to make investment in infrastructure and service improvement.
4.3	We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan
4.4	We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.
5.1	We are unable to effectively recruit our workforce and to positively engage with staff at all levels.
5.2	If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.

Strategic Objective 1: Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients	
Risk 1.1 We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies	
Key controls	Effective risk management processes in place; reviewed locally and at Board sub committees. Review and responding to internal and external reviews, national guidance and best practice. Feedback and implementation of action following "quality walks" and assurance visits. Reinforcement of required standards of patient documentation and review of policies and procedures Accountability agreed and known eg HN, ward matrons, clinical leads. Annual review of Committee structure and terms of reference Effective processes in place to manage and monitor safe staffing levels PMO function supporting quality improvement programme iFIT introduced to track and monitor health records EDM implementation plan being developed Comprehensive quality improvement plan in place with forward trajectory of progress against actions.
Positive assurances	Internal audit reports on governance systems and processes Weekly audits/peer reviews eg observations of practice Monthly reviews of data with each CU 'Quality walks' programme in place and forms part of Board objectives External visits register outcomes and actions reviewed by Quality and Standards Committee Financial Reporting in line with statutory requirements and Audit Committee independently meets with auditors Deep dives into QIP areas such as staff engagement, mortality and medicines management Trust CQC rating moved from 'Inadequate' to 'Requires Improvement'

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/milestone**	**RAG**	**Lead**	**Monitoring Group**
1.1.1	A	Quality improvement programme required to ensure trust is compliant with CQC fundamental standards.	March CQC inspection reports published Sept 15, trust in special measures. Quality Improvement plan developed Improvement Director working with the Trust. Mar-16 In depth review of all warning notice actions by exec team . QIP monitored by stakeholders, medicines management and incident deep dive took place Mar-16. May-16 to Sept-16 2020 Quality Improvement Priorities agreed and key metrics developed to support compliance and monitoring. Commenced preparation for Autumn CQC inspection. Mock inspection took place end June, further mock planned end of July. Continued monitoring of QIP and preparation for CQC inspection. Nov-16 CQC inspection took place October - draft report expect Dec 16. Continuing with quality improvement priorities eg end of life care and optimising patient pathways. Jan-17 Draft report expected this month Mar-17 Report published end of Jan 17. Trust rating moved to 'Requires Improvement' Good progress evidenced in a number of areas however 2 must do actions and 34 should do actions to address. Programme of improvements in place. May-17 Good progress in implementing CQC actions. Mock inspections planned for May-17	end Oct-17	◄►	DN	Q&S SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.1.2	C	In order to deliver an effective service, there is a requirement to improve controls in Health Records; to encompass systems and processes, storage capacity and quality of case note folders.	Oct-15 - Dec15 iFIT embedding with rolling improvement programme. Mitigating actions continue and extended to provide daily information re availability of notes. New escalation procedure for missing notes. Centralisation of Health Records and records management structure reviewed. Ongoing programme of work to support effective delivery of health records service monitored by SLF. Consultation taking place re health records structure. Mar 16 - Significant reduction in missing notes, positive feedback from clinicians.. Storage remains challenging but is being addressed through the development of an off-site facility. Repairs continue but ultimate solution is the EDM programme. May-16 Marked improvement in the availability of records. Progressing offsite record storage Sept-16 New centralised storage facility open, 4 month transition plan to this facility. Short term rise in incidents regarding temporary notes due to the transition period which is monitored daily/reported weekly. Clear escalation processes in place to avoid impact on patient care. Issues regarding tracking of files outside of Health Records is being challenged and positive engagement encouraged. EDM preparation ongoing. Nov-16 Final stages of reconfiguration underway. Further staff consultation taking place. Some delays due to estates work and other operational pressures (18 week recovery plan). Significant improvement in non-availability of records, currently at 2.6% but not back to target of less than 1%. Now accelerating input into EDM preparation; identifying concern's/risks associated with this based on learning from other Trusts. In all other cases Health Records resources was underestimated and with ESHT we have the additional issue of 'change fatigue' Mitigations will be developed. Jan-17 Non availability currently averaging 2.08% (Dec 16). This includes additional 18 week RTT activity in Ophthalmology and Gynaecology. Storage capacity now resolved however quality of records will remain an issue until the roll out of EDM.. 'Go live' of first specialty delayed until February 17 by Project Board Mar-17 Non availability has averaged 1.90% over January and February 2017 which continues to include the 18 week RTT activity. EDM went live on 27/2/17 for deceased health records. Work is ongoing within EDM for specialty go live. Repairs to health records are currently undertaken prior to the notes leaving the library. May-17 Non availability continues to improve and averages 1.4% over last 3 months. Preparing for next stage of EDM roll out to Gynaecology in June 17. Proposed to remove this gap in control from the BAF.	end Mar-17	▲	COO	Q&S SLF

Strategic Objective 2: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.	
Risk 2.1 We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.	
Key controls	Robust monitoring of performance and any necessary contingency plans. Including: Monthly performance meeting with clinical units Clear ownership of individual targets/priorities Daily performance reports Effective communication channels with commissioners and stakeholders Healthcare Associated Infection (HCAI) monitoring and Root Cause Analysis Single Sex Accommodation (SSA) processes and monitoring Regular audit of cleaning standards Business Continuity and Major Incident Plans Reviewing and responding to national reports and guidance Cleaning controls in place and hand hygiene audited. Bare below the elbow policy in place Monthly audit of national cleaning standards Root Cause Analysis undertaken for all IC outbreaks and SIs and shared learning through governance structure Cancer metric monitoring tool developed and trajectories for delivery identified, part of Trust Board performance report.
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Exception reporting on areas requiring Board/high level review Dr Foster/CHKS HSMR/SHMI/RAMI data Performance delivery plan in place Accreditation and peer review visits Level two of Information Governance Toolkit External/Internal Audit reports and opinion Patient Safety Thermometer Cancer - all tumour groups implementing actions following peer review of IOG compliance. Consistent achievement of 2WW and 31 day cancer metrics

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

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.1.2	C	Emergency departments require reconfiguration to support effective patient assessment-treatment time and subsequent discharge to other specialist/bed areas. CQC report identified privacy and dignity issues.	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.	end Sep 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.	end Sep 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	Mortality levels above expected range and assurance is required that there are robust mechanisms in place to understand the metrics and implement best practice.	Action plan developed. Identified top 10 drivers for elevated indices and reviewing pathways for cause in these groups. Internal mortality summit May 2016. Mortality Overview Group in place and additional governance review of deaths using data from the Bereavement Office. Peer review and support being accessed. May-16 Weekly review of deaths undertaken by consultant and senior coder. Work underway to understand further co-morbidity profile of our patients. A number of clinical pathway reviews in place to reduce risks eg colitis, deteriorating patient, gastroenterology. Jul-16 Mortality Improvement project expanded to incorporate AKI, Pneumonia, Sepsis. Sept-16 Full time project manager now in post. Plans in development following scope prioritisation. New Medical Director to review programme. SHMI reduced from 114 to 111 now within the normal range. Nov-16 Extensive mortality project developed to address issues. Groups established to review sepsis, VTE, pneumonia and COPD. Sepsis project being rolled out. Lead for AKI being sought as previous one recently stepped down. Consultant mortality review rates improving, with provision of clinical governance support. Mortality review data at individual consultant level to be discussed in appraisals. Independent mortality reviews performed weekly for last 6 months – project completed, report awaited (due shortly). Jan-17 Report or independent review received and being reviewed; no deficiencies in care identified, but note taking poor across the organisation. SHMI remains 111, preliminary data from RAMI suggests risk adjusted mortality is falling towards national mean. Due to delayed reporting of SHMI it will take a while for this to be reflected. Still no AKI lead - advertised for nurse lead to take project forward. Mar-17 SHMI reduced to 110. RAMI monthly data encouraging, suggesting further fall in mortality over the next few months (SHMI reported 6 months in arrears). AKI lead now in place and the project is progressing. 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.	end Sep-17	◄► Oct-16	MD	Q&S
2.1.5	C	Effective controls are required to ensure children requiring an appointment with a community consultant paediatrician are seen in a timely manner.	Feb-15 to Oct-15 Action plan implemented and waiting list backlog cleared. Patient Tracking List developed and activity being monitored. Dec-15 Business Case (BC) and PTL considered Dec. Further updates to the BC and PTL will be reviewed at Jan meeting. Mar-16 CCG reviewed community paediatric business case, negotiations taking place. Following approval of business case substantive recruitment will take place to reduce the reliance on locums. Date moved to Sept to recognise recruitment timeframe. May-16 – Implementation timeframe of the recruitment plan is currently worked up. This will allow the service to build a recovery trajectory to reduce the waiting time and list size. Jul-16 Wait time to be seen reduced to 6 months for initial community paediatrician assessment. Active recruitment for CDC coordinator and 2 substantive consultant posts. 2 locum consultants start 4th July. Further part time locum consultant starting Aug. Sept-16 Locums in place. Difficulties in division of acute and community patients undertaking validation exercise, moving to Systm one which will support this. Nov-16 Work ongoing as outlined above - no further update. Jan-17 Recruiting to 4 substantive posts interviews mid January, good field of candidates. Validation process in place and waiting list continuously monitored. Community paeds will be fully utilising Systm One by April. Mar-17 Continuing increase in referrals to community paeds, 3 locums supporting. New referrals first appointment reduced to 6 months. Ad hoc clinics for follow up. Systm One data being uploaded for 21 March go live. 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	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. May-17 No update provided	end Jan-17	◄►	COO	SLF Q&S
2.17	C	Effective controls are required to monitor and formally report on follow up appointments in order to ensure there is no clinical risk to patients suffering a delay.	Mar -17 Inability to formally extract data from Oasis PAS to report on patients follow up by time period. Local systems in place but require Trust wide system for monitoring and analysis. Liaising with supplier regarding options for reporting. May-17 Position resolved with community paediatrics due to data transition to Sytm One. Ongoing discussion to find Trustwide solution.	end Jun-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.	end Sep-17	◄► Mar-16	HRD	POD SLF

2.2.2	A	The Trust needs to develop and support its clinical leadership to empower them to lead quality improvement in order to realise the ambition of becoming an outstanding organisation by 2020.	Jul-16 Reviewing medical leadership roles to ensure they are appropriately resourced. Faculty of Medical Leadership Programme in place. CEO leading regular meetings with consultant body. Medical education team continue to work with junior doctors to improve engagement and enhanced support. New Medical Director appointment (subject to central approval) Revision and reappointment of all key medical role job descriptions: CU Lead; Speciality Lead; Chairs of Clinical Boards (urgent care, elective, cancer); Chairs and ToR of key Medical Clinical Governance sub committees. Sept-16 New Medical Director in post, progressing appointments of Chiefs and deputies. Nov-16 Consultant meeting 3rd Nov with CEO, MD, FD. Faculty of Medical Leadership and management training for newly appointed medical leaders 8th and 9th November. Appointments made for Divisions of Medicine and Surgery/Anaesthetics/Diagnostics, but no appointment as yet for W+C. Chairs of Urgent Care and Elective Care Boards have been made. Jan-17 Final FMLM training end of Jan. All Chiefs now appointed, including Women's and Children. Specialist leads advertised. Mar-17 Most speciality leads now appointed. Job planning training to follow. Other training possibilities arranged eg for “case investigation” 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.	end Mar-17	◄►	MD	POD

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.2.1	A	Assurance is required that the Trust will be able to develop a five year integrated business plan aligned to the Challenged Health Economy work.	Challenged Health Economy and Better Together Work on-going. Trust developing clinical strategy. Dec-15 ESBT work continues. Board to Board meeting with Eastbourne, Hastings and Rother CCG took place Dec15. Mar-16 SPT footprint agreed. Trust to work with stakeholders to develop strategic plans. Board Seminar planned April 16. May-16 Trust fully engaged with SPT and ESBT programmes. Trust strategy being developed and "stakes in the ground" identified. Priority specialities for clinical strategy development identified and specific work commenced Jul-16 Continuing to work closely with commissioners on aligning ESBT plans with the emerging clinical strategy. Multiple integrated strategic planning workstreams underway and recruiting to better support the planning process. Sept-16 STP for Sussex and East Surrey now incorporates placed based care (ESBT) as one of its key elements. We continue to work proactively with commissioners and other providers to ensure that opportunities to deliver efficiencies at scale and pace are maximised. This includes working across STP boundaries. ESHT CEO is now joint SRO with CCG and ESCC leaders in the emerging Accountable Care Organisation Steering Group which will develop the delivery mechanism by which the challenged health economy issues will be tackled. Nov-16 STP has been submitted which includes 5 year plans reflecting the ESBT position. ESHT has been fully involved in developing these draft plans and they will be considered at November Board Seminar. Jan-17 STP now published and available on Trust website. ESHT continue to be involved in all appropriate work streams with a specific focus our local ESBT plans and the emerging Accountable Care model. Mar-17 Trust are continuing to work with all STP partners to further develop plans. Current work includes participation in the Acute Networks Steering group which is being facilitated by Carnall Farrar. Work is ongoing in developing the governance structures and framework for the ACO which is due to enter shadow form in April 2017 May-17 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.	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.	end Jan-17	▲ May-16	COO	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.3.2	C	A number of concerns have been identified following the centralisation of reception and outpatient services on the two acute sites. Shortage of staff in appointment and admissions booking teams Further controls are required to support delivery of an efficient service and good patient experience.	Review instigated to support implementation of focussed actions. Feb-15 Central team in place and systems being monitored. Considering developing specialist teams to support areas with complex processes. Apr-15 -Dec15 Close liaison between service managers and booking team. Increased working space/ essential equipment. Monitoring of performance via dashboard. Reviewed processes to minimise short notice clinic cancellation and ensure appropriate clinical assessment of affected patients. New call management system introduced to address technical and resource issues in appointments centre/provide enhanced service Review of 700+ letter templates underway to improve patient communication. SOPs and specialty booking rules agreed and implemented. March 16 – 80% referrals registered within 48hrs of receipt, scanned on to e searcher to minimise paper referrals going missing. First specialty about to go live with e referral system, continued roll out through 16/17. Staff capacity/demand remains an issue and is being addressed through business planning. Planning to develop some self- service check in facilities in 16/17 May-16 Business Case for Clinic Manager and Self-Serve check in underway with PMO and IT. New structure with additional resources for OP booking to support retention of staff due for implementation by end of July 16. Informal staff engagement underway. Jul-16 Progressing with new structure but will require formal consultation to extend operational hours, improving access for patients, which is primary cause of complaints. Clinic Manager business case to be submitted to BDG in July. Sept-16 Consultation with staff and additional recruitment completed, training underway and new structure will be in place by Oct/Nov 16.Clinic Manager Case approved but is subject to PAS hardware and software upgrades. Project expected to start Nov-16 for implementation by Spring 17. Nov-16 Consultation complete, final stages of recruitment. Specialty based 'pods' in early stages of development, good feedback to date. Ongoing training in relation to Access Policy and Clinic Manager Case approved but is subject to PAS hardware and software upgrades. Self Check in kiosks ordered and will be introduced alongside reception redesign, retaining face to face contact for those who require it. Significant 'data cleansing' of waiting list in Urology had identified a major area of work across the Trust to support effective utilisation. Jan-17 The team is now able to support services more effectively as demonstrated by the management of referrals, gradual implementation of eRS and new structure. Independent audit (TIAA draft) demonstrates a reasonable level of assurance. Trust is now moving into an improvement programme that supports the overall outpatient pathway. The main area of concern that remains is Cardiology which is under-resourced for the activity. A business case has been prepared for this. Mar-17 The recent CQC report highlights improvements in the administration services since the previous inspection which echoes the TIAA independent audit report. The business case in respect of cardiology will be finalised this month in conjunction with the Clinical Unit. May-17 No major changes since March 17 and service is stable. Continue to work on improvement but not an outlier in terms of national/regional experience. Proposal to remove from BAF	end Mar-17	◄► Jan-17	COO	SLF Q&S

Strategic Objective 4: We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable.	
Risk 4.1 We are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.	
Key controls	Clinical strategy development informed by commissioning intentions, with involvement of CCGs and stakeholders QIPP delivery managed through Trust governance structures aligned to clinical strategy. Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work Modelling of impact of service changes and consequences Monthly monitoring of income and expenditure Accountability reviews in place PBR contract in place Activity and delivery of CIPs regularly managed and monitored.
Positive assurances	Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. Written reports to SLF on progress with QIPP targets to ensure improvements in patient outcomes are planned and co-ordinated. Performance reviewed weekly by CLT and considered at Board level. Evidence that actions agreed and monitored. Decrease in medical admissions at CQ continued and new practice being developed at EDGH (medical input is key)

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
4.1.1	C	Require evidence to ensure achievement of the 2016/17 Financial Plan and prevent crystallisation of risks as follows: activity and income targets are not achieved; contractual fines and penalties are levied; activity, capacity and unplanned cost pressures arise; the CIP plan is not delivered; [Gap will be updated to reflect 2017/18 challenges in next iteration of BAF]	Sept-16 - Month 4 remains adverse to financial plan, after an improvement in Month 3 stemming from a full formal close-down and opportunity review. Key pressures remain agency spend, CIP delivery and cost of operational pressures. FRP developed and shared with F&I, and with Exec Directors. New Financial Improvement and Sustainability Committee being formed to ensure leadership and oversight of both strategic and operational finance. Additional capacity secured within finance team, including short-term ad hoc cost-limited consulting support on temporary resourcing. The level of risk remains significant, but the Trust is developing a measured and coherent response to the key issues. Nov-16 Trust variance to plan improved from Month 5 to 6, but Trust was £2.3m adverse to operational plan and £4.9m adverse to plan after STF funding lost is taken into account. The Trust continues to forecast delivery of the plan, but the level of risk within the financial position remains significant, monitored through the Finance and Investment Committee on behalf of the Trust Board. The Trust was, as a result of its in-year in financial performance, placed in Financial Special Measures by NHS Improvement in October 2016. This is a new control and support regime, which requires the Trust to agree a financial recovery plan within 30 days, present this to NHS Improvement and then review jointly the implementation and delivery of the plan over the remainder of the financial year. The Trust has secured additional external support from professional advisors to work alongside the Trust staff and the Board in the development of the Financial Recovery Plan for 2016/17. The recovery plan will be reviewed at the forthcoming Board Seminar and by a special additional meeting of the F&I Committee in November 2016. Jan-17 Financial Recovery Plan developed and presented to Board, F&I and NHSI in Nov/Dec and is tracking performance on a monthly basis. A strengthened PMO and a series of additional 'grip and control' measures have been put in place. Mar-17 Trust is forecasting £4.8m adverse variance to overall forecast, drive by non-delivery of £3.5m of FRP and £1.3m escalation pressures. The Trust is continuing to strengthen the FRP and the support provided by PMO, with the aim of improving the year end focus. However, the overall level of risk in the financial forecast is such that, at its most recent review, Exec team and F&I Committee maintained the forecast at £46.5m. The Trust is continuing to develop a pipeline of new savings, but these will be impact on the 2017/18 financial year rather than 2016/17 financial plan. Additional scrutiny and support continues to be provided to the Trust through the Financial Special Measures programme. May-17 Trust has reported £4.8m adverse variance to plan, and a reported deficit of £46.5m, subject to audit. This includes a number of disputed items with local clinical commissioners, which are under review and dialogue between Chief Financial Officers. Appointed a Director of Financial Improvement, providing additional support to the Executive Team and Board on the development of the financial plan for 2017/18. For 2017/18, the financial challenge has increased to £28.7m, reflecting these contract challenges and additional interest charged by NHS Improvement through Financial Special Measures. Trust is presenting a refreshed financial plan to NHSI on 4th May 2017.	Commenced and on-going review and monitoring to end Mar-17	◄►	DF	F&I

Risk 4.2 In running a significant deficit budget we are unable to invest in delivering and improving quality of care and patient outcomes. This could compromise our ability to invest in our ability to make investment in infrastructure and service improvement.
Risk 4.3: We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan.

Key controls	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Monitoring by F&I Committee Essential work prioritised within Estates, IT and medical equipment plans
Positive assurances	Draft assessment of current estate alignment to PAPs produced Essential work prioritised with Estates, IT and medical equipment plans. Significant investment in estate infrastructure, IT and medical equipment required over and above that included in the Clinical Strategy FBC. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly. Trust achieved its CRL in 2015/16

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
4.2.1	A	Assurance is required that the Trust has the necessary investment required for estate infrastructure, IT and medical equipment over and above that included in the Clinical Strategy FBC. Available capital resource is limited to that internally generated through depreciation which is not currently adequate for need. As a result there is a significant overplanning margin over the 5 year planning period and a risk that essential works may not be affordable. [Gap will be updated to reflect 2017/18 challenges in next iteration of BAF]	Jul-16 - 5 year capital plan agreed by FIC, reviewed in Board Seminar. Discussions with NHSI re submission of capital bid, with £5m initial amount included in refreshed submitted plan. DoF reviewing internal capacity to develop FBC for submission in Q£ for £35m, and interim bid, in partnership with DoN, in Q2. Finance and Estates teams reviewing alternative sources for finance for discussion in September 2016 FIC. Sep-16 - Additional support secured for development of £35m overarching capital bid and in-year initial bids for £5m to support delivery of financial plan. Capital Review Group taking forward bid development and prioritisation process, the management of in-year expenditure, and the exploration of alternative sources of financing. Initial LTFM includes refreshed capital requirements and being refined to support submission of bid pipelines. Nov-16 There are two risks reflected on the operational risk register. First, the in-year capital plan has a component of overplanning to allow for flexibility in the deployment of the budgets. This is being actively managed within the Capital Review Group, and a prioritised list of schemes has been agreed to ensure that the Trust does not overspend, but continues to develop and maintain the infrastructure. Second, the Trust continues to develop a programme of business cases within the overarching £35m 'minimum ask' baseline case. This is reflected in the STP financial plan, as well as the Trust's own forward programme. As the Trust moves through the financial special measures regime, the forward plan for the capital programme will be clarified in advance of the next iteration of the Trust's long-term financial plan. Jan-17 Capital Review Group continues to closely monitor capital expenditure in year to ensure that over planning does not lead to overspend. The Trust continues to review its capital budget. In developing business cases to address the systematic shortfall in capital the Trust has begun exploring alternative means of financing including lease and hire purchase. Two business cases have been submitted to NHSI for capital loans in respect of ambulatory care and work continues on a series of further cases. Mar-17 – The Trust continues to develop a forward capital plan, but recognises that there is a local and national constraint on capital expenditure which needs to be addressed. The 2016/17 capital plan is forecast to meet budgets, but has been constrained by the availability to access loan funding. The Trust has developed an initial capital plan for 2017/18, which has bids in train of £22m against an available capital fund of £11m, and a detailed clinically-led prioritisation process is in train to ensure an appropriate budget can be agreed for 2017/18. A robust five year capital plan is being developed, supported by and reviewed by F&I on behalf of the Trust Board. 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.	On-going review and monitoring to end Mar-17	◄►	DF	F&I

Risk 4.4 We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.	
Key controls	Horizon scanning by Executive team, Board and Business Planning team. Board seminars and development programme Robust governance arrangements to support Board assurance and decision making. Trust is member of FTN network Review of national reports 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

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 (April to November). 80 offers made to overseas nurse, due to start Mar-17, able to work as RGN's by July 2017. Currently working on introduction of a number of new roles to address recruitment issues Project to introduce Doctors Assistants to support Junior Doctors, 6 starting Jan-17. Impact of this role will be evaluated and a business case developed to roll out across the Trust. In discussions with Brighton University to establish Physicians Associate role, expect to have work placements for these posts starting Aug-17 and appointable from Aug-18. GP Fellowship role being developed. Part of this will be to undertake some working hours in the acute sector in emergency medicine, rheumatology and dermatology. Skill-mix review being undertaken with nursing to consider the role of Nurse Associate within the Trust. Mar-17 6 Doctors assistants started,3 in SAU at Conquest, 3 in MAU at EDGH. Initial feedback positive in terms of the impact on the workload of Junior Doctors, and consideration will be given to roll-out to other specialties in the Trust. GP Fellowship role being advertised with an anticipated start date of September 2017. Quarterly CU workforce planning and recruitment meetings commenced to review short medium and long term action plans to address recruitment issues. 7 Head hunters engaged to assist with Hard to fill positions. Overseas nurse recruitment continues with additional 76 Philippine nurses offered (start date Oct/Nov 2017. EU nurses c30 offers. Targeted UK nurse campaign commenced Feb 2017. Joined NHS Employers Retention programme and will be undertaking a project internally on the retention of staff. Attending local carers fairs to promote the Trust and roles within the NHS, and Out of Hospital Division have also attended careers fairs for AHP's. 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 skills and numbers of staff required and will result in new skill mix and identify new roles.	end Mar-17	◄►	HRD	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
5.1.3	C	Assurance is required that the Trust has effective controls in place to maintain sufficient staffing levels in A&E; recruitment difficulties in consultant, middle grade and nursing. Deanery short falls in fill rate for junior positions.	Aug-15 Business continuity plans in place to cover short term difficulties. Overseas recruitment taking place. Longer term review of staff model planned. Dec-15 Discussion taking place with commissioners as part of East Sussex Better Together. Mar-16 Recruitment taking place however short falls in staffing remains. Mitigating actions such as use of long term locums Jul-16 Working with ESBT to develop GP triages in A&E. Post currently in recruitment process. Sep-16 Successful recruited consultant and specialist A&E registrars. Number of vacancies in registered nurses in MAU being actively monitored and mitigating actions in place. Nov-16 Skype interview arranged for A&E. CVs requested from Head-Hunters. Discussions with CCG ref GP/Acute rotational posts. First cohort will not be until August 2017. Jan-17 No further update linked to actions in 5.1.1 Mar-17 see above update for 5.1.1 May-17 Proposal to remove as amalgamated with gap in control above.	end Mar-17	◄►	COO	SLF

Strategic Objective 5: All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.

Risk 5.2 If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.

Key controls	Leading for Success Programme Leadership meetings Listening in Action Programme Clinically led structure of Clinical Units Feedback and implementation of action following Quality Walks. Organisation values and behaviours developed by staff and being embedded Staff Engagement Plan developed OD Strategy and Workstreams in place
Positive assurances	Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Embedding organisation values across the organisation - Values & Behaviours Implementation Plan Staff Engagement Action Plan Leadership Conversations National Leadership programmes Surveys conducted - Staff Survey/Staff FFT/GMC Survey Staff events and forums - "Unsung Heroes"

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
5.2.1	A	The CQC staff surveys provide insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others.	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	end Sep-17	◄►	HRD	POD SLF

Chief Executive's Report

Meeting information:	
Date of Meeting: 9th May 2017	Agenda Item: E
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

At the year end the Board will note a significant improvement in our quality standards, as reported by the CQC in their inspection of last October and from which I am confident that we have further improved. The Board will also note a significant improvement in our culture as reflected in the national NHS survey and ongoing Pulse survey results.

Our performance against the 4 hour standard in ED remains challenging. As a result of the operational plans we have been implementing over the past year we are beginning to see improvements in that performance. On some days we are now achieving in excess of 90% performance. Our average performance is held down by some disappointing days. But this is enabling us to demonstrate that we can achieve the standard and to identify the specific issues that continue to cause problems.

Recruitment and the management of our staffing levels remains a key challenge although the position again is improved from last year.

Our financial outturn will be £46.5m deficit (£43.9m after STF) compared to an initial budget of £48m deficit and control total of £41.5m deficit.

2. People, Leadership and Culture

2.1 Recruitment and Retention

Recruitment – Developing a number of initiatives to address recruitment issues to include refer-a-friend, welcome packages and reviewing the use of recruitment and retention premiums. International recruitment continuing in the Philippines, India and Australia for Nursing, medical and AHP staff groups.

Temporary Workforce - The introduction of IR35 has had an impact on the supply of agency staff; we are introducing a process to convert agency staff to bank and bank to permanent where appropriate.

Workforce Planning – We are working to develop a long term workforce plan to address recruitment issues which will include the introduction of new and enhanced roles. The analysis is being undertaken on a task basis to look again at how these tasks may be reallocated from traditional roles (eg consultants) to new or enhanced roles (such as surgical care practitioners).

2.2 New junior doctors contract

Junior Doctors – Exception reporting has reduced in March. The total cost to date for additional payments as a result of exception reporting is £19,448 and fines are £7413. There are further transitions in April and we are now preparing for full implementation on 1st August 2017 when all 240 doctors will transition to the new contract. Rota reviews are being conducted to address any issues. A new senior medical rota steering group is being established.

2.3 Staff engagement

Following the publication of the national staff survey there are meetings with each division to discuss specific areas for improvement and developing action plans. Over 100 staff

have either booked or have had a health checks. Support continues for those staff who need to make lifestyle changes through healthy weights, stop smoking, exercise programmes
Five band 1-4 staff were finalists in the KSS apprenticeship awards

The trust Awards takes place at the De la Warr pavilion on Tuesday 23rd May 2017

250 leaders have attended the Management essentials programme for existing managers, clarifying expectations of managers in terms of staff engagement.

The 1-1's and focus groups as part of the training Needs analysis for the Leading Excellence Programme are currently underway. The first programme will start in July. Meanwhile the trust is developing a Business skills programme for service managers and Heads of Nursing

2.4 Apprenticeships

Support is in place for level 2 and level 3 Health and Social care programmes; during 16/17 we recruited 17 HCAs to the programmes. Staff are able to commence these programmes delivered by Sussex Downs College as a rolling programme allowing flexibility of start dates.

Work is ongoing with other providers to identify programmes as requested by business units such as; maternity and paediatric support workers
Recruitment is taking place for 4 Foundation Degree Assistant Practitioner (AP) programmes as band 4 development roles to support specialist nursing and AHP.

3. Quality and Safety

Our patient safety incident data for 1st April 2016 to 30th September 2016 was recently published by the National Reporting and Learning System (NRLS) via the NHS Improvement website. When we benchmark ourselves against other non-specialist acute trusts, we have moved from being in the middle, to 7th in the country of acute Trusts. This is excellent news and shows that as an organisation we are identifying incidents and learning from them. Learning from incidents and near misses as a Trust is really important for us to be able to be able to identify where we need to focus resources, and understand our gaps and vulnerabilities - this information helps us formulate a risk register.

Our one stop swallow disorder clinic and the work by Speech and Language Therapist Anita Smith has been recognised with a major national award. Anita and the team won the Advancing Practice Award at the prestigious Advancing Healthcare Awards. The judges commented: 'The team saw the vision for the future and transformed the service so that instead of the patient needing to attend five appointments, they had simply to attend one clinic. Already this is being adopted elsewhere.' The one stop swallow disorder clinic offers a quality, holistic and patient-centred approach to swallowing disorders. It provides a 'one stop' clinic which gives patients a timely, detailed assessment, good communication with immediate advice and therapy, and improved patient safety, potentially reducing unnecessary exposure to radiation. Using a more holistic approach has dramatically reduced waiting times - the patient pathway has been reduced from 24 to just 5 weeks.

ESHT Health Visiting and ESCC Children's Centre - the combined service has achieved stage 2 of the Baby Friendly Initiative. BFI is a UNICEF programme which provides external accreditation of a service that support families with their infant feeding choices with an emphasis on promoting good breast feeding outcomes with all the health benefits this brings both mother and child. Following a rigorous 3 day assessment the inspectors recorded "Excellent result. Skilled knowledgeable and sensitive workforce"

There have been developments with the ward improvement project which will provide and monitor the quality of nursing care given at ward level whilst driving a culture in which staff are not afraid of inspection and scrutiny, but understand and embrace it.

As a result we will:-

- Demonstrate which wards are improving.
- Empower and support staff to understand what is expected of them.
- Provide clear direction and clarity of where focused work is required to drive improvements.

A new Nursing Strategy to underpin other key programmes of work has been launched and is closely aligned to the workforce and OD strategy.

4. Finance and Capital

Subject to satisfactory resolution of remaining contract discussions we will end the year with a deficit (pre-STF funding) of £46.5m. We will have earned £2.5m STF funding to make a net figure of £43.9m. This is an improvement on the original budget of £48m deficit but does not meet our financial control total of £41.5m. Our monthly run rate at the start of the year was in excess of £5m deficit which would have given an outturn in excess of £60m deficit. The final position represents significant progress in dealing with the underlying financial challenges, with an underlying monthly run rate of just over £3m deficit.

Our current financial control total for 17/18 is a deficit of £36m. Given our year end position and known in-year cost pressures, this represents a financial challenge of some £27m. Plans to address this are well in hand.

5. Access and Delivery

5.1 A&E

We have seen an improvement in the A&E performance in March to 80.7% (4.7% improvement on February's performance). However we recognise this falls short of the expected standards and reflects the continued pressure on beds and the impact of lack of substantive medical staff in the Emergency Department.

We have however started to see a reduction in the number of patients with a length of stay over 7 days and this is starting to impact positively on patient flow through the hospital. We have been planning with the CCG to manage the expected additional demand at Easter, this includes the introduction of a GP co-located with the Emergency Department. This provides reduces the pressure on ED staff, where the patient has a primary care need.

The Trust has been successful in winning a bid to expand the emergency departments to develop the GP and ENP service from October 2017.

The Urgent Care Programme continues to focus on

- Minors process in the Emergency Department
- A&E workforce re-design
- Development of the acute assessment, ambulatory and short stay medical facilities, with an increase in capacity due in May
- Development of an Integrated Discharge Team

- Implementation of a Discharge to Assess model, where patients long term needs are assessed in an appropriate setting, rather than an acute bed

5.2. 18 weeks Referral to Treatment

The Trust continues to improve against the 18 week target, 90.75%, (against a target of 92%) of patients on the waiting list are under 18 weeks, which is a further improvement on previous months. This is the highest performance since February 2016.

The waiting list has stabilised over the past 2 months, although has seen a further decrease of 366 patients. The efficiency plans are seeking to release capacity to reduce this further, also reducing the reliance on use of the private to meet demand.

5.3 Diagnostics

Due to equipment failure and lack of capacity in Ultrasound, the ability to ensure patients do not wait longer than 6 weeks from referral is impacted. In March 1.4% of patients waited longer than 6 weeks (1% target). We are seeking to recruit additional staff and new equipment will be installed moving forwards.

5.4 Cancer

The Trust achieved both the two week wait target and the 31 day target. The Trust failed to meet the target for 62 days (February), achieving 69.9% against the 85% target.

The Trust has seen an increase in both primary care referrals and two week wait referrals. These have put a pressure on the teams involved to continue to achieve and have had a resultant effect on the 62 day target. Primary care referrals have increased 2.2% overall on 15/16 with March seeing a 10% increase on the same month last year. Two week wait referrals have increased by 12.4% overall year on year, with some specialties being particularly affected.

Additional 62 day patient tracking list meetings are taking place in order try and reduce the number of patients with longer waits and shared meetings with Brighton began in February to support patients with cross provider requirements.

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.

East Sussex Healthcare NHS
NHS Trust

Month 12 – March 2017

TRUST INTEGRATED PERFORMANCE REPORT

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East Sussex Healthcare NHS
NHS Trust

Contents

East Sussex Healthcare NHS
NHS Trust

March 2017

Key Issues

•All four of the key trajectories (A&E, RTT, Diagnostics and Cancer 62 Days) failed to meet the planned level of performance and are under the national targets. 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
5. Safer Staffing

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NHS Trust

Indicators

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	This Yr	Last Yr	Var	
Total patients safety incidents reported	M	1054	1078	1012	1499	1799	1786	1396	1241	1396	1307	1236	1247	978	27.5%	16051	10868	32.3%	
% Patient safety incidents with no harm or near miss	70.0%	64.4%	67.0%	72.5%	84.1%	86.5%	84.5%	82.7%	80.7%	84.5%	82.3%	79.8%	82.4%	67.8%	14.6%	80.3%	66.9%	13.3%	
% Patient safety incidents causing severe harm or death	0	0.2%	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.3%	0.2%	0.7%	-0.6%	0.1%	0.3%	-0.2%	
Total Non-ESHT patients safety incidents reported	M	319	243	148	168	145	164	136	130	151	177	150	148	85	74.1%	2079	1322	36.4%	
No of never events reported	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	4	-3	
No of serious incidents reported	M	7	0	3	8	8	4	3	6	2	6	7	5	14	-9	59	124	-65	
No of moderate incidents reported	M	6	5	11	3	6	9	9	9	4	12	12	4	2	2	90	9	90.0%	
Total Falls per 1000 beddays	7	6.0	6.0	6.0	6.3	6.3	6.2	6.4	5.0	6.4	6.5	6.4	6.3	6.1	0.2	6.2	6.7	-0.5	
Total falls reported	M	152	149	144	152	156	152	160	124	159	174	155	160	169	-5.3%	1837	1981	-7.8%	
No of falls no harm	M	97	101	99	109	116	92	115	80	113	130	107	122	118	3.4%	1281	1302	-1.6%	
No of falls minor/moderate	M	55	48	45	43	40	59	45	44	46	44	47	38	51	-25.5%	554	675	21.8%	
No of falls major/catastrophic	M	0	0	0	0	0	1	0	0	0	0	1	0	0	0	2	4	-2	
Falls Assessment Compliance	M	92.2%	93.9%	89.6%	91.4%	92.5%	85.2%	90.3%	85.6%	85.3%	90.9%	88.9%	91.8%			90.2%			
No of pressure ulcers grade 3 & 4 (trust acquired)	R	6	5	2	2	4	0	5	3	5	5	7	5	5	0	49	73	-24	
No of pressure ulcers grade 2 (trust acquired)	R	62	45	51	32	46	53	54	53	46	56	66	64	73	-9	628	697	0	
Pressure Ulcer Assessment Compliance	M	93.4%	86.0%	87.5%	92.0%	86.7%	94.0%	91.2%	95.8%	94.4%	96.3%	93.2%	92.1%			91.5%			
No of medication administration incidents	M	29	25	16	32	24	31	33	28	37	25	36	16	17	0	332	253	0	
Medication errors causing severe harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Indicators

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	This Yr	Last Yr	Var	
Observations completed on time (per protocol)	M	79.7%	80.7%	83.4%	82.5%	84.2%	83.2%	81.2%	82.1%	83.2%	83.1%	83.3%	84.3%	76.8%	7.5%	82.6%	72.1%	10.5%	
No of Cardiac Arrest calls		1	8	1	1	1	4	0	3	1	2	1	9	0	0	32	0	1	
No of MRSA cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	-4	
No of CDI cases	4	2	7	7	2	6	3	4	2	0	0	2	0	5	-5	35	48	-13	
No of MSSA cases	M	2	0	2	1	0	4	1	1	0	0	0	0	1	-1	11	7	4	
Safety thermometer overall score	92.0%	93.0%	93.6%	94.0%	95.4%	93.0%	95.0%	93.3%	93.6%	93.4%	92.7%	92.5%	91.7%	94.0%	-2.2%	6.6%	6.2%	0.4%	
% of VTE risk assessments completed	95.0%	95.2%	97.9%	98.1%	97.9%	96.8%	97.0%	95.4%	97.0%	96.2%	96.7%	96.9%	96.8%	94.8%	2.0%	96.8%	95.3%	1.5%	
Emergency C-Section rate	9.0%	15.4%	13.4%	14.5%	12.6%	11.9%	17.4%	14.6%	16.0%	25.8%	15.2%	13.1%	12.4%	12.8%	-0.5%	15.1%	15.0%	0.0%	
Mixed sex accomodation breaches	0	0	7	0	0	0	0	0	0	0	20	0	0	0	0	27	130	-103	
Inpatient FFT Response rate	45.0%	13.30%	14.01%	13.94%	16.97%	17.31%	14.89%	14.00%	21.37%	27.60%	24.31%	26.76%	31.77%	13.2%	18.6%				
Inpatient FFT Score (% positive)	96.0%	95.51%	98.26%	97.29%	96.70%	96.75%	96.13%	96.61%	97.02%	97.07%	97.26%	96.74%	97.35%	96.5%	0.9%				
A&E FFT Response rate	22.0%	6.52%	8.96%	9.91%	8.40%	7.69%	5.98%	6.98%	7.91%	6.40%	8.01%	7.47%	7.52%	7.9%	-0.4%				
A&E FFT Score (% positive)	88.0%	80.12%	87.97%	83.69%	84.11%	82.00%	81.91%	81.73%	82.80%	84.57%	87.96%	83.60%	82.68%	87.9%	-5.2%				
Outpatients FFT Score (% positive)	M	95.38%	96.02%	96.08%	95.41%	97.06%	96.02%	94.96%	94.59%	96.54%	92.27%	96.39%	95.56%	95.7%	-0.1%				
Maternity FFT Response rate	45.0%	24.22%	29.19%	11.59%	33.21%	25.25%	29.03%	30.25%	26.70%	46.40%	24.31%	37.12%	39.79%	20.1%	19.7%	29.3%	24.4%	4.9%	
Maternity FFT Score (% positive)	96.0%	92.93%	90.21%	92.45%	93.72%	96.65%	92.86%	94.84%	96.08%	92.57%	96.94%	93.81%	96.68%	89.8%	6.9%	94.2%	94.9%	-0.7%	
No of complaints reported	R	75	55	58	46	56	53	53	54	50	62	41	55	55	0.0%	658	703	-6.8%	
All ward moves	M	2303	2344	2265	2313	2304	2280	2210	2194	2316	2389	2114	2317	2331	-0.6%	27349	27325	0.1%	
Night ward moves	M	470	434	409	416	445	399	375	407	433	391	407	387	512	-24.4%	4973	5422	-9.0%	
Crude Mortality Rate	M	2.0%	1.7%	1.5%	1.4%	1.4%	1.4%	1.9%	1.5%	2.1%	2.7%	2.1%	1.7%	2.3%	-0.6%	1.8%	1.8%	0.0%	
HSMR (CHKS)	100	104	104	102	102	101	100	99	97										
SHMI (CHKS)	100	77	80	75	85	72	74	64											
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	10.0%	8.0%	7.6%	7.3%	6.9%	6.5%	6.8%	6.8%	7.1%	7.2%	7.9%	7.2%	8.0%	8.1%	-0.1%	7.3%	7.3%	-0.1%	

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 March. 3 related to slips/trips/falls, 1 related to availability of a theatre bed and the other to a delay in treatment

No new Never Events have been reported.

Infection control reported no incidents of MRSA, CDIFF or MSSA

The emergency caesarean showed a further reduction to 12.4%.

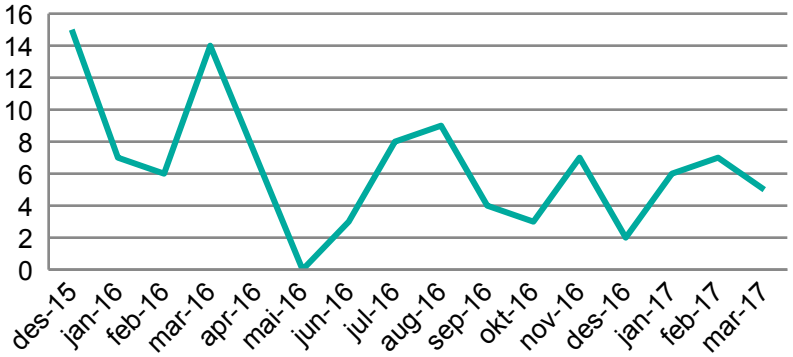
There were no overnight mixed sex accommodation breaches were reported.

There were 5 grade 3 and 4 Pressure Ulcers reported this month, these are outlined below:

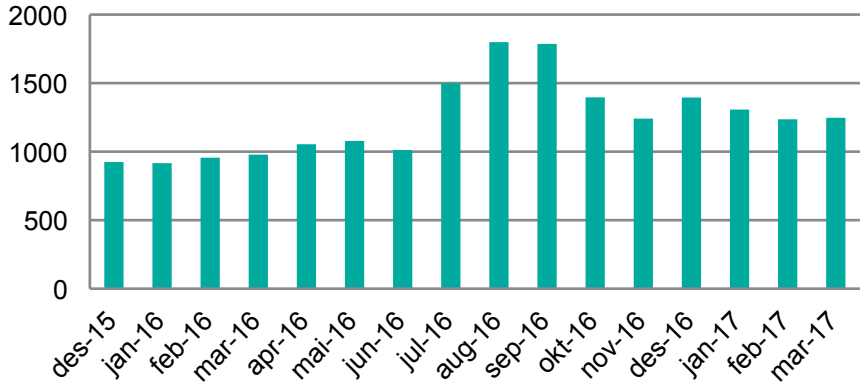
- 3 x category 3 ESHT Community acquired PUs have been confirmed and the remaining two are being reviewed

2. Serious Incidents, Never Events and Patient Safety Incidents

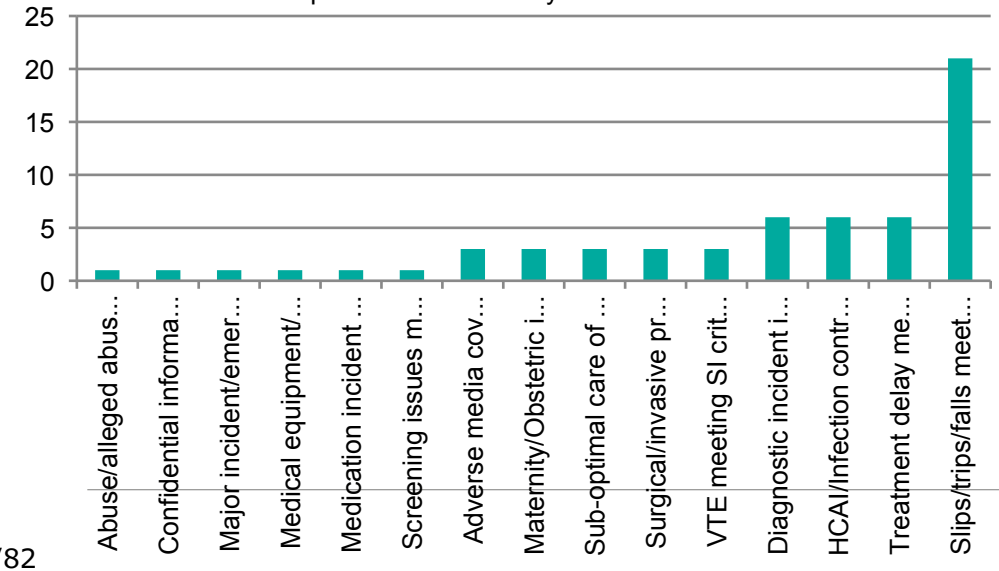
Serious Incidents Reported



Patient Safety Incidents



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

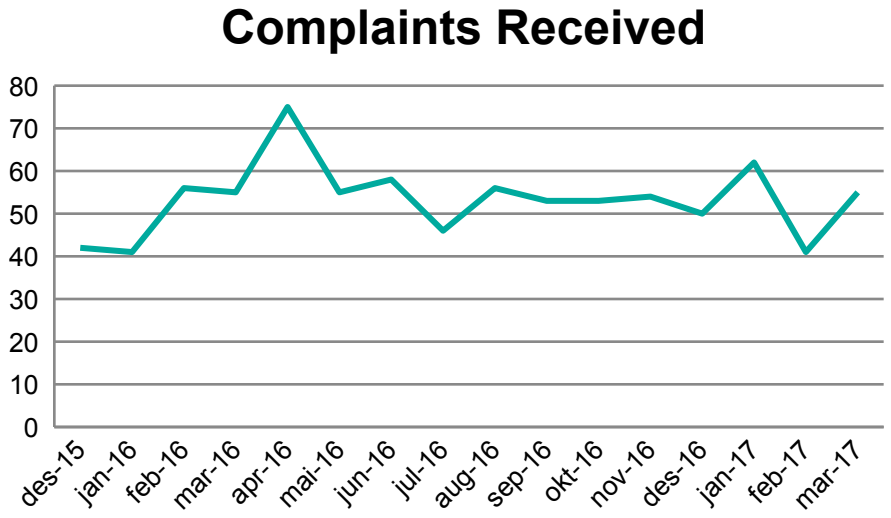


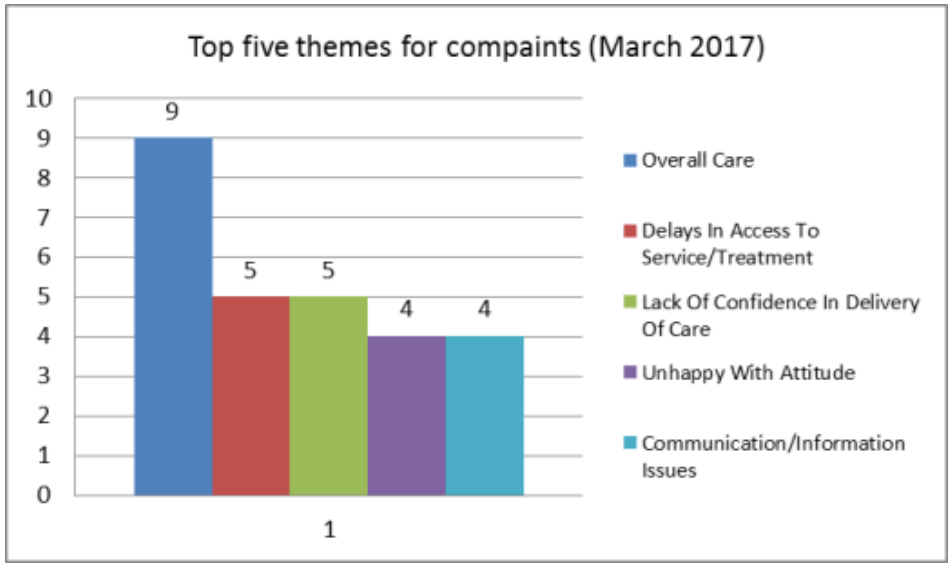
The number of serious incidents reported in March reduced to 5.

Patient Safety incidents showed a marginal decrease in the higher harm categories to 0.2%

East Sussex Healthcare NHS
NHS Trust

3. Complaints

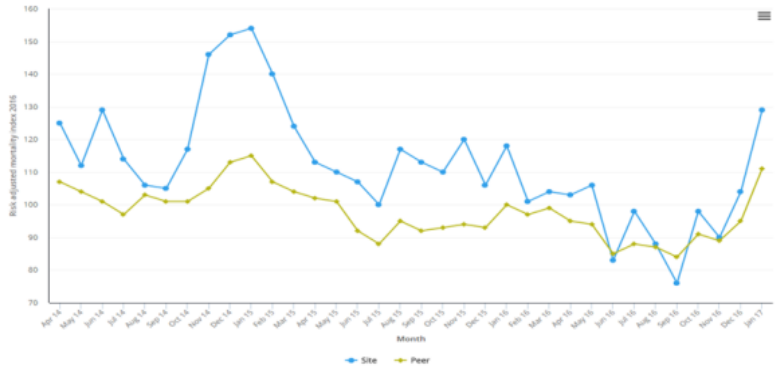




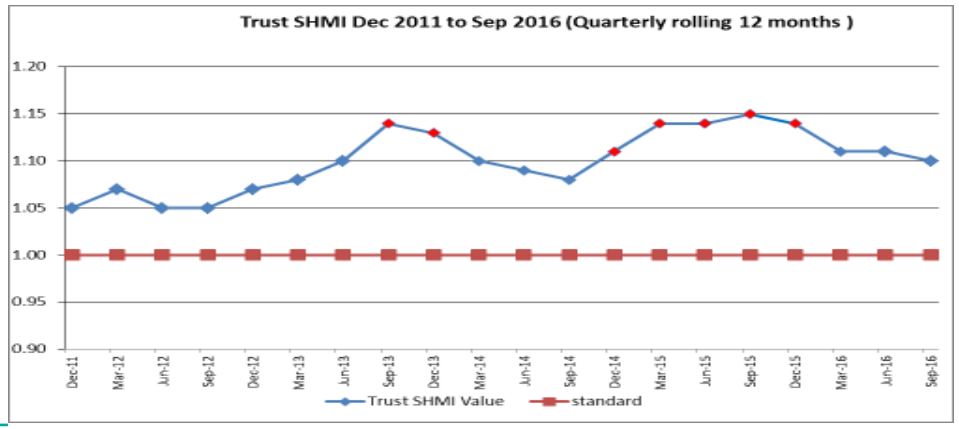
"Overall Care" remains the top theme of complaint. Further analysis of the nine complaints recorded with the primary subject of "overall care" has identified that with the exception of the Emergency Department at Conquest Hospital (three cases – 33.3%), there were no other specific areas reported as being a repeated concern. In terms of the five complaints with the primary subject of "delays in access to service/treatment", two (40%) related to Urology and two (40%) related to the Emergency Department at Eastbourne DGH (the fifth complaint was recorded against Frailty). In terms of the five complaints with the primary subject of "lack of confidence in delivery care", there was no one clinical area identified as being an area of concern

4. Mortality

RAMI 2016



SHMI (Rolling 12 months)



SHMI for the period July 2015 to June 2016 is the latest published and remains at 1.11. The Trust is currently within the EXPECTED range.

SHMI for the period October 2015 to September 2016 has now been published, it is now 1.10 and remains in the **expected** range.

RAMI February 2016 to January 2017 rolling 12 months is 99 compared to 115 for the same period last year (February 2015 to January 2016). January 16 to December 16 was 98

RAMI is showing a January monthly value of **129** compared to HES Acute Peer of **111**. The December position was 104 against peer value of 95

Crude mortality shows February 2016 to January 2017 at 1.89% compared to February 2015 to January 2016 at 1.83%

Deaths reviewed within 3 months	Oct-16	Nov-16	Dec-16
TRUST	61%	82%	65%

SHMI (NHS Digital) Top 10 diagnostic groups with deaths in excess of expected Oct 15 to Sep 2016

Description	SHMI	Spells	Observed deaths	Expected deaths	Excess deaths
Septicaemia (except in labour), Shock.	1.21	571	153	126.14	26.86
Acute cerebrovascular disease.	1.20	673	149	124.59	24.41
Urinary tract infections.	1.19	1521	117	98.67	18.33
Acute & unspecified renal failure.	1.24	406	86	69.28	16.72
Acute myocardial infarction.	1.27	519	59	46.35	12.65
Chronic obstructive pulmonary disease and bronchiectasis.	1.26	816	60	47.79	12.21
Liver disease, alcohol related.	1.59	120	28	17.59	10.41
Deficiency and other anemia, Acute posthemorrhagic anemia.	1.52	493	28	18.44	9.56
Congestive heart failure; nonhypertensive.	1.09	709	116	106.56	9.44
Biliary tract disease.	1.44	785	30	20.86	9.14

5. 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	88.1%	109.2%	100.0%	131.5%
CONQUEST HOSPITAL	90.5%	112.3%	93.4%	109.9%
EASTBOURNE DISTRICT GENERAL HOSPITAL	92.8%	119.3%	92.9%	116.3%

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

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

Information about staffing levels is published monthly.

Access & Delivery

ACCESS AND DELIVERY

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

East Sussex Healthcare NHS
NHS Trust

Indicators

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	Yr	Last Yr	Var	
A&E Performance (4 hour wait)	95.0%	83.9%	85.0%	83.2%	82.6%	79.5%	80.5%	78.1%	82.4%	77.6%	73.4%	76.1%	80.7%	79.0%	1.7%	80.3%	88.1%	-7.8%	
A&E 12 Hour trolley waits	0	0	0	0	0	1	0	2	0	0	0	0	0	0	0	3	1	2	
A&E Unplanned re-attendance	5.0%	3.3%	3.3%	2.8%	3.0%	2.9%	3.0%	3.1%	3.0%	3.0%	3.2%	2.7%	3.1%	3.0%	0.2%	3.0%	3.1%	-0.1%	
A&E Time to Initial Assessment (% Ambulance conveyan	M	94.3%	93.1%	90.7%	91.8%	90.1%	90.6%	89.6%	92.1%	90.1%	89.9%	81.7%	79.7%	88.5%	-8.9%	89.5%	94.5%	-5.0%	
A&E Time to Treatment (% within 60 Minutes)	M	47.0%	40.1%	36.6%	36.8%	36.7%	38.8%	39.5%	43.5%	41.6%	45.4%	48.5%	43.0%	42.0%	1.0%	41.3%	49.6%	-8.3%	
A&E Left before seen	M	2.1%	2.2%	1.3%	1.4%	1.4%	1.2%	1.2%	1.5%	1.8%	1.8%	1.0%	1.3%	2.7%	-1.4%	1.5%	1.9%	-0.4%	
Non Elective Conversion Rate	M	26.5%	24.6%	25.1%	23.5%	23.4%	23.1%	24.8%	26.6%	28.2%	27.6%	27.8%	27.5%	24.8%	2.7%	25.6%	25.9%	-0.3%	
A&E Cubicle Waiters (average number per day)	M	48	51	50	51	52	53	46	47	53	56	56	50	52	-3	56	56	0	
Number of zero LOS NEL Ambulatory admissions	R	656	610	595	562	521	404	519	502	555	459	451	584	556	5.0%	6418	8055	-25.5%	
% Zero LOS NEL Ambulatory admissions	M	43.4%	40.5%	39.6%	38.4%	36.9%	31.5%	37.6%	35.3%	37.6%	35.6%	35.8%	38.5%	38.0%	1.5%	37.7%	42.7%	-5.0%	
Total Non Elective Beddays	M	23704	22725	21687	21989	23046	22718	22948	22622	23366	24885	22397	23192	25760	-10.0%	275279	273846	0.5%	
RTT Incomplete (%achievement)	92.0%	90.2%	90.7%	89.5%	88.5%	87.5%	86.7%	85.7%	85.6%	85.6%	88.9%	89.3%	90.8%	90.5%	0.3%	88.2%	93.0%	-4.8%	
RTT Backlog (number of patients waiting over 18 weeks)	M	2936	2931	3399	3791	4239	4534	4809	4714	4425	3243	3131	2680	2823	-5.1%	334530	303304	9.3%	
RTT 52 Week waiters	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	1	
RTT 35 week waiters	0	112	140	172	185	180	245	320	275	348	302	326	302	84	218	2907	281	2626	
Diagnostic performance (% patients waiting over 6 weeks	1.0%	2.9%	2.7%	2.6%	2.2%	3.0%	2.5%	0.9%	1.6%	0.8%	0.9%	1.2%	1.4%	6.7%	-5.3%	98.1%	97.6%	0.5%	

East Sussex Healthcare NHS
NHS Trust

Indicators

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	Yr	Last Yr	Var	
Cancer 2WW standard	93.0%	96.0%	95.6%	96.5%	97.1%	97.3%	97.1%	97.2%	98.7%	98.0%	97.1%	98.4%		96.9%		97.2%	91.7%	5.5%	
Cancer 2WW standard (Breast Symptoms)	93.0%	93.2%	98.5%	96.9%	95.8%	95.8%	96.9%	97.2%	98.2%	97.3%	95.5%	98.8%		90.0%		96.8%	89.6%	7.2%	
Cancer 31 Day standard	96.0%	98.5%	99.4%	98.3%	97.7%	99.1%	98.8%	98.7%	99.5%	98.3%	99.5%	98.8%		99.3%		98.8%	97.6%	1.2%	
Cancer 31 Day subsequent drug treatment	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100.0%	100.0%	0.0%	
Cancer 31 Day subsequent surgery	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	100.0%	100.0%	100.0%	100.0%	94.1%		100.0%		98.6%	100.0%	-1.4%	
Cancer 62 day urgent referral standard	85.0%	67.6%	68.3%	82.3%	75.3%	79.5%	72.6%	82.5%	78.3%	84.1%	78.6%	69.9%		79.4%		76.5%	75.1%	1.3%	
Cancer 62 day screening standard	90.0%	100.0%	66.7%	62.5%	100.0%	88.9%	85.7%	91.7%	100.0%	100.0%	92.6%	66.7%		42.9%		88.0%	78.5%	9.5%	
Urgent operations cancelled for a 2nd time	0	0	0	0	0	0	0	0	1	0	0	0	0	1	-1	1	6	-5	
Proportion of patients not re-booked within 28 days of las	0.0%	0.0%	0.0%	0.0%	2.4%	0.0%	3.8%	3.8%	0.0%	0.0%	0.0%	2.7%		9.4%		1.4%	3.7%	-2.3%	
Delayed Transfer of Care	3.5%	5.3%	5.7%	7.0%	7.7%	8.0%	9.7%	9.7%	7.6%	7.1%	7.6%	7.6%	7.6%	9.4%	-1.8%	7.5%	7.6%	0.0%	
Outpatient appointment cancellations < 6 weeks	R	14	29	47	34	37	30	41	44	64	27	44	46	18	155.6%	457	371	18.8%	
Outpatient appointment cancellations > 6 weeks	R	1121	1033	1289	1438	1530	1302	1271	1250	1251	1184	1130	1385	1551	-10.7%	15184	14777	2.7%	

East Sussex Healthcare NHS
NHS Trust

Access and Delivery overview

- The trust remains challenged against the key constitutional targets and trajectories
- A&E performance was 80.7% against the 95% standard. This is a further increase from February
- RTT incompletes was 90.8% against the 92% standard. This represents a further improvement.
- Diagnostics failed the standard – 1.4% against the 1% target
- Cancer 62 Days achieved 69.9% against the 85% standard (for February), one month in arrears)
- No urgent operations were cancelled for a second time.
- There were no patients waiting more than 52 weeks
- A&E attendances increased to the highest level since September 2016. The year to date figure remains 3.3% up on the same period last year.

2. ELECTIVE CARE

East Sussex Healthcare NHS
NHS Trust

Outpatients

			05.03.17	12.03.17	19.03.17	26.03.17
Registration of referrals (referral received & logged on Oasis)						
0-2 days	Percentage	80%	88%	90%	88%	89%
3-13 days	Percentage	18%	10%	9%	11%	9%
14 days +	Percentage	2%	2%	1%	1%	2%
Total number of referrals received	Total number		2065	2230	2231	2238
ERS (Referrals Received & Waiting for triage)						
Number of ERS Referrals Received (Current Month - March 2017)	Total number					986
Number of e-referrals waiting for Triage (Current Month - March 2017)	Total number	225				328
Number of e-referrals still waiting for triage from previous months (Jan/Feb 2017)	Total number	0				21
Cashing up (incomplete)						
Current Month - March 2017 (Deadlines: RTT Submission 15/4/17 & Trust 17 /5/17)	Total number	1750	1862	2350	3157	3524
February 2017 (Deadlines: RTT Submission 16/03/17 & Trust 20/4/17)	Total number	175	1093	190	0	0
January 2017 (Deadlines: RTT Submission 16/2/17 & Trust 16/3/17)	Total number		1	0	0	0
YTD outcome forms not submitted within required deadline			190	190	189	188
Clinical letters						
Total number of letters submitted to BigHand	Total number		7511	8225	7341	7585
Total number of letters completed and sent in less than 7 days	Total number		4346	4683	4789	4396
Percentage of letters completed within 7 days	Percentage	80%	58%	57%	65%	58%
DNAs						
New appointments	Total number	-	193	193	168	214
Follow up appointments	Total number	-	499	427	411	448
New appointments %	Median Target	7.91%	7.82%	8.46%	7.80%	8.79%
Follow Up appointments %	Median Target	7.91%	8.59%	8.05%	7.64%	7.70%
Health Records						
Number of temporary file notes created			180	145	190	197
Total Number of outpatient appointments			9879	9543	9744	10247
Percentage of temporary notes created based on number of outpatient appointments		1.00%	1.82%	1.52%	1.95%	1.92%
Cancer - 2ww booking by tumour site						
Brain	Percentage of referrals booked within 7 days		50%	100%	67%	100%
Breast			55%	29%	50%	68%
Colorectal			51%	40%	5%	15%
Gynaecology			34%	39%	35%	39%
Head & Neck			18%	4%	4%	52%
Lung			12%	8%	9%	53%
Max Fax			10%	36%	50%	100%
Other			67%	33%	75%	50%
Paediatrics			100%	N/A	100%	100%
Skin			39%	22%	8%	33%
Upper GI			40%	54%	13%	10%
Urology			61%	40%	49%	57%
Total Number of 2ww Referrals Received (processed within timescales - see below for details)	Total Number		433	411	399	402
Number of 2ww referrals booked within 7 days			182	129	95	165
Number of 2ww referrals booked within 8 - 14 days			250	282	304	235
Number of 2ww referrals booked outside 14 days			1	0	0	2
Theatre Cancellations due to Notes not being Present						
Number of patients who had their TCI cancelled	Total number	0	0	0	0	1

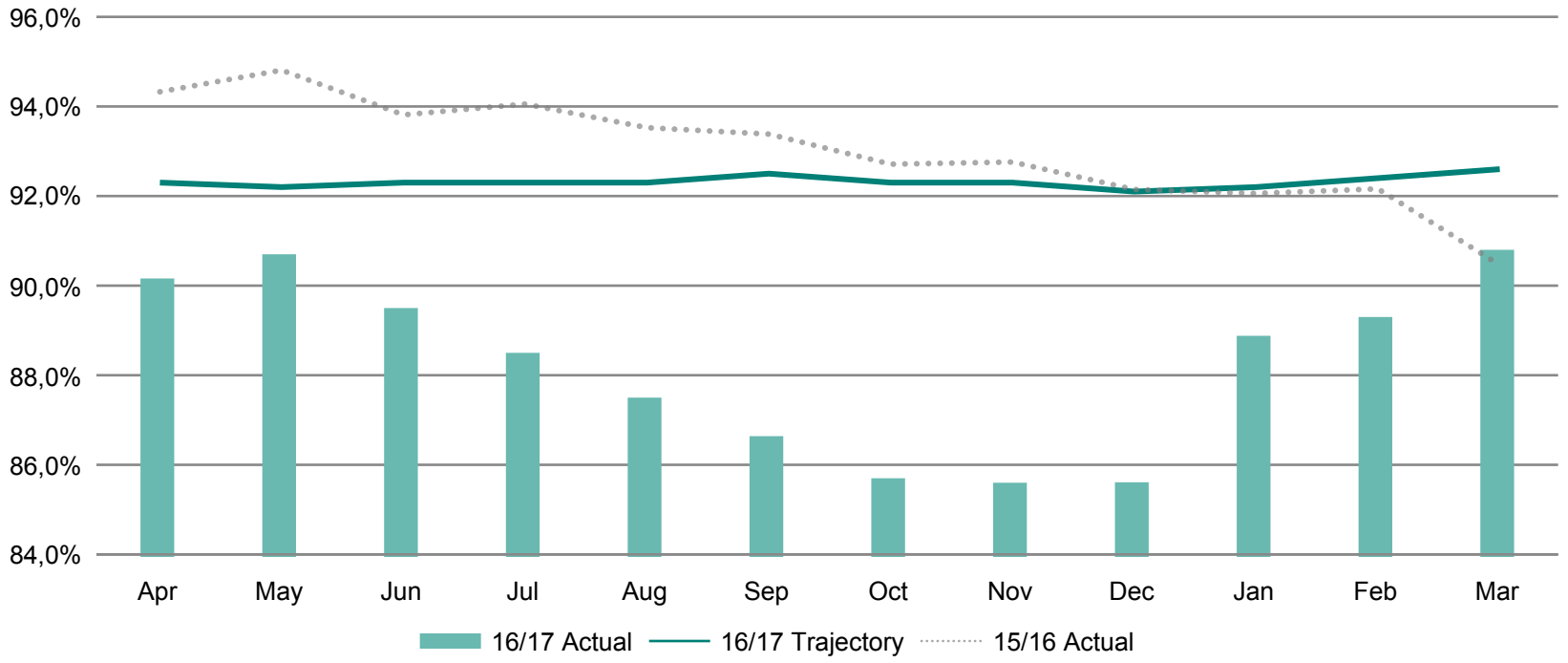
Complaints						
Total number received re clinical administration via PALS contacts	Total number	0	30	18	5	7
Total number formal written complaints re clinical administration being the Lead Investigator (data supplied by PALS/Complaints team)	Total number	0	0	0	0	0
Datix incidents raised relating to Patient Experience during OPA (reported per week)	Total number		0	0	0	0
Number of PALs contacts relating to Patient Experience during OPA	Total number		0	0	0	0
Number of formal complaints relating to Patient Experience during OPA	Total number		0	0	0	0
Outpatient Clinic Cancellations / Changes						
Total clinic cancellations received	Total number	-	170	248	155	195
Clinic cancellations requests received less than 6 weeks notice	Total number		80	102	58	68
Percentage of cancellations less than 6 weeks notice	Percentage	25%	47%	41%	37%	35%
Clinic cancellations received less than 4 weeks notice to patients	Total Number		56	73	41	49
Percentage of cancellations less than 4 weeks notice to patients	Percentage	10%	33%	29%	26%	25%
Number of Days in advance, clinics are being cancelled	Total number	42	42+	42+	42+	42+
Outpatient Appointments Cancelled by Hospital						
Number of New Appointments Cancelled	Total number		519	442	375	337
Number of Follow-Up Appointments Cancelled	Total number		2084	2275	1777	1673
Number of New and Follow Up Appointments Cancelled as overall % of average outpatients bookings	Percentage		26%	28%	22%	20%
Outpatient Appointments Cancelled by Patient						
Number of New Appointments Cancelled	Total number		499	453	388	421
Number of Follow-Up Appointments Cancelled	Total number		1079	1065	1051	1098
Outpatient Clinic Utilisation						
Cardiovascular			N/A	N/A	N/A	N/A
Medicine			63.1%	60.3%	58.1%	64.2%
Surgery			68.9%	66.7%	69.4%	67.1%
Women and Children (excludes Paed Epilepsy and Paed Surgery)			65.4%	62.7%	60.7%	58.3%
Inpatient Theatre Utilisation						
Theatre Utilisation		85.00%	87.73%	85.29%	86.89%	87.71%
Theatre hours available			578.5	461.25	556.25	584.5
Theatre hours utilised			507.5	393.4	483.35	512.65
Unused theatre sessions (figure quoted in hours)			140	191	119.5	150
OP Booking (Conquest) - Telephone Call Handling						
Number of calls presented			2291	2542	2820	2422
Number of calls incorrectly presented to OP booking office			42	94	68	92
Number of calls answered			1936	2257	2225	2153
Number of calls not answered after automated welcome message			355	285	595	269
Average waiting time (minutes)			04:26	03:30	03:12	03:28

Outpatients

Weekly Exception Reporting:
Registering of Referrals: KPI continues to be achieved.
ERS: This is the first week of measuring ERS KPI's will be adjusted to get the most accurate results.
Cashing up: February cashing up achieved and the team are continuing to work on March outcome forms. The introduction of new outcome forms went live on Monday 27/02/2017 which should assist this process.
Clinical Letters: Reduction 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.
DNA Performance: KPIs for follow-up's have achieved the target last week. New appointments just missed the KPI (Cardio, Gastro and Diab being the outliers).
Health Records: Overall percentage of temp sets created was 1.92% last week. Monitored daily and detailed analysis being undertaken to establish reason for temporary wallets being created.
Cancer 2ww booking performance: 41% of referrals received were booked within seven days an increase on previous weeks . With two booked over 14 days due to capacity.
Theatre Cancellations due to Notes not being Present: One cancellation due to the health record not being available.
Complaints: No formal complaints and seven 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: A slight reduction in percentage of short notice clinic cancellations last week on both categories (less than six weeks and four weeks).
OP Booking (Conquest) Telephone Call Handling: Waiting time similar to the previous week for patients calling in.

RTT

March performance was 90.8% against the trajectory of 92.6%. This represents a further increase in performance from February. The improvements are predominantly in the non-admitted waiting list and are as a result of focussed validation and waiting list initiatives..



All Incomplete Pathways Main Specialty Report

[Back]

Specialty	Breaches	NonBreaches	Total Cases	Performance	
General Surgery	545	3695	4240	87.15%	✗
Urology	153	1828	1981	92.28%	✓
Trauma & Orthopaedics	342	2064	2406	85.79%	✗
Ear, Nose & Throat (ENT)	565	3386	3951	85.70%	✗
Ophthalmology	319	3195	3514	90.92%	✗
Oral Surgery	54	1622	1676	96.78%	✓
General Medicine	2	104	106	98.11%	✓
Gastroenterology	47	1778	1825	97.42%	✓
Cardiology	51	1817	1868	97.27%	✓
Dermatology	1	678	679	99.85%	✓
Thoracic Medicine	6	613	619	99.03%	✓
Neurology	71	963	1034	93.13%	✓
Rheumatology	8	319	327	97.55%	✓
Geriatric Medicine	5	302	307	98.37%	✓
Gynaecology	353	1717	2070	82.95%	✗
Other	158	2263	2421	93.47%	✓
Totals	**2680**	**26344**	**29024**		

Non-Admitted Incomplete Main Specialty Report

[Back]

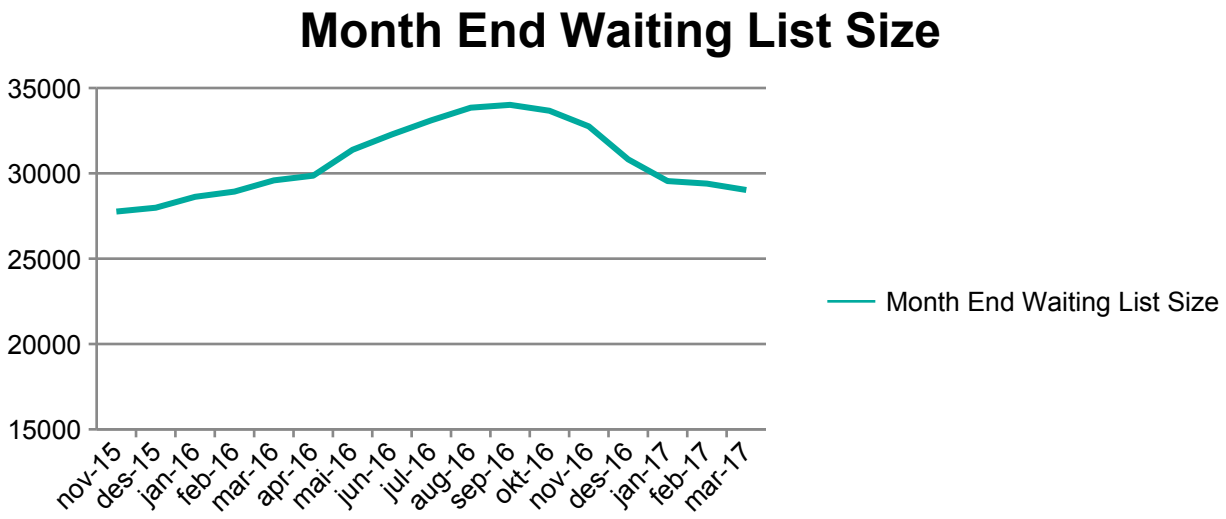
Specialty	Breaches	NonBreaches	Total Cases	Performance	
General Surgery	353	3291	3644	90.31%	✗
Urology	57	1448	1505	96.21%	✓
Trauma & Orthopaedics	81	1534	1615	94.98%	✓
Ear, Nose & Throat (ENT)	206	3064	3270	93.70%	✓
Ophthalmology	63	2182	2245	97.19%	✓
Oral Surgery	21	1207	1228	98.29%	✓
General Medicine	2	104	106	98.11%	✓
Gastroenterology	46	1765	1811	97.46%	✓
Cardiology	47	1728	1775	97.35%	✓
Dermatology	0	618	618	100.00%	✓
Thoracic Medicine	6	608	614	99.02%	✓
Neurology	71	963	1034	93.13%	✓
Rheumatology	8	319	327	97.55%	✓
Geriatric Medicine	5	302	307	98.37%	✓
Gynaecology	39	1351	1390	97.19%	✓
Other	158	2263	2421	93.47%	✓
Totals	**1163**	**22747**	**23910**		

Admitted Incomplete Main Specialty Report

[Back]

Specialty	Breaches	NonBreaches	Total Cases	Performance	
General Surgery	192	404	596	67.79%	✗
Urology	96	380	476	79.83%	✗
Trauma & Orthopaedics	261	530	791	67.00%	✗
Ear, Nose & Throat (ENT)	359	322	681	47.28%	✗
Ophthalmology	256	1013	1269	79.83%	✗
Oral Surgery	33	415	448	92.63%	✓
Gastroenterology	1	13	14	92.86%	✓
Cardiology	4	89	93	95.70%	✓
Dermatology	1	60	61	98.36%	✓
Thoracic Medicine	0	5	5	100.00%	✓
Gynaecology	314	366	680	53.82%	✗
Totals	**1517**	**3597**	**5114**		

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



RTT

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

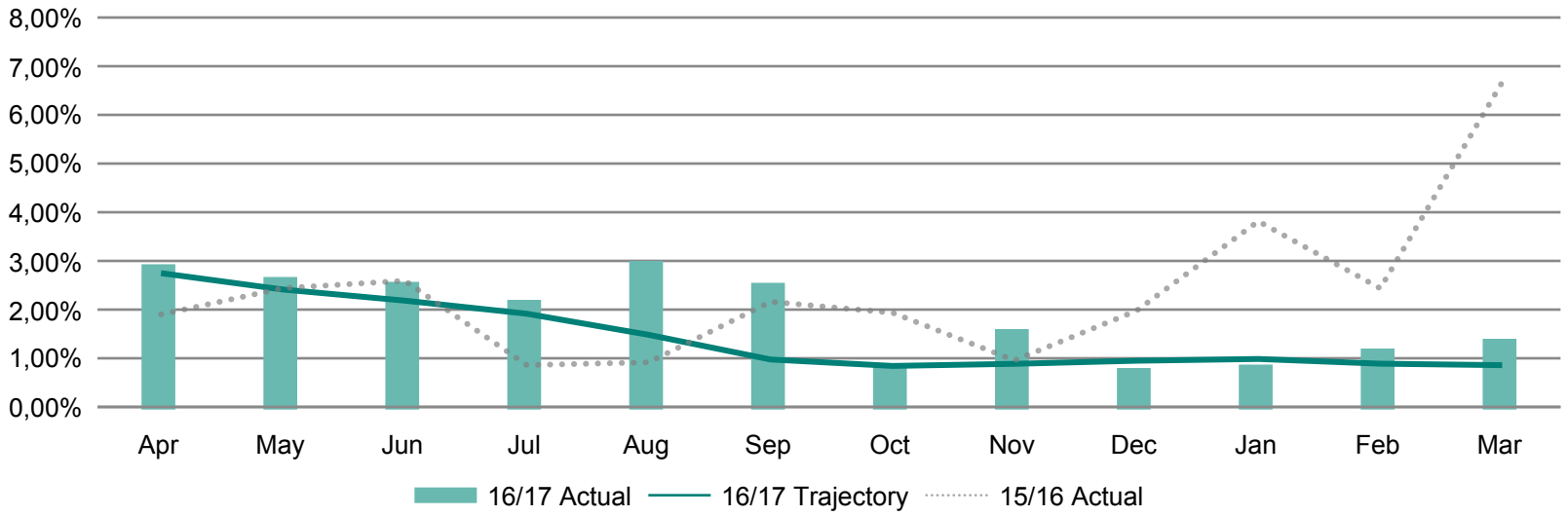
Trust is exceeded the projected partial recovery of 88% by March '17 and is on track for full recovery to 92% by December '17. Recovery plans for full recovery still in development.

The Trust has been working with NHSI and external support to review the waiting list. This has helped highlight further areas for improvement including training and process development.

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

East Sussex Healthcare NHS Trust

Diagnostics



Diagnostics failed to meet the 1% standard with a performance of 1.4% in March.

The breaches were:
65 Radiology
14 Endoscopy

3. EMERGENCY CARE

Sitrep YTD March 2016/17

Conquest Hospital, Hastings

		Admissions								Cancelled Surgery		
A&E Attend (Type 1)	Emergency	Emergency Thru A&E	Ordinary	Day Cases	Over 4 Hrs in A&E	% less than 4 Hrs	4-12 Hrs Trolley Waits	>12 Hrs Trolley Waits	Medical Outliers (avg per day)	Elective	Urgent Elective	2nd Urgent Elective
4,718	2,423	1,506	343	1,793	920	80.5%	373	0	145	1	0	0

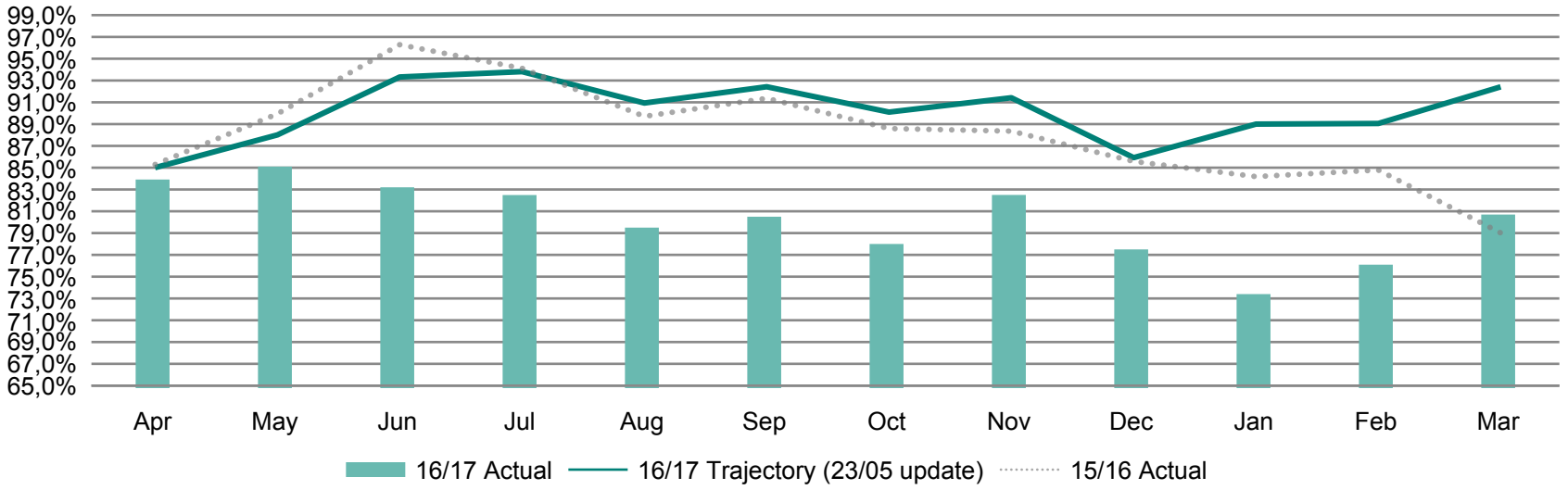
Eastbourne District General Hospital

		Admissions								Cancelled Surgery		
A&E Attend (type 1)	Emergency	Emergency Thru A&E	Ordinary	Day Cases	Over 4 Hrs in A&E	% less than 4 Hrs	4-12 Hrs Trolley Waits	>12 Hrs Trolley Waits	Medical Outliers (avg per day)	Elective	Urgent Elective	2nd Urgent Elective
4,724	1,554	1,117	362	2,461	902	80.9%	334	0	147	3	0	0

East Sussex Healthcare Trust

		Admissions								Cancelled Surgery		
A&E Attend (Type 1, 2 and 3)	Emergency	Emergency Thru A&E	Ordinary	Day Cases	Over 4 Hrs in A&E	% less than 4 Hrs	4-12 Hrs Trolley Waits	>12 Hrs Trolley Waits	Medical Outliers (avg per day)	Elective	Urgent Elective	2nd Urgent Elective
9,442	3,977	2,623	705	4,254	1,822	80.7%	707	0	292	4	0	0

A&E Trajectory



A&E performance deteriorated further in January with a Trust wide figure of 80.7%

Attendances were remain on the increase across both sites by 3.3% on the year to date

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

East Sussex Healthcare NHS
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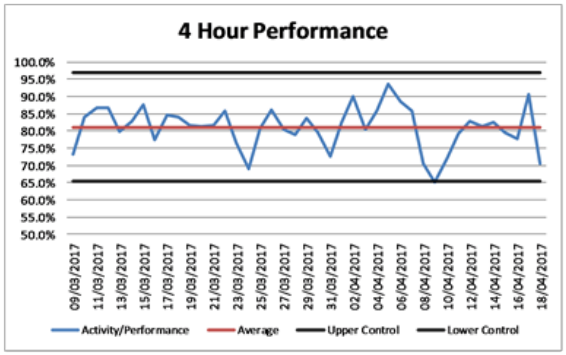
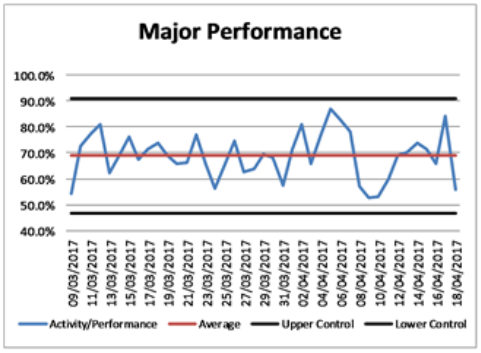
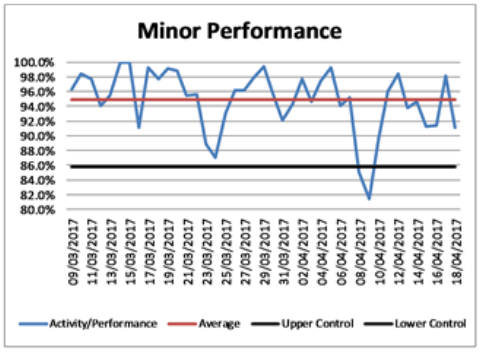
East Sussex Healthcare Trust; Urgent & Emergency Care Improvement Programme

Headline Summary; Data Refreshed on 21-04-2017



This week so far	81.6%
6 Week	81.0%
Month so far	81.0%
Quarter so far	81.0%
Year so far	81.0%



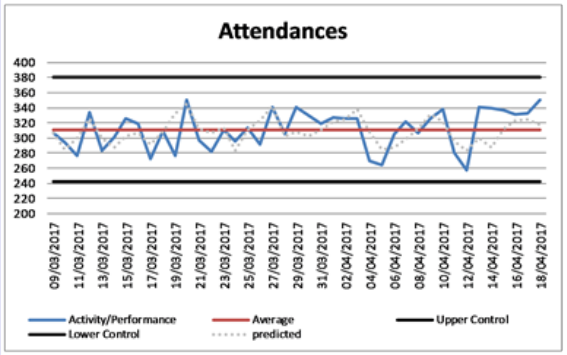


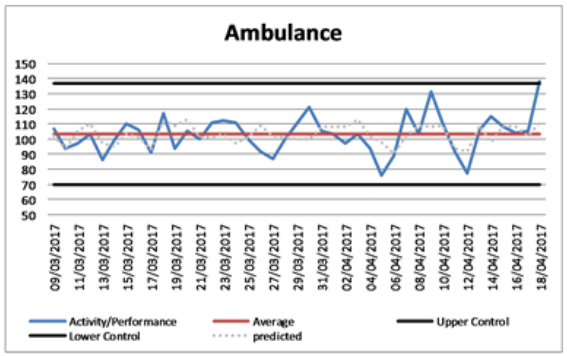
Performance Summary

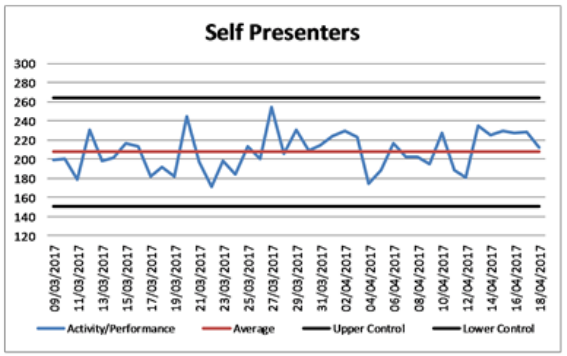
4 hour performance has improved in recent weeks, as patient flow has improved and ED staff are able to focus on managing 4 hours within their departments. Jan performance was 73%, February 76% and March 80.7% There is minimal difference in performance between sites.

The new minors streaming process was implememted mid March, with the aim of improving data quality, ensure a more robust streaming process with the aim of increasing throughput via the ENP service. Whilst performance varies, and this should be a sustainable services in excess of 95% daily, performance has improved to 96% in March. IT has alos highlight the fagility of the ENP service as if the single ENP is not available, then this puts further pressures on the ED Drs. The TRust is working with the CCG to establish a GP stream and further develop the ENPs which will increase the acuity of patients thorugh the minors stream and reduce pressure is the majors area ad ED Drs.

The ED team need to focus on ensuring 95% min daily performance through the ENP service (data quality and new process to be reviewed).





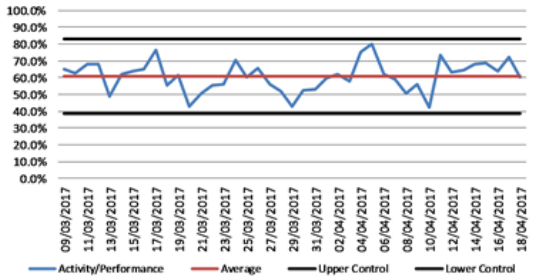


East Sussex Healthcare NHS
NHS Trust

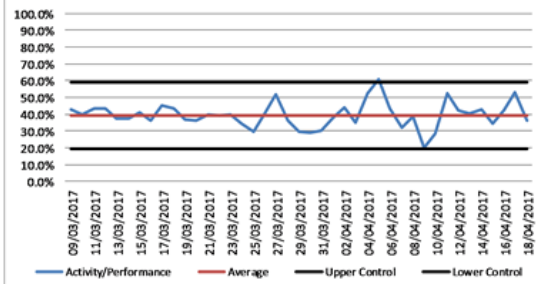
East Sussex Healthcare Trust; Urgent & Emergency Care Improvement Programme

Emergency Department Performance Detail

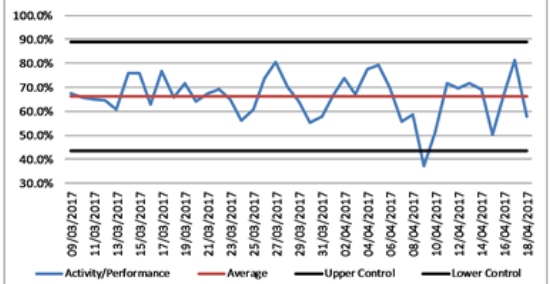
Time to Assessment<15 Minutes



Time to Treatment< 60 Minutes



Time to Treatment< 120 Minutes



Issues

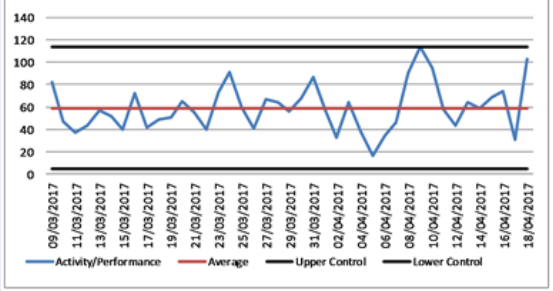
Flow through ED and subsequant breaches impacted by new Jr Drs, and lack of ENP on 10 April.

Conversion rate has reduced in its variation and would suggest a system under control and within normal limits of 25%, but could be further reduced.

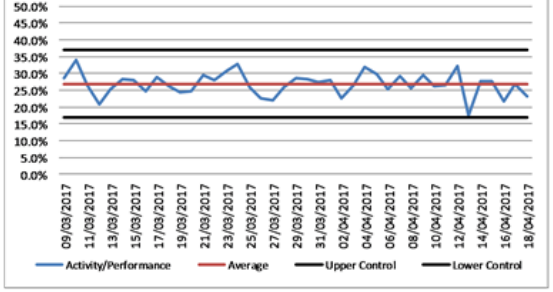
Actions

Specific focus by ED on overnight breaches and staff availability with review of overnight wait times and breaches
Aim to reduce conversion of attendance to admission, with specific focus on HIT at front door and faster turnaround back to care homes
Understand what specifics impact the variation in breaches on daily basis. Hospital Directors to start daily recording of previous 24 hour exceptions to poulate this report and identify specific areas to focus.

4 Hour Breaches



Conversion Rate



A&E improvement progress

Completed

A&E

- GP streaming
  - protocols developed, pilot in place over Easter Period
  - Extended pilot at DGH with GPs recruited to
  - Capital bid submitted for Eastbourne and Hasting
- Implemented new minors streaming process
- Mapped nursing rotas against activity, requires additional staff
- Initial workforce review in ED started
- 12 ED streaming pathways reviewed and implemented
- New consultant appointed

Medical Model

- Medical Model, clarity on project plans (extension of assessment and ambulatory capacity from May)
- New Acute Physician Consultant appointed

Discharge

- Red to Green Pilot extended
  - 2 model wards
  - Ward based education sessions
  - Ward buddies allocated and trained
- 2 x MAD events to identify key issues and set baseline
- Introduced daily CHC review process, to reduce delays
- Enhanced stranded patient review meetings

Other

- New Hospital Director started
- Trust Board Seminar, focus on Urgent Care Delivery

Planned

A&E and site Management

- Increased focus on ED measures and process improvements
- Improve minors performance to min 95% daily
- Hospital Directors to implement diary sheet, to improve narrative
- Introduce GP streaming at Eastbourne
- Complete full capacity protocol
- Complete review and implementation of streaming to SAU and ENT
- Review and sign off revised trust wide escalation plan

Medical Model

- Close Seaford 2 to accommodate shift from general escalation ward to ambulatory/assessment unit
- Shift Folkington (MFFD ward) to acute ward
- Full plan for phase 1 Medical Model to be signed off

Discharge Improvement

- Red to Green roll out to all Medical wards and Community wards
- Integrated tracking process for all referrals to ASC, joint tracking process
- Develop proposal for structure of the Integrated Discharge Team
- Develop proposal for move to trusted assessor model

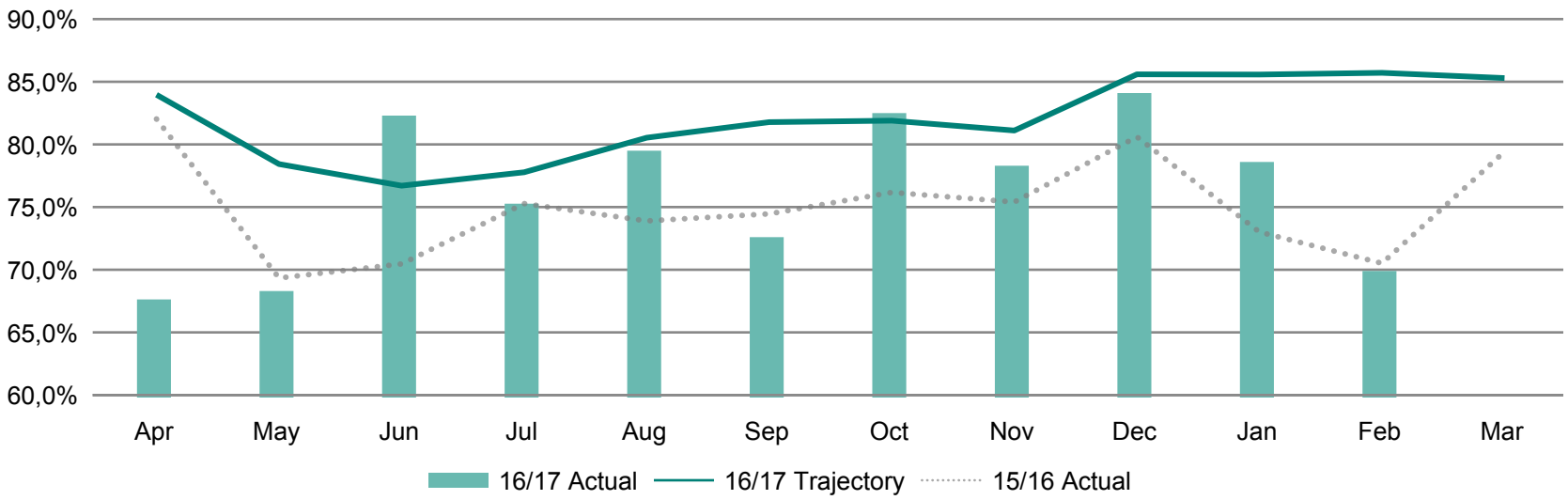
A&E improvement progress

Key Issues

- IR35, impacting on Dr availability and short notice cancellations
- New (and inexperienced) Jr Drs in ED, impacting on slow decision making and extended wait times in ED
- ENP service, significant impact if ENP not available, with no dedicated minors stream in place
- Medical staffing levels within ED and at ward level
- Onward care capacity to support patient flow
- Overnight wait times and timely decision making

4. CANCER

CANCER



Achieved: 2 week wait

Achieved: 31 Day Standard

Did not achieve trajectory (85.6%) or the Standard (85%) for 62 Days with a performance of 69.9%

East Sussex Healthcare NHS
NHS Trust

62 Days by tumour site

February 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	
Brain/CNS	0.5	0.0	0.5	0.5	0.0	0.5	0.0	0.0	0.0	100 %		100 %	85 %
Breast Cancer	9.5	9.0	18.5	9.5	7.0	16.5	0.0	2.0	2.0	100 %	77.8 %	89.2 %	85 %
Colorectal	8.0	2.5	10.5	1.0	1.5	2.5	7.0	1.0	8.0	12.5 %	60.0 %	23.8 %	85 %
Gynaecology	3.0	3.5	6.5	1.5	1.5	3.0	1.5	2.0	3.5	50.0 %	42.9 %	46.2 %	85 %
Haematology	1.0	0.0	1.0	1.0	0.0	1.0	0.0	0.0	0.0	100 %		100 %	85 %
Head & Neck	4.0	3.5	7.5	2.5	2.0	4.5	1.5	1.5	3.0	62.5 %	57.1 %	60.0 %	85 %
Lung	2.0	3.5	5.5	1.0	2.0	3.0	1.0	1.5	2.5	50.0 %	57.1 %	54.5 %	85 %
Other	0.0	1.0	1.0	0.0	0.0	0.0	0.0	1.0	1.0		0.0 %	0.0 %	85 %
Sarcoma	0.0	1.5	1.5	0.0	0.0	0.0	0.0	1.5	1.5		0.0 %	0.0 %	85 %
Skin	5.5	20.5	26.0	5.5	19.5	25.0	0.0	1.0	1.0	100 %	95.1 %	96.2 %	85 %
Upper GI	1.5	1.0	2.5	1.5	1.0	2.5	0.0	0.0	0.0	100 %	100 %	100 %	85 %
Urology	3.0	25.5	28.5	2.0	16.0	18.0	1.0	9.5	10.5	66.7 %	62.7 %	63.2 %	85 %
Total	38.0	71.5	109.5	26.0	50.5	76.5	12.0	21.0	33.0	68.4 %	70.6 %	69.9 %	85 %

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.
- 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

- Joint PTL with Guys & St Thomas's is being set up to run weekly in order to replicate the scrutiny on 38 day transfers currently in place with MTW and BSUH.
- 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 April and May 2017.
- Following funding agreement from NHSE, Fusion biopsy software for prostate patients has been purchased.
- Prostate pathway re-review meeting to be arranged in May 17 to review the outcomes of actions from the previous deep dives and a review of pathway data (3 months' worth) for comparison.
- Local EBUS service to commence from 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.

2 week wait referrals

East Sussex Healthcare NHS Trust Somerset Cancer Register (SCR) Urgent Suspected Cancer Referrals (ZWW) by Date of Decision to Refer				
Suspected Cancer Type	Financial Year		Grand Total	
	15/16	16/17	(N)	(%)
Suspected skin cancers	2,882	3,637	6,519	26.20
Suspected lower gastrointestinal cancers	2,599	2,902	5,501	11.66
Suspected breast cancer	2,397	2,162	4,559	-9.80
Suspected urological cancers (excluding testicular)	2,086	2,229	4,315	6.86
Suspected upper gastrointestinal cancers	1,858	2,236	4,094	20.34
Suspected head & neck cancers	1,773	2,269	4,042	27.98
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	1,580	1,779	3,359	12.59
Suspected gynaecological cancers	1,365	1,451	2,816	6.30
Suspected lung cancer	693	775	1,468	11.83
Suspected testicular cancers	88	169	257	92.05
Suspected haematological malignancies (excluding acute leukaemia)	111	100	211	-9.91
Suspected brain/central nervous system tumours	73	102	175	39.73
Suspected childrens cancer	57	31	88	-45.61
Other suspected cancers	30	46	76	53.33
Suspected sarcomas	49	14	63	-71.43
Grand Total	**17,641**	**19,902**	**37,543**	**12.82**

Finance

FINANCE

Financial Summary – March 2017

Key Issue	Summary	Outturn
Overall RAG Rating	The NHS Improvement (NHSI) finance risk assessment criteria are shown in full on page 7. The Trust's overall RAG rating under the revised NHSI criteria is red in month 12.	R
Financial Recovery Plan	The Trust submitted a Financial Recovery Plan to NHSI in November 2016. This was based on delivery of the previously agreed control total of £31.3m. This plan requires the delivery of £16m additional financial improvements, the actual value delivered was £12.5m.	R
Financial Summary	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.	R
Income	Total income received during March was £3.8m above planned levels in spite of a £0.9m adverse variance for non-achievement of STF funding in the month. The year end variance is £15.4m above plan. The main cause of favourable variances in the month and at year end is activity in excess of planned values.	G
Expenditure	Operating Pay costs are above plan by £1.9m in month and are cumulatively £15.1m above plan at year end. Operating Non Pay costs are £2.6m above plan in month and are £13.4m above plan cumulatively. Total costs are £28.4m overspent at year end.	R
Forecast Outturn	The year ended as per the revised forecast of £43.9m, with an operational deficit of £46.5m (excluding STF), a £1.5m improvement against 2015/16 £48m deficit out turn.	R
Balance Sheet	DH loans have increased by £49.8m in year as a result of the draw down of the revolving working capital facility and exceptional working capital.	A
Cash Flow	The cash position of the Trust remains challenging as a result of the current year deficit and historic cash shortages. This continues to result in increasing creditor values and poor performance against the Better Payment Practice Code. The Trust secured cash to back the increased deficit against the original plan.	R
Capital Programme	The Trust delivered its CRL position at 31 March 2017.	A

Income & Expenditure – March 2017

Headlines

• Total income in the month was £35.6m against a plan of £31.7m, a favourable variance of £3.8m. The outturn position is £15.4m above plan.

• Total costs in the month were £37.1m, this was £4.7m above plan. The outturn position is £28.4m above plan.

• The £43.9m outturn deficit against plan is an adverse variance of £12.6m

• The FRP has delivered £3.5m against the £4.9m target, this is £1.4m behind plan in the month, this is £0.3m adverse against the revised forecast trajectory submitted in month 10.

• Operating pay costs in the month, including ad hoc costs, were £1.9m above plan and are £15.1m above plan at year end.

• Operating Non Pay costs were £2.6m above plan in the month and are £13.4m above plan at year end.

£000s	In Mth Plan	In Mth Actual	Variance	Outturn Plan	Outturn Actual	Variance	Annual Plan
NHS Patient Income	25,347	26,450	1,103	286,487	301,724	15,237	286,487
Sustainability & Transformation Fund	867	0	-867	10,400	2,600	-7,800	10,400
Tariff-Excluded Drugs & Devices	2,608	2,871	263	31,300	32,145	845	31,300
Private Patient/ ICR	243	270	27	2,919	2,625	-294	2,919
Trading Income	473	253	-220	5,677	4,719	-958	3,631
Other Non Clinical Income	2,184	5,708	3,524	27,102	35,494	8,392	29,148
Total Income	**31,722**	**35,552**	**3,830**	**363,885**	**379,307**	**15,422**	**363,885**
Pay Costs	-20,745	-22,611	-1,866	-254,517	-269,640	-15,123	-254,517
Non Pay Costs	-7,435	-9,788	-2,353	-90,076	-102,609	-12,533	-90,076
Tariff-Excluded Drugs & Devices	-2,608	-2,843	-235	-31,300	-32,130	-830	-31,300
Total Operating Costs	**-30,788**	**-35,242**	**-4,454**	**-375,893**	**-404,379**	**-28,486**	**-375,893**
Surplus/- Deficit from Operations	**934**	**310**	**-624**	**-12,008**	**-25,072**	**-13,064**	**-12,008**
P/L on Asset Disposal	0	0	0	0	0	0	0
Depreciation	-1,043	-1,039	4	-12,519	-12,406	113	-12,519
Impairment	0	5	5	0	5	5	0
PDC Dividend	-430	-503	-73	-5,162	-5,076	86	-5,162
Interest	-135	-359	-224	-1,611	-1,744	-133	-1,611
Total Non Operating Costs	**-1,608**	**-1,896**	**-288**	**-19,292**	**-19,221**	**71**	**-19,292**
Total Costs	**-32,396**	**-37,138**	**-4,742**	**-395,185**	**-423,600**	**-28,415**	**-395,185**
Net Surplus/-Deficit	**-674**	**-1,586**	**-912**	**-31,300**	**-44,293**	**-12,993**	**-31,300**
Donated Asset/Impairment Adjustment	0	47	47	0	393	393	0
Adjusted Net Surplus/-Deficit	**-674**	**-1,539**	**-865**	**-31,300**	**-43,900**	**-12,600**	**-31,300**

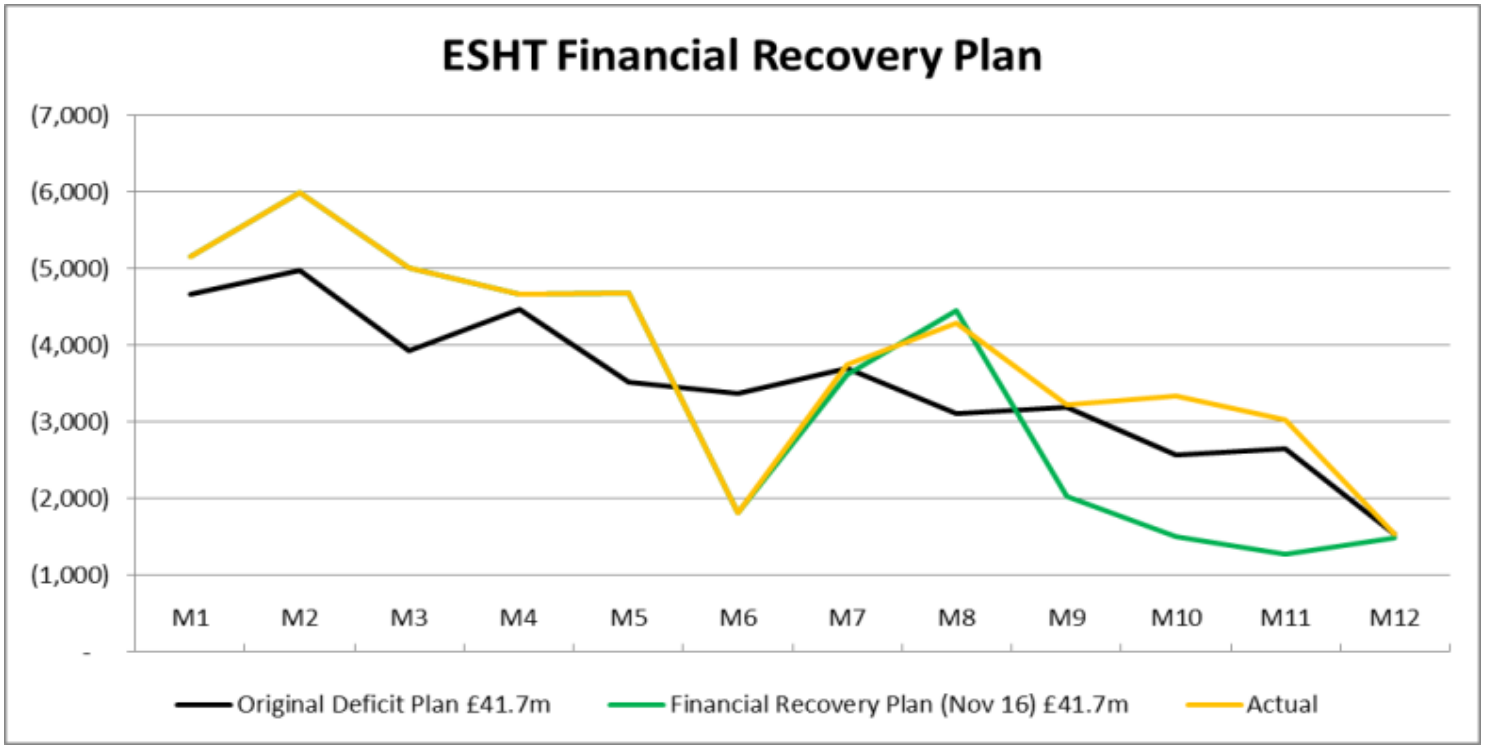
Financial Recovery Plan – March 2017

Headlines

•Month 12 had an operational deficit at £1.5m in the month, this is an £1.5m improvement in run rate compared to last month.

•The revised forecast submitted to NHSi in month 10 planned for £2.2m deficit in the month, March reported £0.7m better than this plan and this ensured the Trust delivered the £46.5m trajectory (excluding £2.6m STF)

•The £3.5m achieved FRP in the month, includes non recurrent adjustments for appropriate capitalisation and VAT reclaim. However there are some schemes that have not delivered as per the plan and these are the cause of the £3.7m undelivered against the FRP.



The revised Financial Recovery Plan target for March was £2.2m, actual performance was £0.7m favourable against this plan, (see page 11 for detail by FRP scheme). Since submitting the November financial recovery plan of £41.7m, the Trust submitted a revised forecast of £46.5m deficit (excluding STF) to take into account risks against FRP schemes and continued operational pressures.

Balance Sheet – March 2017

Headlines

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

• The increased deficit was matched by additional borrowing.

• The reduction in the retained earnings reserve is as a result of the deficit generated in year.

•The annual review of the Trusts non-current assets by the District valuer are reflected in their value and the Revaluation Reserve.

BALANCE SHEET £000s	Actual 31/03/16	Actual 31/03/17
Non Current Assets		
Property plant and equipment	231,172	243,302
Intangilble Assets	1,650	1,860
Trade and other Receivables	1,193	1,308
	234,015	**246,470**
Current Assets		
Inventories	6,472	6,195
Trade receivables	8,397	31,980
Other receivables	8,787	10,422
Cash and cash equivalents	2,100	2,100
	25,756	**50,698**
Current Liabilities		
Trade payables	-13,571	-33,238
Other payables	-26,259	-21,500
DH Capital Investment Loan	-427	-427
Provisions	-253	-502
	-40,510	**-55,667**
Non Current Liabilities		
DH Capital Investment Loan	-3,553	-3,339
Borrowings - Revenue Support Facility	-35,218	-89,449
Provisions	-2,709	-2,488
	-41,480	**-95,276**
Total Assets Employed	**177,781**	**146,224**
Financed by:		
Public Dividend Capital (PDC)	153,562	153,562
Revaluation Reserve	98,247	110,875
Retained Earnings Reserve	-74,028	-118,213
Total Taxpayers' Equity	**177,781**	**146,224**

Cash Flow – March 2017

Headlines

• The cash position of the Trust remained extremely challenging. The Trust meet the £2.1m balance at 31st March 2017 as required by the Department of Health..

• The Trust has utilised its revolving working capital facility (RWCF) of £31.3m received exceptional working capital and additional working capital to meet the increased deficit position

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

Cash Flow Statement April 2016 to March 2017

£000s	Mar Actual	Outturn Actual
Cash Flow from Operations		
Operating Surplus/(Deficit)	-724	-37,473
Depreciation and Amortisation	1,034	12,402
Operating Surplus/(Deficit)	310	-25,071
Interest Paid	-360	-1,761
Dividend (Paid)/Refunded	-2,408	-4,617
Trade and Other Receivables	-782	-13,695
Cash Advance from CCGs	-8,000	0
Trade and Other Payables	5,311	1,638
Provisions Utilised	85	27
Net Cash Inflow/(Outflow) from Operating Activities	**-5,844**	**-43,479**
Cash Flows from Investing Activities:		
Interest Received	1	17
Property, Plant and Equipment	-712	-10,555
Net Cash Inflow/(Outflow) from Investing Activities	**-711**	**-10,538**
Net Cash Inflow/(Outflow) before Financing	**-6,555**	**-54,017**
Revolving Working Capital Facility	0	31,300
Revenue Support Loans (6%)	4,600	23,144
Loan Repayments	-213	-427
Net Cash Inflow/(Outflow) from Financing Activities	**4,387**	**54,017**
Net Increase/(Decrease) in Cash	**-2,168**	**0**
Opening balance	4,268	2,100
Closing balance	2,100	2,100

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

Headlines

- The Better Payment Practice Code (BPPC) requires all NHS organisations to achieve a public sector payment standard for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services.
- The target achievement of BPPC is 95%.
- The Aged Debt (over 90 days) KPI is measured as a percentage of the total level of debt. The target is for this to be no more than 5%.
- The current Aged Debt KPI is 11% at the end of March and key accounts are being reviewed.
- A large credit note (£828K) for MSK Partnership is forcing the Non-NHS over 91 day balance in to a credit.

Trade Receivables Aged Debt Analysis - Sales Ledger System Only	NHS Debt Outstanding		Non-NHS Debt Outstanding	
	Current Month £000s	Previous Month £000s	Current Month £000s	Previous Month £000s
0 - 30 Days	22,898	4,930	3,358	2,147
31 - 60 Days	2,397	821	1,590	325
61 -90 Days	121	225	153	202
91 - 120 Days	110	326	14	(792)
> 120 Days	930	954	409	1,084
Total	26,456	7,256	5,524	2,966

Trade Payables Aged Analysis - Purchase Ledger System Only	No of Invoices		Value Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0 - 30 Days	6,908	7,310	8,305	8,552
31 - 60 Days	9,181	8,010	9,138	9,348
61 -90 Days	6,807	5,197	8,128	7,427
91 - 120 Days	2,299	1,728	3,690	3,093
> 120 Days	2,191	1,268	3,977	3,057
Total	27,386	23,513	33,238	31,477

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	21.78%	39.52%	26.34%	37.64%
NHS invoices paid within contract or 30 days of receipt	27.42%	57.27%	27.15%	79.62%

Key Performance Indicators – March 2017

NHSI Finance Risk Assessment Criteria

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

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

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

Finance and Use of Resources Metrics (UoR)

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

Better Payment Practice Code (BPPC)

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

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

Local Measures	Outturn Actual	Outturn Plan
BPPC – Trade invoices by value (%)	38	95
BPPC – NHS Invoices by value (%)	80	95

Activity & Contract Income – March 2017

Headlines

NHS Patient Income in the month was £499k above the TDA plan, increasing the cumulative favourable variance to £8.3m.

The following are the main variances in performance:

- Electives (including Day Case) £3.1m over-performance across multiple areas including Cardiology (£518k), T&O (£1.2m), Urology (£477k), General Medicine (£360k), General Surgery (£398k), Ophthalmology (£438k), and Gastroenterology (£552k) with under performance in Dermatology (£255k), Clinical Oncology (£190k) and Gynaecology (£198k).

- Non-Electives over performance with £3.74m mainly linked to General Medicine (£1.23m), T&O (£747k), Gastroenterology (£543k), Geriatric Medicine (£1.76m) and Respiratory Medicine (£840k) partially offset by £367k Diabetes and £681k Endocrinology (activity believed to be sitting within General Medicine).

- STF funding shortfall of £7.8m

- Outpatient activity is over performing across multiple specialties, Rheumatology, Ophthalmology and Urology being the most significant over plan.

Under the terms of the Sustainability and Transformation Funding (STF) no provision has been made for fines and penalties, other than £19k relating to MSSA breaches.

Activity	Current Month			Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,931	3,793	-138	43,582	40,585	-2,997
Elective Inpatients	717	703	-14	7,953	7,984	31
Emergency Inpatients	3,665	3,609	-56	43,154	41,423	-1,731
Total Inpatients	**8,313**	**8,105**	**-208**	**94,689**	**89,992**	**-4,697**
Excess Bed Days	2,244	3,771	1,527	26,298	33,180	6,882
Total Excess Bed Days	**2,244**	**3,771**	**1,527**	**26,298**	**33,180**	**6,882**
Consultant First Attendances	8,654	9,700	1,046	95,941	100,129	4,188
Consultant Follow Ups	13,522	12,252	-1,270	149,918	150,016	98
OP Procedures	4,934	7,362	2,428	54,697	62,085	7,388
Other Outpatients inc WA & Nurse Led	13,279	14,225	946	147,219	158,821	11,602
Community Specialist	188	193	5	2,089	2,582	493
Total Outpatients	**40,577**	**43,732**	**3,155**	**449,864**	**473,633**	**23,769**
Chemotherapy Unbundled HRGs	675	1,516	841	7,485	14,753	7,268
Antenatal Pathways	340	335	-5	3,766	3,512	-254
Post-natal Pathways	312	262	-50	3,463	3,375	-88
A&E Attendances (excluding type 2's)	9,476	9,613	137	111,573	112,306	733
ITU Bed Days	517	427	-90	6,093	6,069	-24
SCBU Bed Days	309	216	-93	3,636	3,445	-191
Cardiology - Direct Access	74	80	6	823	840	17
Radiology - Direct Access	5,589	5,933	344	61,961	65,481	3,520
Pathology - Direct Access	302,901	298,536	-4,365	3,358,248	3,389,923	31,675
Therapies - Direct Access	2,782	3,093	311	30,850	34,789	3,939
Audiology	1,110	670	-440	12,311	7,936	-4,375
Midwifery	14	5	-9	156	102	-54

Income £000's	Current Month			Outturn		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,483	4,969	486	49,704	53,254	3,550
Inpatients - Emergency	6,310	6,684	374	74,294	78,040	3,746
Excess Bed Days	495	521	26	5,807	7,177	1,370
Outpatients	4,374	4,923	549	48,502	52,232	3,730
Other Acute based Activity	2,872	2,588	-284	33,278	32,573	-705
Direct Access	846	876	30	9,372	9,915	543
Block Contract	5,374	3,515	-1,859	64,562	61,487	-3,075
Fines & Penalties	0	11	11	0	-19	-19
Other	980	1,819	839	5,607	3,503	-2,104
CQUIN	480	556	76	5,761	6,162	401
Subtotal	26,214	26,462	248	296,887	304,324	7,437
Exclusions	2,608	2,859	251	31,300	32,145	845
GRAND TOTAL	**28,822**	**29,321**	**499**	**328,187**	**336,469**	**8,282**

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

Headlines

Pay

Total Pay reported an overspend of £1.9m against original plan in the month and £15.1m in total.
The variance against original plan is as a result of additional escalation wards being opened to meet demand, higher than planned agency costs and under delivery against original planned CIP.
Additional income partly offsets some of the increased pay costs on escalation beds, externally funded posts and over-performance on PbR income.

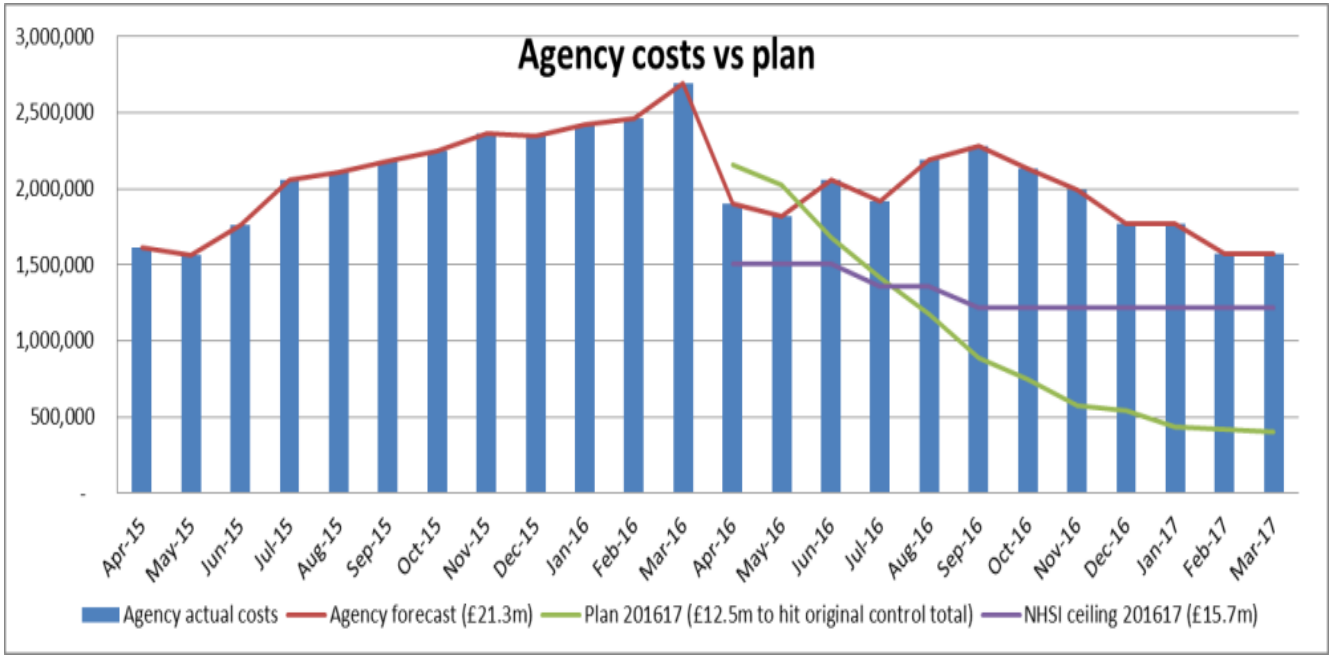
Non pay

Under delivery of original CiP plans.
Activity pressures including escalation beds and outsourcing activity to help with capacity pressures, have reported an overspend of £4m, offset by over-performance on contract income.
Spend on tariff Exclusions was £0.8m higher than planned but offset by over delivery on income.

Income & Expenditure Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	Outturn Plan £000's	Outturn Actual £000's	Var £000's
Urgent Care	-853	-1,001	-148	-11,459	-12,018	-559
Medicine	-3,813	-4,350	-537	-53,759	-63,216	-9,457
Surgery, Anaesthetics & Diagnostics	-7,952	-8,237	-285	-113,369	-118,033	-4,664
Women's, Children's & Sexual Health	-2,375	-2,502	-127	-30,147	-30,655	-508
Out of Hospital Care	-3,322	-3,434	-112	-40,574	-40,217	357
Tariff-Excluded Drugs & Devices	-2,608	-2,843	-235	-31,300	-32,130	-830
Total Clinical Units	**-20,923**	**-22,367**	**-1,444**	**-280,608**	**-296,269**	**-15,661**
Estates & Facilities	-1,835	-1,611	224	-23,519	-24,050	-531
Corporate Services	-3,253	-1,310	1,943	-42,428	-44,454	-2,026
Central Items	-2,593	-5,481	-2,888	-3,281	-19,221	-15,940
Total Central Areas	**-7,681**	**-8,402**	**-721**	**-69,228**	**-87,725**	**-18,497**
Contract Income	28,822	29,321	499	328,187	336,469	8,282
Non-contract Income	-892	-138	754	-9,651	3,232	12,883
Donated Asset/Impairment Adjustment	0	47	47	0	393	393
Adjusted Net Surplus/- Deficit	**-674**	**-1,539**	**-865**	**-31,300**	**-43,900**	**-12,600**

Workforce Plan FTE	Workforce Actual FTE	Pay Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	Outturn Plan £000's	Outturn Actual £000's	Var £000's
226	242	Urgent Care	-943	-972	-29	-11,265	-11,266	-1
1,179	1,312	Medicine	-4,449	-4,716	-267	-54,301	-56,131	-1,830
1,809	1,869	Surgery, Anaes & Diagnostics	-7,418	-7,003	415	-89,327	-88,627	700
641	598	Women's, Children's & Sexual Health	-2,380	-2,432	-52	-28,070	-28,312	-242
918	938	Out of Hospital Care	-2,712	-2,810	-98	-31,695	-31,810	-115
4,773	**4,959**	**Total Clinical Units**	**-17,902**	**-17,933**	**-31**	**-214,658**	**-216,146**	**-1,488**
648	673	Estates & Facilities	-1,332	-1,384	-52	-16,909	-17,365	-456
1,049	1,069	Corporate Services	-2,952	-3,155	-203	-35,520	-36,129	-609
1,697	**1,743**	**Total Non-Clinical Divisions**	**-4,284**	**-4,539**	**-255**	**-52,429**	**-53,494**	**-1,065**
0	**0**	Central Items	1,441	-139	-1,580	12,570	0	-12,570
6,470	**6,702**	**Total Pay Analysis**	**-20,745**	**-22,611**	**-1,866**	**-254,517**	**-269,640**	**-15,123**

Agency Expenditure – March 2017

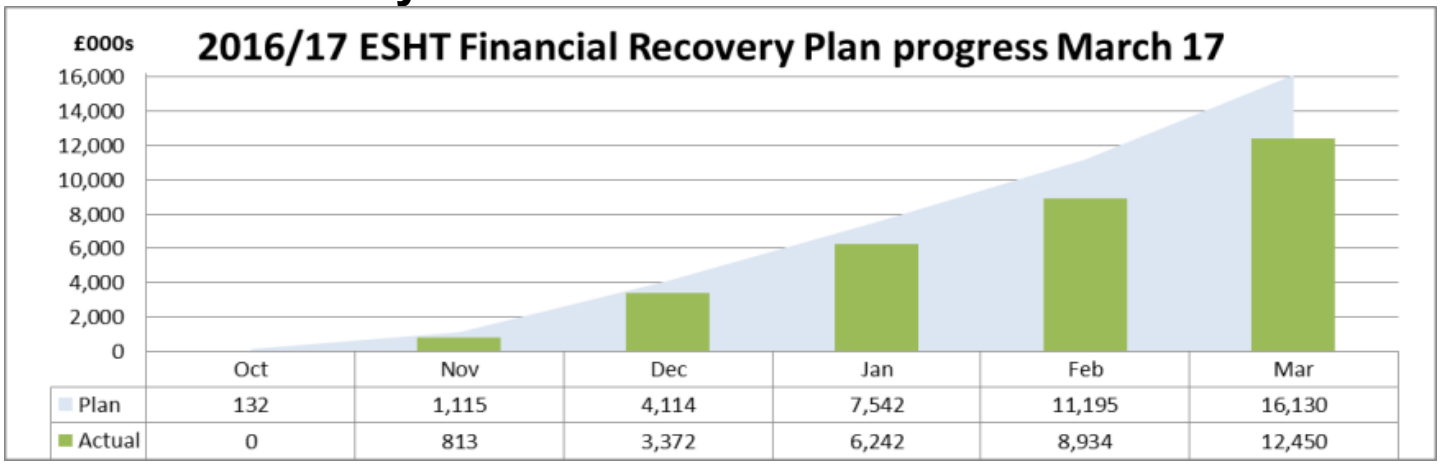


AGENCY STAFF SPEND BY STAFF GROUP (INCLUDING, AGENCY, LOCUM)	In month Actual £'000	In month Plan £'000	In month Variance £'000	Year to date Actual £'000	Year to date Plan £'000	Year to date Variance £'000
Total Pay Bill Agency and Locum Staff	1,651	399	1,252	23,073	12,461	10,612
Non Medical -Clinical Staff Agency	658	249	409	10,835	7,849	2,986
Registered Nurses	464	136	328	4990	3,605	1,385
Qualified Scientific, Therapeutic and Technical Staff	111	23	88	3504	1,303	2,201
HCA nursing	83	90	- 7	2340	2,941	- 601
Non Medical- Non-Clinical Staff Agency	202	41	161	2663	1,070	1,593
Medical and Dental Agency	792	109	683	9575	3,542	6,033
Trainee Grades	391	69	322	4422	2,162	2,260
Consultants	381	40	341	5114	1,380	3,734

Headlines

- March agency costs were in line with the previous month.
- The total spend on agency in 2016/17 was £23.1m, although this is significantly higher than originally planned and above the NHSi ceiling, there has been a steady reduction over the last 6 months.
- Overall 10% lower spend on agency compared with 2015/16.
- Nurse agency costs are reducing as a result of the control measures and increased recruitment to bank and substantive nursing posts.
- Further work is required to ensure a sustainable enhanced observation staffing model as HCA agency shifts are still being booked to cover one to one care needs for patients with dementia or at risk of falls.
- AHP agency are moving to direct engagement.

Financial Recovery Plan – March 2017



	Month			YTD			Full Year		
Division	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000
Corporate	273	1,305	-1,031	1,156	2,171	-1,015	1,156	2,171	-1,015
Specialist Medicine	804	411	392	3,200	1,308	1,891	3,200	1,308	1,891
Surgery, Anaethetics & Theatres, Diagnostics	1,491	417	1,074	5,577	1,265	4,312	5,577	1,265	4,312
Urgent	183	137	46	791	511	280	791	511	280
Women's & Children's	285	35	251	1,170	385	785	1,170	385	785
Out of Hospital	148	68	80	536	339	197	536	339	197
Trustwide	1,750	1,144	606	3,700	6,471	-2,771	3,700	6,471	-2,771
Total	4,934	3,516	1,418	16,130	12,450	3,680	16,130	12,450	3,680

	Month			YTD			Full Year		
Workstream	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000
Data Quality & Clinical Networks	366	106	260	1,389	844	545	1,389	844	545
Elective Pathways	859	482	378	3,246	1,722	1,524	3,246	1,722	1,524
Non-pay	245	321	-76	1,081	1,444	-363	1,081	1,444	-363
Patient Flow	311	151	160	1,207	153	1,054	1,207	153	1,054
Workforce - Medical	221	147	74	814	485	329	814	485	329
Workforce – Non-clinical and other clinical	70	63	7	252	93	159	252	93	159
Workforce - Nursing	197	130	67	478	505	-27	478	505	-27
Clinical Services Contribution	541	1,224	-683	2,163	1,490	673	2,163	1,490	673
Income Cost Recovery	600	300	300	3,000	1,500	1,500	3,000	1,500	1,500
Technical	1,525	593	932	2,500	4,213	-1,713	2,500	4,213	-1,713
Total	4,934	3,516	1,418	16,130	12,450	3,680	16,130	12,450	3,680

Headlines

•March delivered £3.5m savings towards the £4.9m target and cumulatively £12.5m achievement for the year.

•There have been some schemes that have not delivered as expected, this has resulted in the £3.7m adverse variance against the FRP.

Year on Year Comparisons – March 2017

Headlines

- Total Inpatient activity to date is 4.7% lower than last year's level.
- Total outpatients are 6.5% higher than last year.
- Total A&E attendances are 3.6% higher than last year.
- Total income is £23.2m (6.5%) up on the same period last year.
- Total expenditure is £19.7m (3.8%) up on the same period last year.

Activity	2016/17 Outturn Actual	2015/16 Outturn Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Day Cases	40,585	44,557	-3,972	-8.9%
Elective Inpatients	7,984	7767	217	2.8%
Emergency Inpatients	41,423	42,134	-711	-1.7%
Total Inpatients	**89,992**	**94,458**	**-4,466**	**-4.7%**
Elective Excess Bed Days	2,389	1,849	540	29.2%
Non elective Excess Bed Days	30,791	26,228	4,563	17.4%
Total Excess Bed Days	**33,180**	**28,077**	**5,103**	**18.2%**
Consultant First Attendances	100,129	94,061	6,068	6.5%
Consultant Follow Ups	150,016	149,267	749	0.5%
OP Procedures	62,085	52,083	10,002	19.2%
Other Outpatients (WA & Nurse Led)	158,821	147,147	11,674	7.9%
Community Specialist	2,582	2,025	557	27.5%
Total Outpatients	**473,633**	**444,583**	**29,050**	**6.5%**
Chemotherapy Unbundled HRGs	14,753	7,576	7,177	94.7%
Antenatal Pathways	3,512	3,695	-183	-5.0%
Post-natal Pathways	3,375	3,595	-220	-6.1%
A&E Attendances (excluding type 2's)	112,306	108,417	3,889	3.6%
ITU Bed Days	6,069	6,053	16	0.3%
SCBU Bed Days	3,445	3,610	-165	-4.6%
Cardiology - Direct Access	840	859	-19	-2.2%
Radiology - Direct Access	65,481	61,351	4,130	6.7%
Pathology - Direct Access	3,389,923	3,324,984	64,939	2.0%
Therapies - Direct Access	34,789	32,335	2,454	7.6%
Audiology	7,936	11,667	-3,731	-32.0%
Midwifery	102	141	-39	-27.7%

Income £000s	2016/17 Outturn Actual	2015/16 Outturn Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	336,469	318,682	17,787	5.6%
Private Patient/ RTA	2,625	2,518	107	4.2%
Trading Income	4,719	5,740	-1,021	-17.8%
Other Non Clinical Income	35,494	29,212	6,282	21.5%
Total Income	**379,307**	**356,152**	**23,155**	**6.5%**
Pay Costs	-269,640	-258,138	-11,502	-4.5%
Non Pay Costs	-134,739	-125,792	-8,947	-7.1%
Other	0	0	0	
Total Direct Costs	-404,379	-383,930	-20,449	-5.3%
Surplus/-Deficit from Operations	**-25,072**	**-27,778**	**2,706**	**9.7%**
Profit/Loss on Asset Disposal	0	29	-29	
Depreciation	-12,406	-12,664	258	2.0%
Impairment	5	411	-406	
PDC Dividend	-5,076	-6,940	1,864	26.9%
Interest	-1,744	-817	-927	-113.5%
Total Indirect Costs	-19,221	-19,981	760	3.8%
Total Costs	**-423,600**	**-403,911**	**-19,689**	**-4.9%**
Net Surplus/-Deficit	**-44,293**	**-47,759**	**3,466**	**7.3%**
Donated Asset / Other Adjustment	393	-238	631	265.1%
Normalised Net Surplus/-Deficit	**-43,900**	**-47,997**	**4,097**	**8.5%**

Capital Programme – March 2017

Headlines

The Trust has successfully delivered its capital programme within the CRL limit for the year.

Capital Investment Programme £000s	2016/17 Capital Programme	Expenditure Outturn
Capital Resources		
Depreciation	12,019	
Interest Bearing Capital Loan Application £5m. (Not currently approved by the NHSI.)	0	
League of Friends Support	1,000	
Capital Investment Loan Principal Repayment	-552	
Gross Capital Resource	12,467	
Less Donated Income	-1,000	
Capital Resource Limit (CRL)	**11,467**	**-**
Capital Investment		
Medical Equipment	881	780
IT Systems	2,187	1,135
Electronic Document Management	948	647
Estates Strategy	1,600	1,751
Backlog Maintenance	2,285	1,808
Minor Capital Schemes	1,000	2,700
Pathology CLD	797	887
Vital Pac	338	171
Project Management	106	170
Brought Forward Commitments - Various	1,183	1,417
Sub Total	**11,325**	**11,466**
Donated Asset Purchases	1,000	539
Donated Asset Funding	-1,000	-539
Net Donated Assets	**0**	0
Sub Total Capital Schemes	**11,325**	**11,466**
Overplanning Margin (-) Underplanning (+)	142	1
Net Capital Charge against the CRL	**11,467**	**11,467**

Financial Sustainability Risk Ratings – March 2017

Headlines

Use of Resource Metrics (UoR):-

- Liquidity Ratio (days)
  - Days of operating costs held in cash or cash equivalent forms.
- Capital Service Capacity Ratio (times)
  - The degree to which the organisation's generated income covers its financial obligations.
- Income and expenditure (I&E) Margin (%)
  - The degree to which the organisation is operating at a surplus/deficit.
- Distance from financial plan (%)
  - The YTD I&E surplus/deficit compared to plan.
- Agency spend (%)
  - The distance from the providers cap..
- The NHSI assigns ratings between 1 and 4 to each component of the UoR with 4 being the worst rating and 1 the best. The overall rating is the average of the five.
  - The liquidity ratio of -10 days is a rating of 3.
  - The capital servicing capacity ratio of -3.52 results in a rating of 4.
  - The I&E margin of -11.6% results in a rating of 4.
  - The distance from financial plan of 3.0% results in a rating of 4
  - Agency spend of £23.1m YTD is 46.6% above cap, a rating of 3.
  - As a result, the overall Trust rating is 4.

Liquidity Ratio (days) £000s	2015/16 Outturn	2016/17 Outturn
Opening Current Assets	25,115	50,698
Opening Current Liabilities	-39,869	-55,667
Net Current Assets/Liabilities	-14,754	-4,970
Inventories	-6,472	-6,195
Adj Net Current Assets/Liabilities	**-21,226**	**-11,165**
Divided by:		
Total costs in year	383,768	404,379
Multiply by (days)	360	360
Liquidity Ratio	**-20**	**-10**

Capital Servicing Capacity (times) £000s	2015/16 Outturn Actual	2016/17 Outturn Plan	2016/17 Outturn Actual
Net Surplus / Deficit (-) After Tax	-47,759	-31,300	-44,293
Less:			
Donated Asset Income Adjustment	-947	-1,000	-539
Interest Expense	846	1,639	1,761
Profit/Loss on Sale of Assets	-29	0	0
Depreciation & Amortisation	12,664	12,519	12,406
Impairments	-411	0	5
PDC Dividend	6,940	5,162	5,076
Revenue Available for Debt Service	**-28,696**	**-12,980**	**-25,584**
Interest Expense	846	1,639	1,761
PDC Dividend	6,940	5,162	5,076
Temporary PDC repayment			
Working capital loan repayment	31,842	552	426
Capital loan repayment	335		
	39,963	7,353	7,263
Capital Serving Capacity	**-0.72**	**-1.77**	**-3.52**

Financial Efficiency £000s	2015/16 Outturn Actual	2016/17 Outturn Plan	2016/17 Outturn Actual	2016/17 Outturn Variance
Net surplus/ deficit	-47,759	-31,300	-43,900	
Less fixed asset impairments/disposals	-440	0	-5	
	-48,199	-31,300	-43,905	
Divided by:				
Total Income (excl donated assets)	-355,205	-362,885	-378,768	
I&E Margin	**-13.6%**	**-8.6%**	**-11.6%**	**-3.0%**

Sustainability and Strategy

SUSTAINABILITY

Sustainability

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.

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

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

Leadership & Culture

LEADERSHIP & CULTURE

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

East Sussex Healthcare NHS
NHS Trust

1. WORKFORCE EXECUTIVE SUMMARY – KEY POINTS

Actual workforce usage of staff in March was 6702.16 full time equivalents (ftes), 232.09 ftes above budgeted establishment.

Temporary staff expenditure was £3,389K in March (14.99% of total pay expenditure). This comprised £1,699K bank expenditure, £1,651K agency expenditure and £39K overtime. This is an increase of £25K overall compared to February.

There were 389.16 fte vacancies (a vacancy factor of 6.17%). This was a reduction of 46.00 fte vacancies compared to last month.

Annual turnover was 10.31% which represents 568.21 fte leavers in the last year. This was an increase of 0.35% compared to last month.

Monthly sickness was 3.96%, a reduction of 0.44% from February. The annual sickness rate was 4.30%, a reduction of 0.06%.

The overall mandatory training rate increased by 0.51% to 88.54%. Compliance rates increased for all mandatory training courses, except for Health & Safety.

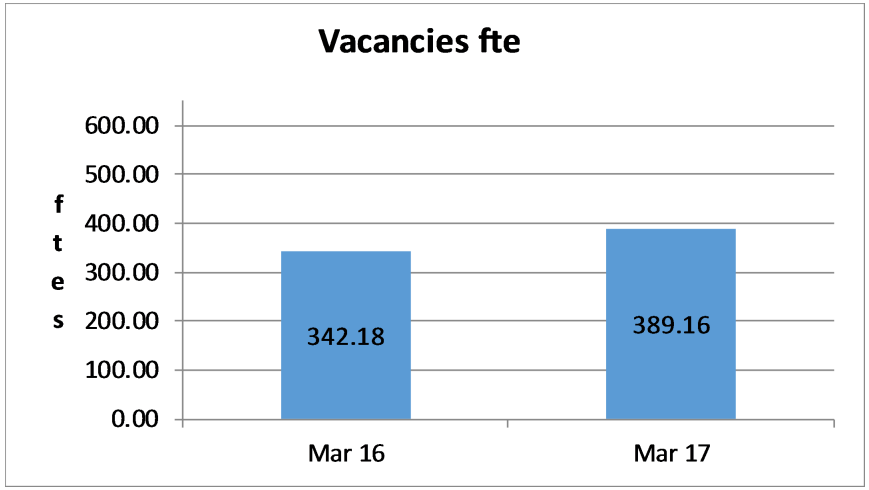
Appraisal compliance decreased slightly by 0.17% to 78.89%

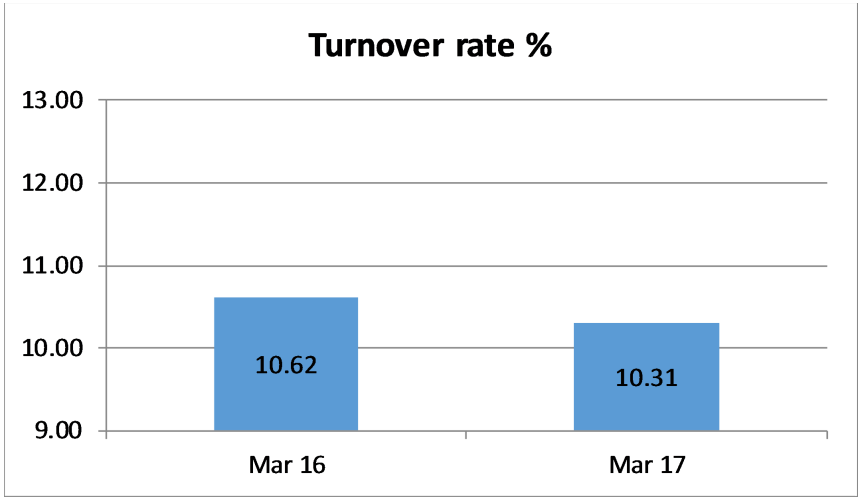
East Sussex Healthcare NHS
NHS Trust

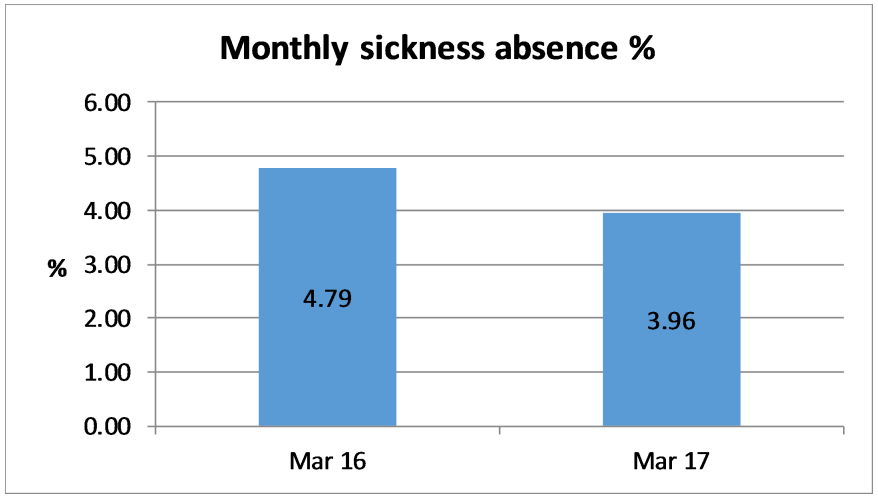
2. Overview

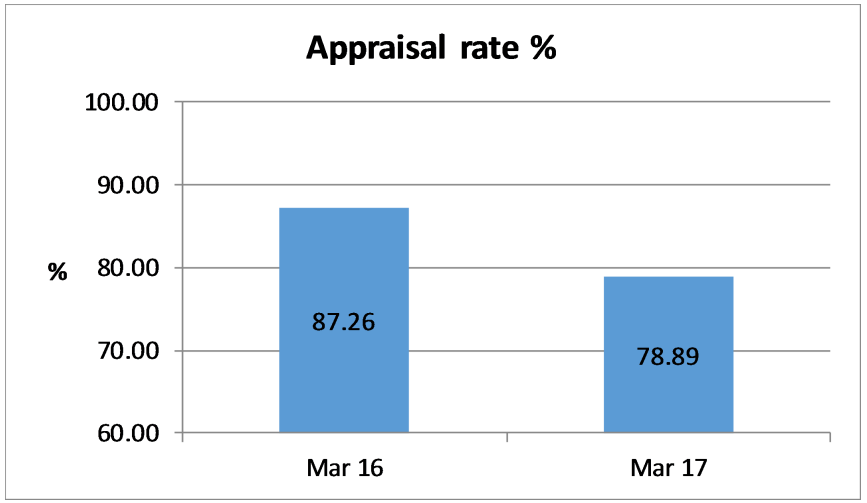
TRUST	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Trend line
WORKFORCE CAPACITY													
Budgeted fte	6368.93	6381.23	6437.07	6328.78	6394.73	6416.78	6477.44	6521.75	6458.23	6470.02	6470.09	6470.07	
Total fte usage	6320.64	6340.02	6370.72	6380.32	6465.06	6516.26	6542.43	6596.92	6526.36	6539.29	6572.22	6702.16	
Variance	48.29	41.21	66.35	-51.54	-70.33	-99.48	-64.99	-75.17	-68.13	-69.27	-102.13	-232.09	
Permanent vacancies	606.76	579.45	611.23	564.18	496.62	517.21	504.71	507.66	472.25	476.68	435.16	389.16	
Fill rate	90.17%	90.66%	90.23%	90.94%	92.01%	91.71%	91.99%	92.00%	92.49%	92.44%	93.10%	93.83%	
Bank fte usage (as % total fte usage)	6.97%	6.23%	6.26%	6.40%	6.31%	7.42%	6.98%	7.23%	7.22%	7.29%	7.29%	8.33%	
Agency fte usage (as % total fte usage)	5.29%	5.37%	5.49%	5.32%	5.71%	5.33%	5.14%	4.98%	4.37%	4.09%	3.88%	3.93%	
WORKFORCE EFFICIENCY													
Annual sickness rate	4.50%	4.46%	4.42%	4.40%	4.39%	4.37%	4.38%	4.37%	4.38%	4.41%	4.36%	4.30%	
Monthly sickness rate (%)	4.18%	3.94%	3.77%	4.08%	4.10%	4.01%	4.68%	4.47%	4.59%	4.78%	4.40%	3.96%	
Turnover rate	10.25%	10.00%	10.03%	10.02%	9.76%	9.66%	9.87%	9.53%	9.72%	9.77%	9.96%	10.31%	
TRAINING & APPRAISALS													
Appraisal rate	88.47%	89.68%	88.07%	85.77%	87.01%	83.14%	81.61%	79.21%	78.35%	78.42%	79.06%	78.89%	
Fire	86.25%	87.01%	87.62%	86.91%	85.51%	86.28%	86.16%	86.27%	84.46%	85.31%	84.35%	84.53%	
Moving & Handling	89.43%	89.57%	89.91%	90.58%	90.09%	90.99%	90.12%	89.75%	87.98%	89.06%	89.02%	89.45%	
Induction	93.67%	94.69%	94.38%	94.50%	93.73%	94.09%	92.54%	92.05%	93.70%	93.15%	95.43%	95.99%	
Infec Control	87.92%	88.40%	89.24%	88.97%	87.95%	89.01%	88.92%	88.63%	86.98%	86.84%	87.25%	87.65%	
Info Gov	84.78%	84.48%	84.51%	83.86%	83.64%	84.79%	84.32%	84.96%	84.21%	85.70%	84.24%	87.25%	
Health & Safety	86.74%	87.42%	87.95%	88.05%	87.75%	88.42%	88.83%	88.96%	88.59%	89.09%	88.51%	87.55%	
MCA	93.92%	93.37%	94.13%	94.09%	93.83%	94.45%	94.68%	95.27%	95.02%	95.43%	95.48%	95.68%	
DoLs	94.06%	95.35%	95.04%	95.68%	95.64%	95.64%	95.97%	96.61%	96.89%	97.42%	97.67%	97.88%	
Safeguarding Vulnerable Adults	81.54%	81.37%	83.10%	83.82%	83.06%	83.90%	84.71%	85.86%	85.87%	86.76%	87.22%	87.49%	
Safeguarding Children Level 2	83.25%	83.35%	82.93%	82.35%	82.43%	83.32%	83.40%	83.43%	83.16%	84.44%	86.35%	86.42%	

3. Recruitment









The medical vacancy rate is unchanged at 8.70% (50.28 fte vacancies), for registered nursing & midwives the rate has reduced by 0.39% to 7.56% (152.54 fte vacancies, down by 7.93 ftes), whilst for unqualified nurses, the vacancy rate has reduced by 1.51% to 1.41% (11.81 ftes, down by 12.72 ftes),

The MSI recruitment agency has been engaged for a visit to Qatar to recruit A&E Doctors, they are also sourcing candidates from South Africa, Pakistan, the Middle East and Europe, for both medical and nurse vacancies, pending sign off of the business plan for this recruitment. Direct contact has also been made with the International Medical College via Doctor Sharma.

The HR team are having regular meetings with Divisional teams to discuss both recruitment and the development of new roles.

7 Italian nurses started with the Trust on 19th April with a further 9 to arrive in May. Those Filipino nurses who were interviewed in October – November 2016 have commenced their language assessments.

Rolling nurse recruitment is now ongoing. Vacancies for all departments are being advertised under the new format with a weekly review to monitor progress. “Golden handshake” and “refer a friend” schemes will also be trialled for theatre nurses.

TTM Agency have been engaged to recruit Occupational Therapists and Physiotherapists in Portugal. We are considering recruitment from Australia through a job board or Skype interviews.

The recruitment campaign continues for integrated support workers. 44 have been recruited to date with further interviews scheduled for 5th May. Social media, local media and a poster campaign have all been utilised.

Recruitment are meeting with the Communications department to discuss a Trust booklet advertising the benefits of working for the Trust and living in Sussex. A draft will be produced in late April.
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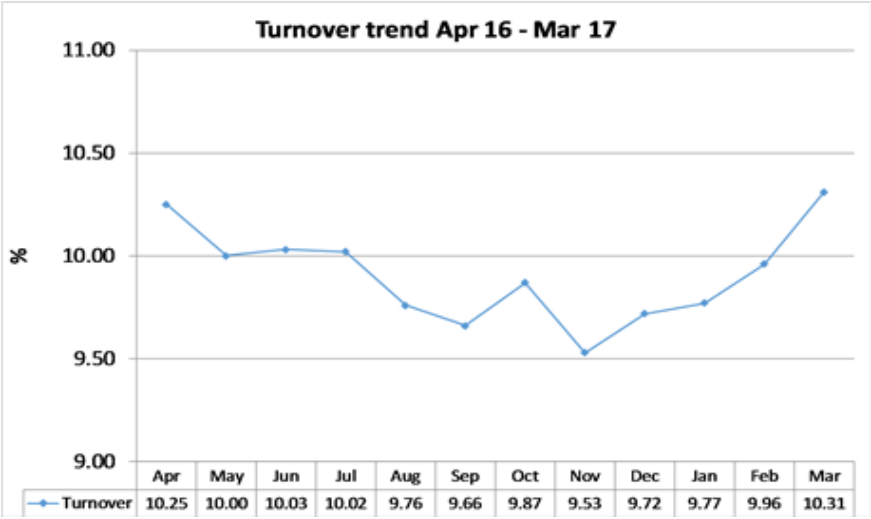
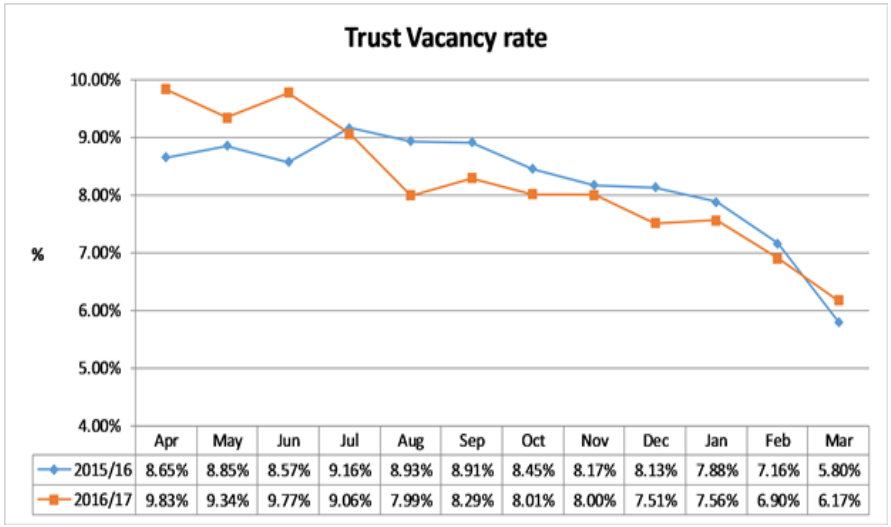
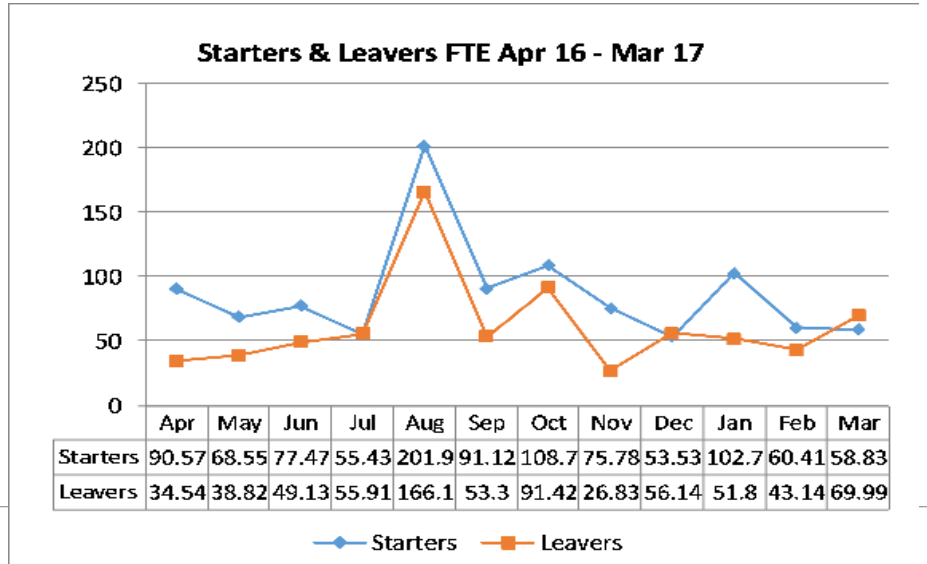
4. Turnover



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Turnover	10.25	10.00	10.03	10.02	9.76	9.66	9.87	9.53	9.72	9.77	9.96	10.31

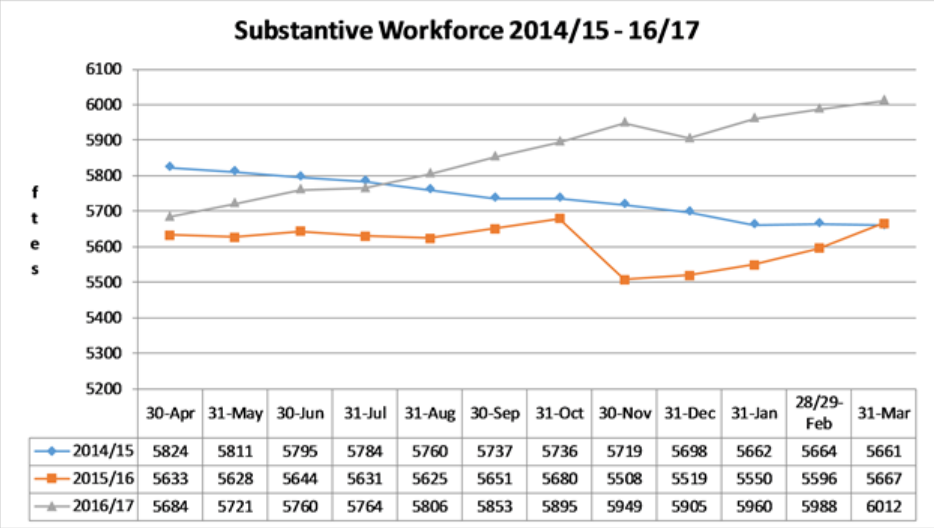


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	8.65%	8.85%	8.57%	9.16%	8.93%	8.91%	8.45%	8.17%	8.13%	7.88%	7.16%	5.80%
2016/17	9.83%	9.34%	9.77%	9.06%	7.99%	8.29%	8.01%	8.00%	7.51%	7.56%	6.90%	6.17%

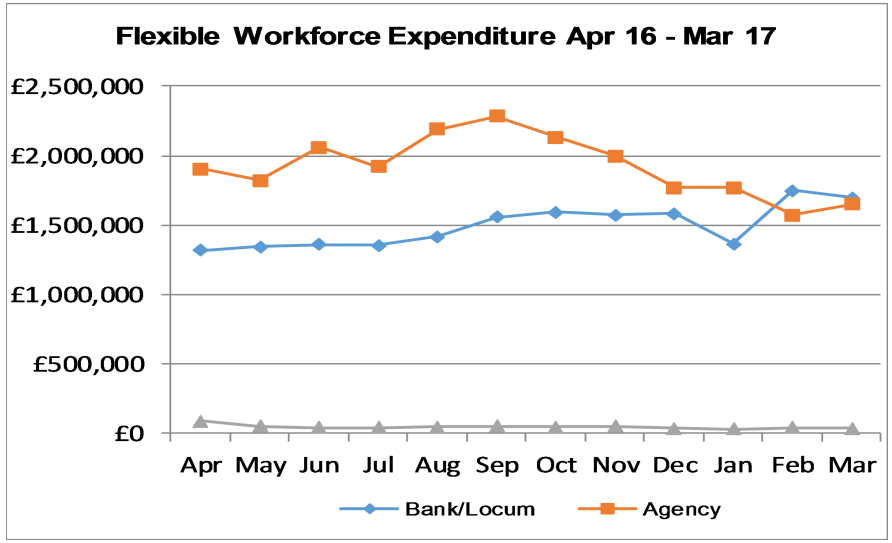


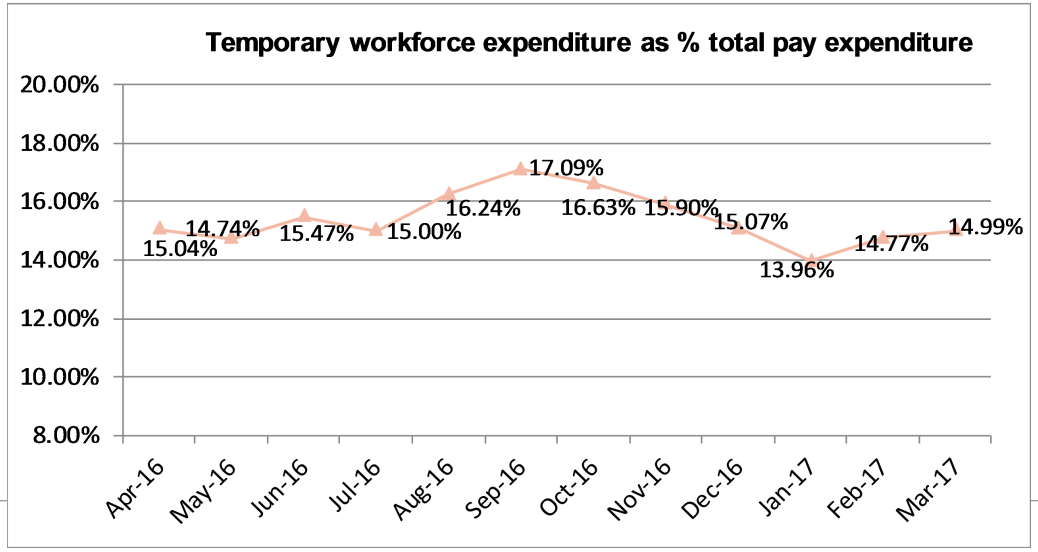
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Starters	90.57	68.55	77.47	55.43	201.9	91.12	108.7	75.78	53.53	102.7	60.41	58.83
Leavers	34.54	38.82	49.13	55.91	166.1	53.3	91.42	26.83	56.14	51.8	43.14	69.99

5. Workforce Expenditure

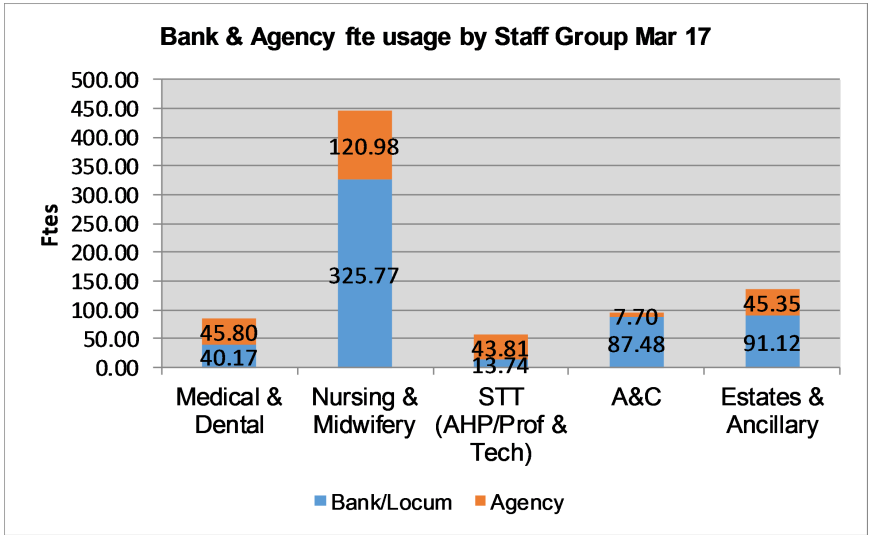


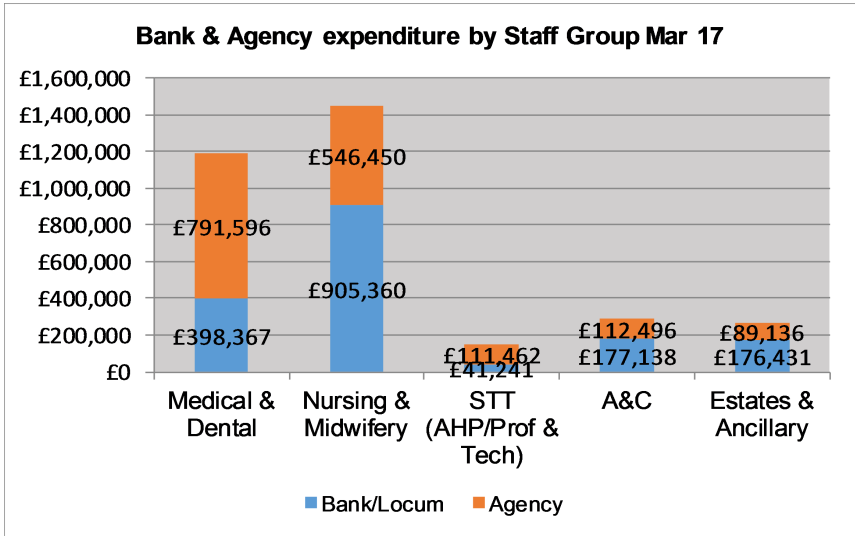
	30-Apr	31-May	30-Jun	31-Jul	31-Aug	30-Sep	31-Oct	30-Nov	31-Dec	31-Jan	28/29-Feb	31-Mar
2014/15	5824	5811	5795	5784	5760	5737	5736	5719	5698	5662	5664	5661
2015/16	5633	5628	5644	5631	5625	5651	5680	5508	5519	5550	5596	5667
2016/17	5684	5721	5760	5764	5806	5853	5895	5949	5905	5960	5988	6012





3. Recruitment





Temporary workforce expenditure increased by £25K overall compared to February. This was due to an increase of £77K in agency expenditure, partly offset by a reduction of £50K in bank expenditure. Overtime expenditure decreased by £2K.
There have been a number of accounting adjustments this month for the end of the financial year and additional sickness in Urgent Care has also increased agency expenditure.
In Womens & Childrens, there was a reduction in bank expenditure due to recruitment and staff returning to work.

East Sussex Healthcare NHS
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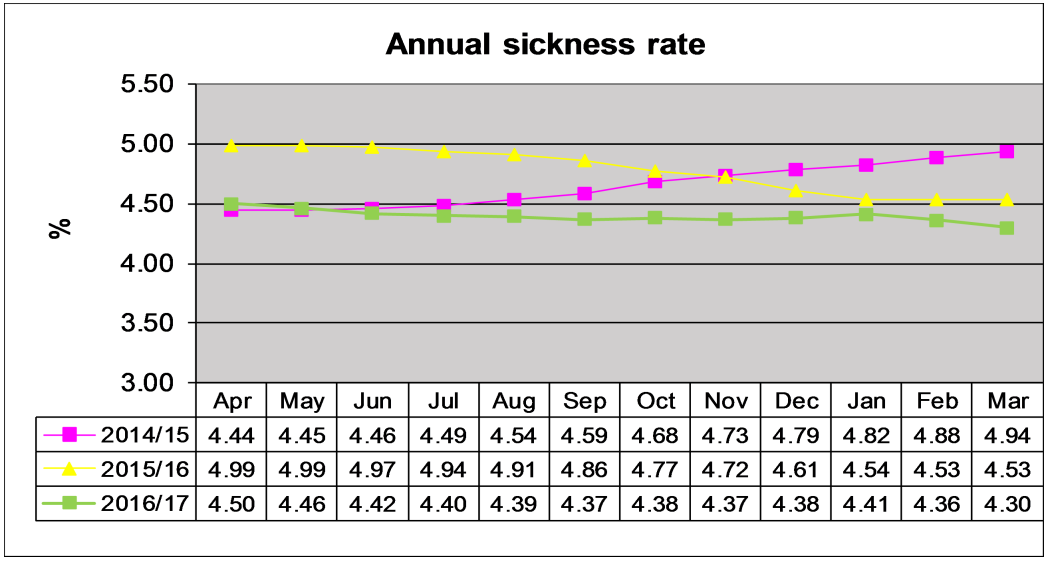
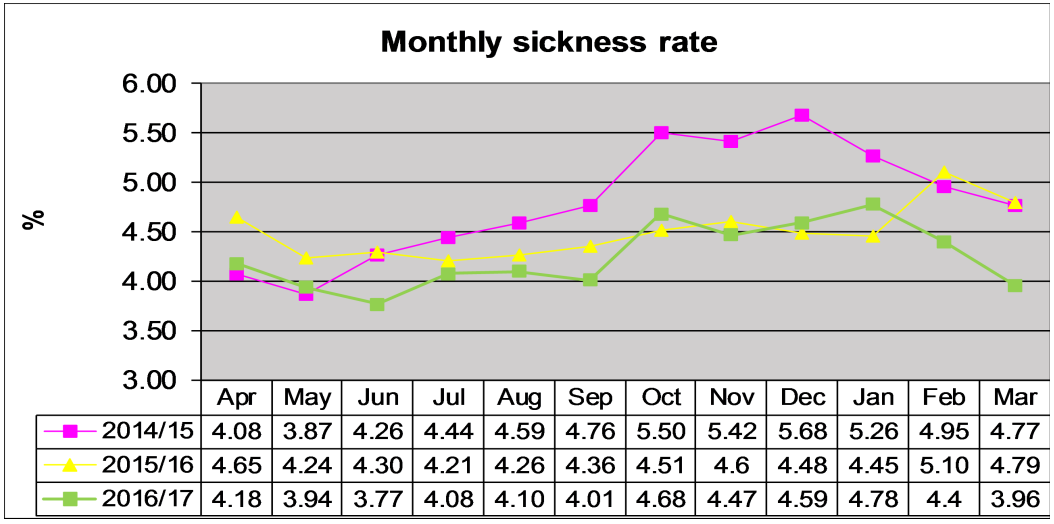
6. Absence



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	4.44	4.45	4.46	4.49	4.54	4.59	4.68	4.73	4.79	4.82	4.88	4.94
2015/16	4.99	4.99	4.97	4.94	4.91	4.86	4.77	4.72	4.61	4.54	4.53	4.53
2016/17	4.50	4.46	4.42	4.40	4.39	4.37	4.38	4.37	4.38	4.41	4.36	4.30



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	4.08	3.87	4.26	4.44	4.59	4.76	5.50	5.42	5.68	5.26	4.95	4.77
2015/16	4.65	4.24	4.30	4.21	4.26	4.36	4.51	4.6	4.48	4.45	5.10	4.79
2016/17	4.18	3.94	3.77	4.08	4.10	4.01	4.68	4.47	4.59	4.78	4.4	3.96

Monthly sickness has reduced again this month by 0.44% to 3.96%. This is 0.83% lower than the rate for March 2016 and thus the annual sickness rate has also reduced by 0.06% to 4.30, a fall of 0.23% over the financial year.
Monthly sickness is particularly high in Urgent Care where there was an increase of 0.81% to 6.63%. Monthly sickness rates fell in Medicine (-0.30%), Diagnostics, Anaesthetics & Surgery (-1.00%) and Out of Hospital Care (-0.66%) (there was a slight increase in Womens & Childrens (+0.03%)) whilst in Estates & Facilities, the monthly rate fell by 0.82% to 4.34%.
The HR Team are supporting Urgent Care Leads with regular meetings to review absence and to consider wider strategies to support staff attendance.
Estates and Facilities are considering a range of new initiatives to reduce short and long term absence and, where successful, initiatives may be rolled out more widely

East Sussex Healthcare NHS
NHS Trust

7. Mandatory Training

Mandatory training course	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Induction %	92.54	92.05	93.70	93.15	95.43	95.99
Fire %	86.13	86.27	84.46	85.31	84.35	84.53
Moving & Handling %	90.12	89.75	87.98	89.06	89.02	89.45
Infection Control %	88.92	88.63	86.98	86.84	87.25	87.65
Info Gov %	84.23	84.96	84.21	85.70	84.24	87.25
Health & Safety %	88.83	88.96	88.59	89.09	88.51	87.55
Mental Capacity Act %	94.68	95.27	95.02	95.43	95.48	95.68
Depriv of Liberties %	95.97	96.61	96.89	97.42	97.67	97.88
Safeguard Vuln Adults	84.71	85.86	85.87	86.76	87.22	87.49
Safeguard Child Level 2	83.40	83.43	83.16	84.44	86.35	86.42

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	80.30%	85.71%	97.67%	83.74%	83.25%	76.85%	92.44%	89.25%	84.30%	87.79%	78.33%	84.15%
Medicine Division	83.41%	84.96%	92.97%	83.92%	86.60%	85.65%	93.27%	96.94%	86.05%	83.40%	n/a	81.85%
Out of Hospital Care Division	83.78%	90.85%	98.11%	89.45%	83.88%	87.56%	97.18%	99.45%	87.01%	83.09%	n/a	72.09%
Diagnostics Anaesthetics & Surgery	84.29%	89.31%	96.24%	86.47%	88.16%	90.18%	96.82%	98.55%	89.45%	90.03%	n/a	82.92%
Womens Childrens & Sexual Health Division	80.79%	87.59%	97.87%	85.63%	79.27%	80.33%	95.81%	97.30%	86.39%	87.71%	88.21%	75.85%
Estates & Facilites	86.93%	89.61%	100.00%	94.97%	95.64%	92.80%	n/a	n/a	n/a	n/a	n/a	71.83%
Corporate	88.82%	95.29%	94.78%	90.00%	90.69%	88.73%	97.41%	96.88%	90.52%	85.27%	100.00%	83.52%
TRUST	**84.53%**	**89.45%**	**95.99%**	**87.65%**	**87.25%**	**87.55%**	**95.68%**	**97.88%**	**87.49%**	**86.42%**	**87.55%**	**78.89%**

The majority of subjects are maintaining or increasing in compliance and are close to, or in excess of 90% compliance. The Learning and Development Team, together with specialist trainers, will continue to target areas of low compliance throughout the Trust and to look at effective ways to approach those staff who are consistently out of date.

The appraisal rate has fallen back slightly this month to 78.89% which is disappointing. Urgent Care (+2.33%), Medicine (+1.56%), Diagnostics, Anaesthetics & Surgery (+4.75%) all increased their rates whilst Out of Hospital Care (-3.06%), Women & Childrens (-1.42%), Estates & Facilities (-11.12%) and Corporate areas (-1.70%) all saw reductions.

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

Staff Family and Friends Test – January – March 2017

The Trust is required to complete the Staff Family and Friends test every quarter. There are two generic questions that are asked every time

- If a friend or relative needed treatment would you be happy with the standard of care provided by the organisation?
- Would you recommend your organisation as a place to work?

We also have the opportunity to ask additional questions if required. This quarter, staff were asked about the Schwartz rounds. The feedback has been given to the Schwartz rounds facilitators to identify key areas for action.

Below is the data for the Staff FFT since 2014 and the same questions that are asked as part of the main Staff Survey. The Trust continues to demonstrate improvement in response to the two main questions.

Period	Care %	Work %	Response %
Q1 2014	65	39	9
Q2 2014	65	36	15
Q4 2014	72	53	8
Q1 2015	63	44	23
Q2 2015	65	46	17
Q4 2015	61	38	8
Q1 2016	72	55	17
Q2 2016	75	58	13
Q4 2016	77	66	14.5

Staff survey		Care %		Work %	Response %
2014	52	39	42		
2015	54	40	40		
2016	62	53	46		

Both tables demonstrate significant improvement although there is still scope for further improvements, with the following actions being in place:

- Increase the response rate to the Staff family and friends test to at least 20% of respondents by 2018.
- Increase the positive response rate to the question “If a friend or relative needed treatment, would you be happy with the standard of care provided by the organisation” to 80% in the staff family and friends test
- Maintain the positive response rate to the question “Would you recommend your organisation as a place to work?” at 66% or higher.

East Sussex Healthcare NHS Trust

Staff Survey response

Staff survey	Care %	Work %	Response %
2014	52	39	42
2015	54	40	40
2016	62	53	46

Both tables demonstrate significant improvement although there is still scope for further improvements, with the following actions being in place:

- Increase the response rate to the Staff family and friends test to at least 20% of respondents by 2018.

- Increase the positive response rate to the question “If a friend or relative needed treatment, would you be happy with the standard of care provided by the organisation” to 80% in the staff family and friends test
- Maintain the positive response rate to the question “Would you recommend your organisation as a place to work?” at 66% or higher.

Activity

ACTIVITY

1. Activity overview

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	Yr	Last Yr	Var	
Primary Referrals	M	9249	9047	9551	8859	9169	9205	8989	9328	7665	8726	8653	10151	9169	10.7%	108592	106195	2.2%	
Cons to Cons Referrals	M	1406	1422	2006	1648	1448	1500	1438	1480	1321	1516	1414	1773	1294	37.0%	18372	17327	5.7%	
First OP Activity	M	9853	9876	10839	9868	10706	10989	11653	12491	10644	10913	10570	11834	10076	17.4%	130236	122534	5.9%	
Subsequent OP Activity	M	23216	23403	24446	22052	23389	23933	22845	25167	21863	24899	23351	26981	23716	13.8%	285545	279171	2.2%	
New:FU Ratio	M	2.4	2.4	2.3	2.2	2.2	2.2	2.0	2.0	2.1	2.3	2.2	2.3	2.4	-0.1	2.2	2.1	0.0	
Elective IP Activity	M	596	697	656	715	649	670	682	717	619	642	644	716	627	14.2%	8003	7888	1.4%	
Elective DC Activity	M	3521	3839	4119	4036	4199	4207	3932	4164	3755	4086	3826	4430	3785	17.0%	48114	45259	5.9%	
Non-Elective Activity	M	4038	3772	3791	3879	3801	3663	3721	3789	3966	3719	3494	4075	4077	0.0%	45708	47015	-2.9%	
A&E Attendances	M	8715	9573	9239	10144	9711	9470	9397	8989	9136	8771	7951	9442	9398	0.5%	110538	106876	3.3%	
Admissions Via A&E	M	2357	2398	2363	2409	2302	2215	2381	2416	2620	2464	2241	2622	2433	7.8%	28788	28005	2.7%	
Ambulance Conveyances	M	2848	3068	2995	3133	3092	3051	3138	3163	3331	3223	2886	3156	3084	2.3%	37084	35370	4.6%	
Average LOS Elective	M	2.7	3.4	3.0	3.1	2.4	3.1	2.7	2.5	3.1	2.6	2.9	3.5	3.0	0.5	2.92	2.99	-0.1	
Average LOS Non-Elective	M	6.1	5.8	5.5	5.6	5.9	6.1	6.1	5.9	6.1	6.3	6.5	6.2	6.0	0.2	6.01	5.62	0.4	

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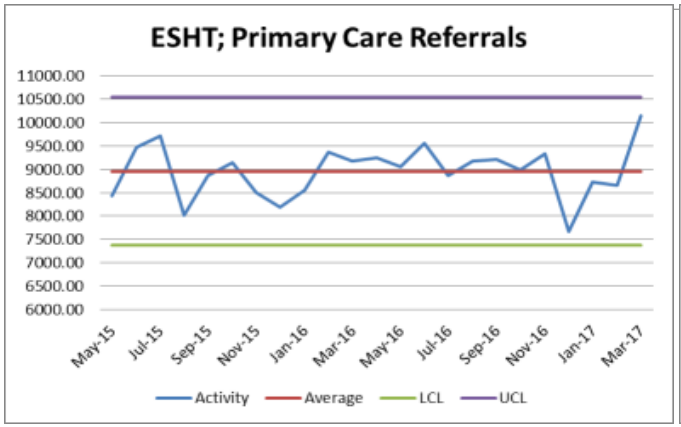
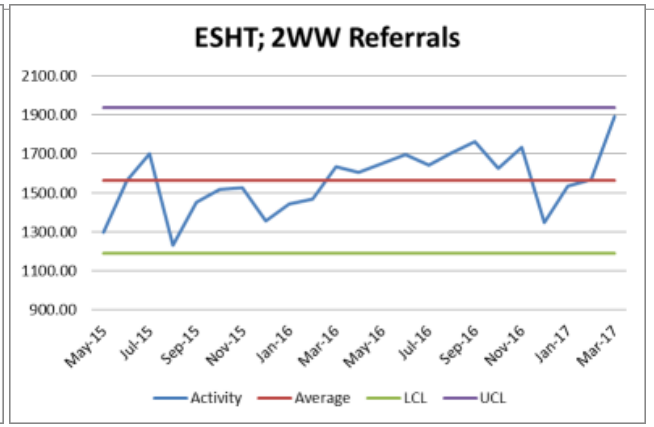
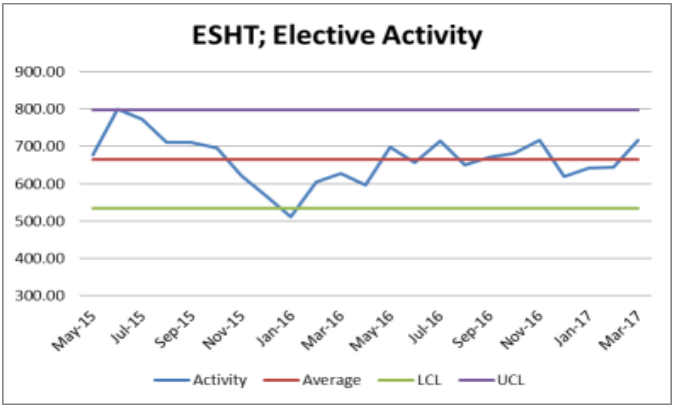
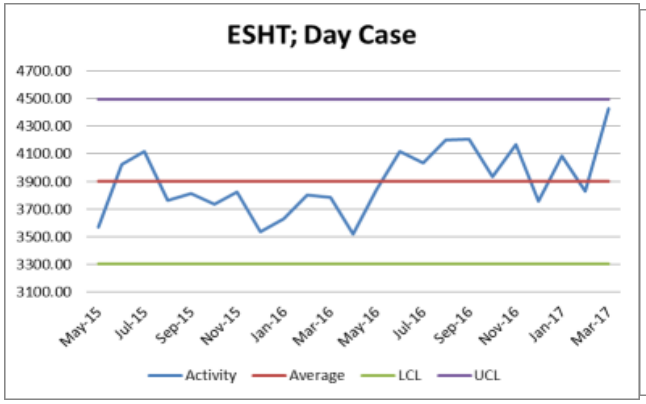
NHS Trust

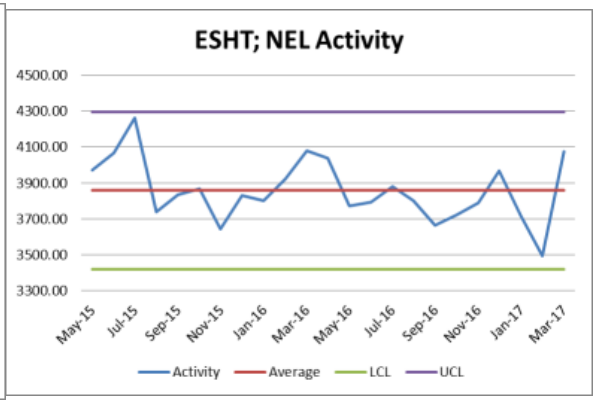


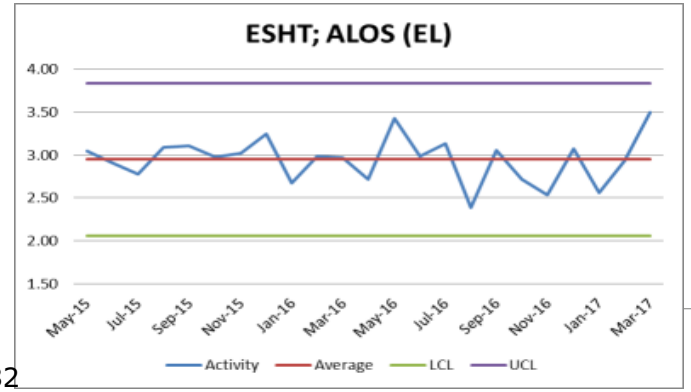


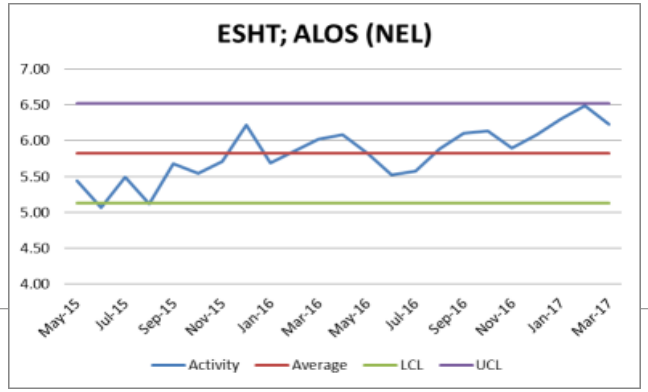
Referrals from primary care have seen a steep increases in March, with both referrals and 2ww's approaching the upper control limits.











Community

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	Yr	Last Yr	Var	
Community Nursing Referrals	M	3902	3768	3962	3994	3975	4100	4157	4182	3997	4714	4281	4520	3840	17.7%	49552	38475	22.4%	
Community Nursing Total Contacts	M	33652	35504	36021	33717	34998	32851	33544	33436	33070	36718	34092	37895	34518	9.8%	415498	408176	1.8%	
Community Nursing Face to Face Contacts	M	19125	20065	19520	19055	19684	18734	19426	19244	18956	20342	18506	21259	19535	8.8%	233916	233333	0.2%	
% Patient Facing Time	60.0%	56.8%	56.5%	54.2%	56.5%	56.2%	57.0%	57.9%	57.6%	57.3%	55.4%	54.3%	56.1%	56.6%	-0.5%	56.3%	56.2%	0.1%	
Community Nursing ALOS	42.0	24.5	23.1	20.3	18.6	19.0	17.7	15.7	14.7	13.7	10.9	8.8	5.6	26.2	-20.6	15.77	31.55	-15.8	
SALT WL <13 Weeks %	85.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	0	90.6%	100.0%	-0.09409	
Podiatry WL <13 Weeks %	85.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	0	88.7%	100.0%	-0.11332	
Dietetics WL <13 Weeks %	85.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.7%	100.0%	100%	0	91.6%	100.0%	-0.08438	
MSK WL <13 Weeks %	85.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	81.0%	96.5%	100%	-0.035188	98.2%	98.5%	-0.00285	
SALT Total WL	M	146	160	0	176	202	182	149	130	140	128	133	139	117	22	1685	690	995	
Podiatry WL Total WL	M	841	830	0	998	842	942	633	418	293	284	284	380	749	-369	6745	4204	2541	
Dietetics WL Total WL	M	73	32	0	43	65	54	30	64	39	43	74	69	146	-77	586	1400	-814	
MSK WL Total WL	M	101	101	0	1922	1922	105	1641	1265	1938	2087	434	2029	211	1818	13545	4201	9344	
IP ALOS (including Irvine Stroke Unit)	M	30.6	33.3	25.8	30.9	36.0	28.5	27.0	26.9	32.3	35.0	33.8	38.0	31.1	6.9	31.42	26.35	5.1	
IP Activity (including Irvine Stroke Unit)	M	92	97	85	85	85	81	84	93	85	69	75	85	89	-4.5%	1016	1523	-49.9%	

East Sussex Healthcare NHS
NHS Trust

Access and Delivery overview:

Intermediate Care:

Average length of stay decreased in BIU Generic and Stroke with the other units, Rye and Firwood seeing an increase in the LoS for Rye and Firwood for this period. Reasons for increase has been due to patients becoming medically unwell, requiring further diagnostics prior to rehab, access to POC, SPT placements and family decisions. Flow out of units remains challenging, we continue to work with partner organisations to improve flow. Continue to work with commissioners on longer term strategy for Intermediate care.

Joint Community Rehabilitation Teams:

Remains challenged for meeting targets on response rates. Focusing on reducing the inappropriate referrals and continue to work with commissioners on capacity demand and agreement for funding of locums at point when fully established and reduction in level of inappropriate referrals. Commencement of Integrated Duty and Triage Function April 2017

Community Nursing:

There has been a slight overall reduction in referrals received in Feb. In H&R there is an increase response performance targets. Otherwise targets being maintained or improving with data accuracy and reporting initiatives. Workforce modelling and capacity demand being finalised as part of the community rebasing project.

Community AHPs:

Maintain 13 week waiting time target with the exception of MSK in H&R this has been due to an spike in referrals over last 3 months., and dietetics which has had an increase in waiting times following an increase in referral numbers in Feb.

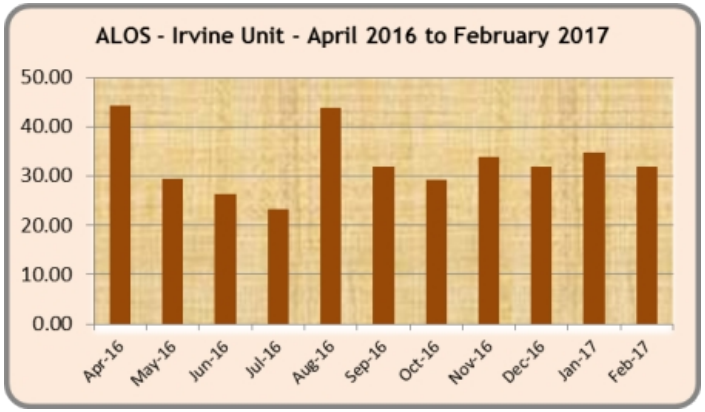
Acute AHPs:

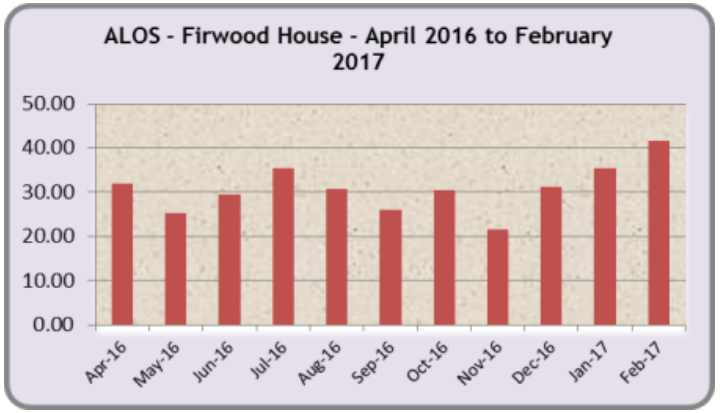
Continue with recruitment to Enhanced HIT – trajectory to be fully implemented by June 2017. HIT have seen an increase in conversion rates for Feb (DGH 64% without medically unfit).

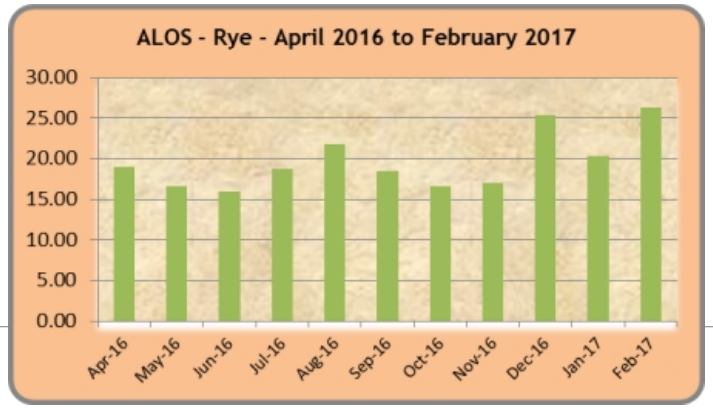
East Sussex Healthcare NHS
NHS Trust

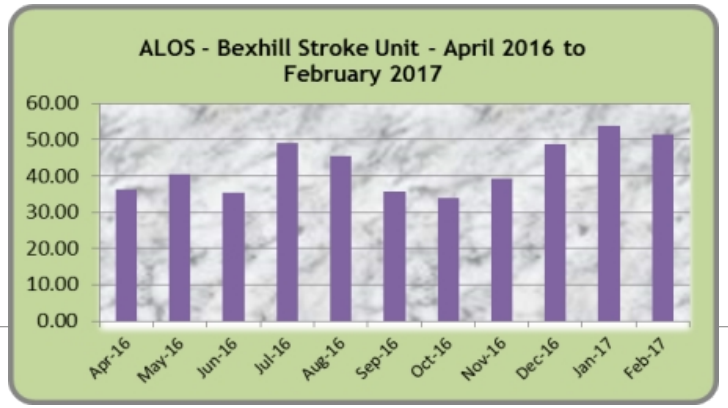
Intermediate Care

Total In Month Length of Stay (Days)	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Irvine Unit	44.20	29.43	26.36	23.32	43.93	31.84	29.23	33.82	31.94	34.65	31.88
Firwood House	31.88	25.41	29.47	35.47	30.76	26.00	30.53	21.68	31.29	35.43	41.57
Rye Memorial Care Centre	18.96	16.63	15.88	18.70	21.76	18.52	16.63	16.96	25.33	20.33	26.26
Bexhill Stroke Unit	36.44	40.33	35.50	49.00	45.46	35.60	34.06	39.25	48.80	53.75	51.55
Total YTD ALOS (average excludes Bexhill Stroke Unit)	**31.83**	**23.52**	**23.86**	**25.83**	**32.15**	**25.46**	**25.46**	**24.15**	**29.52**	**30.14**	**33.24**

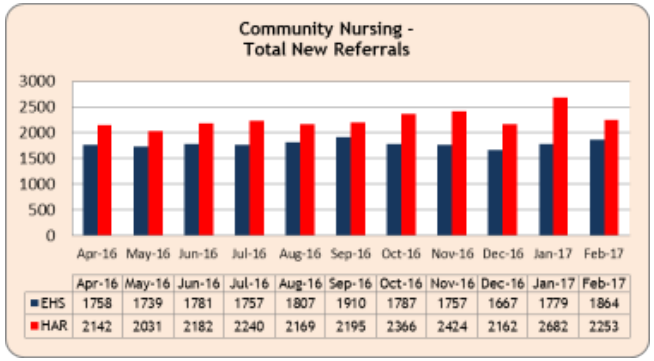




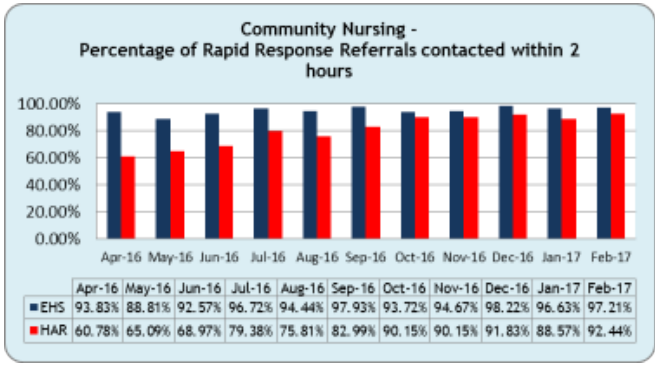




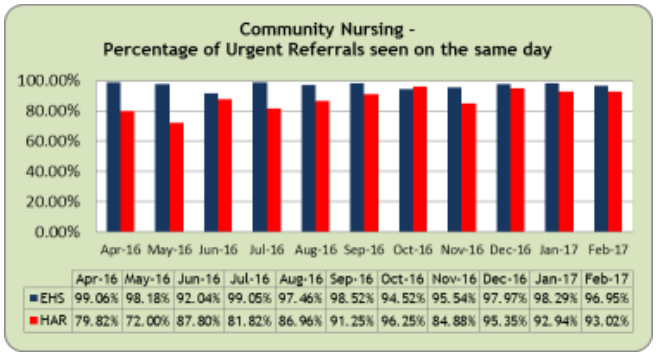
Community Nursing:



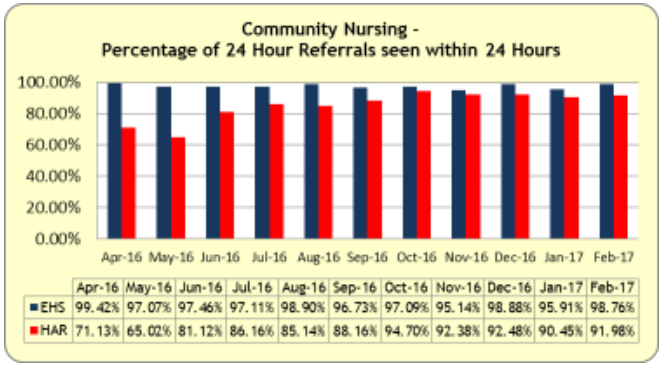
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
EHS	1758	1739	1781	1757	1807	1910	1787	1757	1667	1779	1864
HAR	2142	2031	2182	2240	2169	2195	2366	2424	2162	2682	2253



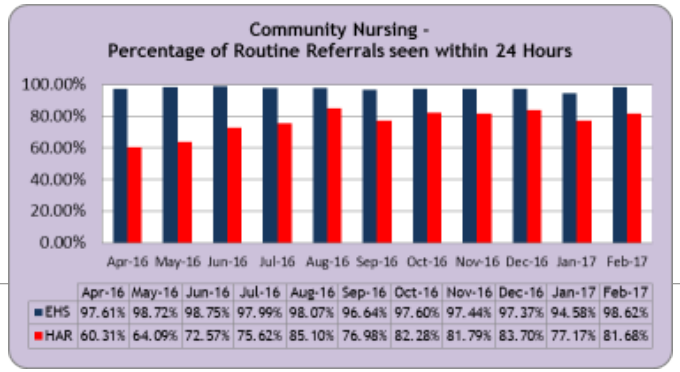
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
EHS	93.83%	88.81%	92.57%	96.72%	94.44%	97.93%	93.72%	94.67%	98.22%	96.63%	97.21%
HAR	60.78%	65.09%	68.97%	79.38%	75.81%	82.99%	90.15%	90.15%	91.83%	88.57%	92.44%



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
EHS	99.06%	98.18%	92.04%	99.05%	97.46%	98.52%	94.52%	95.54%	97.97%	98.29%	96.95%
HAR	79.82%	72.00%	87.80%	81.82%	86.96%	91.25%	96.25%	84.88%	95.35%	92.94%	93.02%



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
EHS	99.42%	97.07%	97.46%	97.11%	98.90%	96.73%	97.09%	95.14%	98.88%	95.91%	98.76%
HAR	71.13%	65.02%	81.12%	86.16%	85.14%	88.16%	94.70%	92.38%	92.48%	90.45%	91.98%



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
EHS	97.61%	98.72%	98.75%	97.99%	98.07%	96.64%	97.60%	97.44%	97.37%	94.58%	98.62%
HAR	60.31%	64.09%	72.57%	75.62%	85.10%	76.98%	82.28%	81.79%	83.70%	77.17%	81.68%

2020 Metrics

2020 METRICS

East Sussex Healthcare NHS
NHS Trust

2020 Metrics: Safety & Quality

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	This Yr	Last Yr	Var	
Total patients safety incidents reported	M	1054	1078	1012	1499	1799	1786	1396	1241	1396	1307	1236	1247	978	21.6%	16051	10868	32.3%	
Total Non-ESHT patients safety incidents reported	M	319	243	148	168	145	164	136	130	151	177	150	148	85	74.1%	2079	1322	36.4%	
Falls Assessment Compliance	M	92.2%	93.9%	89.6%	91.4%	92.5%	85.2%	90.3%	85.6%	85.3%	90.9%	88.9%	91.8%			90.2%			
Pressure Ulcer Assessment Compliance	M	93.4%	86.0%	87.5%	92.0%	86.7%	94.0%	91.2%	95.8%	94.4%	96.3%	93.2%	92.1%			91.5%			
No of MRSA cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	-4	
No of CDI cases	4	2	7	7	2	6	3	4	2	0	0	2	0	5	-5	35	48	-13	
No of MSSA cases	0	2	0	2	1	0	4	1	1	0	0	0	0	1	-1	11	7	4	
Mixed sex accomodation breaches	0	0	7	0	0	0	0	0	0	0	20	0	0	0	0	27	130	-103	
No of complaints reported	R	75	55	58	46	56	53	53	54	50	62	41	55	55	0.0%	658	703	-6.8%	
All ward moves	M	2303	2344	2265	2313	2304	2280	2210	2194	2316	2389	2114	2317	2331	-0.6%	27349	27325	0.1%	
Night ward moves	M	470	434	409	416	445	399	375	407	433	391	407	387	512	-32.3%	4973	5422	-9.0%	
Crude Mortality Rate	M	2.0%	1.7%	1.5%	1.4%	1.4%	1.4%	1.9%	1.5%	2.1%	2.7%	2.1%	1.7%	2.3%	-0.6%	1.8%	1.8%	0.0%	
HSMR (CHKS)	100	100	109	104	104	102	102	101	100	99									
SHMI (CHKS)	100	100	71	77	80	75	85	72	74	64	0								

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
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	Yr	Last Yr	Var	
A&E Performance (4 hour wait)	95.0%	83.9%	85.0%	83.2%	82.6%	79.5%	80.5%	78.1%	82.4%	77.6%	73.4%	76.1%	80.7%	79.0%	1.7%	80.3%	88.1%	-7.8%	
A&E 12 Hour trolley waits	0	0	0	0	0	1	0	2	0	0	0	0	0	0	0	3	1	2	
A&E Unplanned re-attendance	5.0%	3.3%	3.3%	2.8%	3.0%	2.9%	3.0%	3.1%	3.0%	3.0%	3.2%	2.7%	3.1%	3.0%	0.2%	3.0%	3.1%	-0.1%	
A&E Time to Initial Assessment (% Ambulance conveyances within 15 minutes)	M	94.3%	93.1%	90.7%	91.8%	90.1%	90.6%	89.6%	92.1%	90.1%	89.9%	81.7%	79.7%	88.5%	-8.9%	89.5%	94.5%	-5.0%	
A&E Time to Treatment (% within 60 Minutes)	M	47.0%	40.1%	36.6%	36.8%	36.7%	38.8%	39.5%	43.5%	41.6%	45.4%	48.5%	43.0%	42.0%	1.0%	41.3%	49.6%	-8.3%	
A&E Left before seen	5.0%	2.1%	2.2%	1.3%	1.4%	1.4%	1.2%	1.2%	1.5%	1.8%	1.8%	1.0%	1.3%	2.7%	-1.4%	1.5%	1.9%	-0.4%	
Non Elective Conversion Rate	M	26.5%	24.6%	25.1%	23.5%	23.4%	23.1%	24.8%	26.6%	28.2%	27.6%	27.8%	27.5%	24.8%	2.7%	25.6%	25.9%	-0.3%	
A&E Cubicle Waiters (average number per day)	M	48	51	50	51	52	53	46	47	53	56	56	50	51	-1	56	56	0	
Zero Length of Stay NEL admissions	R	656	610	595	562	521	404	519	502	555	459	451	584	556	4.8%	6418	8055	25.5%	
% Zero LOS NEL Ambulatory admissions	M	43.4%	40.5%	39.6%	38.4%	36.9%	31.5%	37.6%	35.3%	37.6%	35.6%	35.8%	38.5%	38.0%	1.5%	37.7%	42.7%	-5.0%	
Total Non Elective Beddays	M	23704	22725	21687	21989	23046	22718	22948	22622	23366	24885	22397	23192	25760	-11.1%	275279	273846	0.5%	
RTT Incomplete (%patients waiting over 18 weeks)	92.0%	90.2%	90.7%	89.5%	88.5%	87.5%	86.7%	85.7%	85.6%	85.6%	88.9%	89.3%	90.8%	90.5%	0.3%	88.2%	93.0%	-4.8%	
RTT 52 Week waiters	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	1	
Diagnostic performance (% patients waiting over 6 weeks)	1.0%	2.9%	2.7%	2.6%	2.2%	3.0%	2.5%	0.9%	1.6%	0.8%	0.9%	1.2%	1.4%	6.7%	-5.3%	98.1%	97.6%	0.5%	
Cancer 2WW standard	93.0%	96.0%	95.6%	96.5%	97.1%	97.3%	97.1%	97.2%	98.7%	98.0%	97.1%	98.4%				97.2%	91.7%	5.5%	
Cancer 2WW standard (Breast Symptoms)	93.0%	93.2%	98.5%	96.9%	95.8%	95.8%	96.9%	97.2%	98.2%	97.3%	95.5%	98.8%				96.8%	89.6%	7.2%	
Cancer 31 Day standard	96.0%	98.5%	99.4%	98.3%	97.7%	99.1%	98.8%	98.7%	99.5%	98.3%	99.5%	98.8%				98.8%	97.6%	1.2%	
Cancer 31 Day subsequent drug treatment	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%	100.0%	0.0%	
Cancer 31 Day subsequent surgery	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	100.0%	100.0%	100.0%	100.0%	94.1%				98.6%	100.0%	-1.4%	
Cancer 62 day urgent referral standard	85.0%	67.6%	68.3%	82.3%	75.3%	79.5%	72.6%	82.5%	78.3%	84.1%	78.6%	69.9%				76.5%	75.1%	1.3%	
Cancer 62 day screening standard	90.0%	100.0%	66.7%	62.5%	100.0%	88.9%	85.7%	91.7%	100.0%	100.0%	92.6%	66.7%				88.0%	78.5%	9.5%	
Delayed Transfer of Care	3.5%	5.3%	5.7%	7.0%	7.7%	8.0%	9.7%	9.7%	7.6%	7.1%	7.6%	7.6%	7.3%	9.4%	-2.1%	7.5%	7.6%	0.0%	
Outpatient appointment cancellations < 6 weeks	R	14	29	47	34	37	30	41	44	64	27	44	46	18	60.9%	457	371	18.8%	
Outpatient appointment cancellations > 6 weeks	R	1121	1033	1289	1438	1530	1302	1271	1250	1251	1184	1130	1385	1551	-12.0%	15184	14777	2.7%	

East Sussex Healthcare NHS
NHS Trust

2020 Metrics: Leadership &Culture

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	Yr	Last Yr	Var	
Trust Turnover rate	10.0%	10.3%	10.0%	10.0%	10.0%	9.8%	9.7%	9.9%	9.5%	9.7%	9.8%	10.0%	10.3%	10.6%	-0.3%	9.9%	12.2%	-2.3%	
Temporary costs and overtime as a % of total paybill	10.0%	15.0%	14.7%	15.5%	15.0%	16.2%	17.1%	16.6%	15.9%	14.9%	14.0%	14.8%	15.0%	18.7%	-3.8%	15.4%	16.9%	-1.5%	
Proportion of staff with up to date annual appraisal	85.0%	88.5%	89.8%	88.1%	86.3%	87.0%	83.2%	81.7%	79.3%	78.5%	78.8%	79.1%	79.0%	87.3%	-8.3%	83.2%	79.0%	4.3%	

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


WHAT
MATTERS
TO YOU
MATTERS
TO US
ALL

Guardian of Safe Working Hours Annual Report

Meeting information:			
Date of Meeting:	9th May 2017	Agenda Item:	10G
Meeting:	Trust Board	Reporting Officer:	Barry Phillips / Waleed Yousef

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

- Approximately half our Juniors Doctors have transitioned to new 2016 Contract TCS (117 of 240 total)
- Cost to date to the Trust in fines is £11,266
- Trend shown of reducing numbers of exception reports despite rise in numbers of juniors eligible to exception report
- 6 areas showing vulnerability to exception reporting (Orthogeriatrics, General Medicine EDGH, Urology H@N, General Medicine CQ F1 and F2, A&E EDGH)
- Work Schedule Reviews urgently needed for the above. However considerable work already undertaken to support A&E EDGH with Chief Executive and Medical Director input. A new rota is now in place and thus A&E EDGH is now an example of a good outcome for this process.
- Recognition that Rotations set at 45-46 hrs per week do not generate fines as seen in other trusts. All rotations requiring work schedule reviews are very close to the 48 hours per week limit and thus inclined to breach incurring the fines seen.

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

- People & Organisational Development Committee, 30th March 2017

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

a) Acknowledge goals should be to target 45-46 hours per week average for the above rotas
b) Understand that the Guardian admin support is approaching a vulnerable phase. Full support is needed in the area to continue this vital role effectively.
c) Recognize that exception reporting fines are considerably higher than locum and bank rates but that this process appears to be associated with lower cost than the previous banding system.

Guardian of Safe Working Hours - Annual Report

1.0 Purpose

The purpose of this report is to provide an overview to the Trust Board by the Guardians of Safe Working Hours on the Annual report which was presented and reviewed by the People and Organisation Development Committee in March 2017.

2.0 Background

The New 2016 Junior Doctors Contract came into effect on 3rd August 2016. Implementation guidance has been published by NHS Employers who also established a national transition timeline which has been monitored weekly.

ST3 Doctors in Obstetrics and Gynaecology transitioned on 5th October 2016 and Foundation Doctors transitioned on 7th December 2016. Trainees also transitioned in February and April 2017, all remaining Trainees will transition between August and October 2017.

Number of doctors / dentists in training at ESHT	240
Number of doctors / dentists in training on 2016 TCS as at 5/4/17	117

Safe Patient Care, Safe Working Hours and the achievement of Education Outcomes are the primary objectives of the new contract. To ensure this, the Trust is required to provide the following:-

- A personalised Work Schedule which details the educational outcomes of their rotation
- A personalised Work Pattern which details their rota
- A Mechanism by which Trainees can report exceptions to their Work Schedule or Work Pattern
- Appointment of a Guardian of Safe Working Hours (GOSWH)
- Establish a Junior Doctor Forum

Trainees have been provided with the necessary contractual paperwork. The Trust has implemented DRS; software which develops rota's, provides the platform for trainees to exception report and supports central monitoring and review of exception reports. Two Guardians of Safe Working Hours have been appointed and the Junior Drs Forum has been established with two meetings held to date. The Local Negotiating Committee have also been kept abreast of the implementation and of any issues of concern.

3.0 Exception Reporting

Trainees can exception report for breach of working hours or for educational reasons. Training and information on Exception Reporting have been provided to trainees and they have been given the opportunity to meet and discuss areas of concern with both Medical Staffing and GOSWH.

3.1 Exception Reporting Working Hours

If a trainee exception reports for working hours this is reviewed by their education supervisor who will either approve Time Off In Lieu (TOIL) or will authorise payment for the additional hours worked.

The following table indicates the number of exception reports and the payments made to Drs as a result of exception reporting. The number of exceptions reports have decreased per month whilst the number of trainees entitled to exception report has increased. The main causes of breaches in working hours are additional workload and rota gaps. The cost to date to the Trust is £11,268K

Month	No of Drs Eligible to Submit ER	No of Drs Who Submitted Exception Report	No of ER Processed for Payment by Month	Total Hrs Paid at Basic Rate	Total £ Paid at Basic Rate	Total Hrs Paid at Enhanced Rate	Total £ Paid at Enhanced Rate	Total Hours Paid Overall	Total Cost of ER
Jan	86	14	76	102.75	1955.04	6	195.08	108.75	2150.12
Feb	86	27	173	188.65	4574.63	18	592.74	206.65	5167.37
March	95	17	90	114.65	2729.42	19.25	641.09	133.9	3370.51
April	117	9	19	13.25	342.10	6.5	228.42	19.75	580.52
									11,268.52

3.2 Working pattern reviews and GOSWH Fines

Where there is a pattern of working hours breaching 48 hours over the rota reference period the GOSWH will issue fines to the Divisions for these breaches, this also triggers a working pattern review. The money from the fines is placed in a fund for the support of trainees.

The table below details the fines issued to date.

Division	Grade	Rota No	Breach Time	Total Fines	No of Trainees on Rota	No of ER Received	No of Drs on Rota who submitted Exception Reports	Exception Report Nos for Education Issues
Othogeriatrics	F1	24353	60 mins	2,247.61	4	43	4/4	1
GM (EDGH)	F1	24333	12 Mins	2,009.36	16	133	8/16	3
Urology (H@N)	F2	24336	30 mins	1,744.60	13	30	4/13	7
GM Conquest	F2	24340	12 mins	800.93	16	18	3/16	0
GM Conquest	F1	24331	60 mins	527.63	8	37	4/8	0
A&E (EDGH)	F2	24339	45 min	83.11	9	36	3/9	0
				7,413.24				11

Due to ongoing safety concerns work pattern reviews will be undertaken for:-

- Orthogeriatrics
- General Medicine EDGH FY1

- General medicine Conquest FY1 and FY2

Due to the Trust approving the recruitment of six LAS FY2 Drs for the ED department, a new rota is already in place and will not require a Work Pattern review.

3.3 Exception Reporting Education Provision

To date the Trust has received 11 Exception Reports, raised because of education issues these have been dealt with in a robust manner. Failure to deliver our contractual educational commitments could result in the deanery withdrawing trainees from the trust.

Rota No	No of Exceptions Reports	No of Drs who Submitted
24336	7	2
24353	1	1
24333	3	1

4.0 Action taken to address issues

The GOSWH have analysed The Exception Report downloaded from DRS which provides specific data as to why Trainees are submitting Exception Reports.

The GOSWH have identified trends and discussed areas of concern with Clinical Supervisors and Divisional Leads.

The GOSWH have met and discussed concerns relating to the data with both Trainees, Clinical Supervisors and Chiefs of Division and where necessary the GOSWH have recommended preventative measures to the Division to prevent further Exception Reporting in the Division.

Recommendations have been made to the Medical Director and CEO with a view to implementing the main trainee rotation in August 2017.

The GOSWH will address the issue of Fines and Work Pattern Reviews at the Next Junior Doctor Forum which is due to be scheduled on 7th of June 2017.

Junior Doctors will be engaged in the process of Rota Design enabling them to better understand the function and the operational constraints of providing service within the parameters of the new contractual rules.

5.0 Risks & Concerns

The Guardians are pleased with the engagement of the trust management at the senior level with the problems that have risen in the Emergency Department rota because of the new Terms & Conditions of Service (TCS) for junior doctors. The approval of six new posts allowed the safe implementation of the new rota. Preliminary verbal reports suggest that juniors' working hours is safely compliant.

5.1 Medical Staffing Capacity and Capability

GOSWH are mindful of the additional Band 4 support role that will be appointed to support the Medical Staffing adviser. They remain concerned as to the capacity within medical staffing to deliver and support the transition and if this will be adequate when the contract is embedded. The GOSWH are of the view that there is a need for additional support over the next 6 months when new trainees rotate and commence in their new posts August – October 2017.

Evidence has shown that both Trainees, Educational Supervisors and GOSWH have required significant support in understanding the new TCS and using the technical aspects of DRS. The GOSWH are concerned that there is no contingency or succession planning in respect of supporting the on-going requirements of the new 2016 Junior Doctor Terms and Conditions of service.

5.2 Exception Reporting Approval

The GOSWH recognize that there are some delays in response to Exception reports by Educational Supervisors. Also, the Clinical Supervisors are not always aware of the exception reports that are raised by their trainees. The Guardians are keen to implement delegated responsibility for approving Exceptions Reports to the Clinical Supervisors. The Guardians are currently having talks with the Director of Medical Education and Medical Director to find a solution. If this is not resolved ensuring that exceptions reports are reviewed and approved will continue to require additional follow up, the trainees will feel that the Trust is not meeting its contractual obligations and the Divisional leads and managers will not have transparency on the additional working hours paid for.

5.3 Operational Issues Impacting on Working Hours

The increase in patient demand, which has led to additional clinical areas being open through the winter without additional medical staff, has led to an increased workload. This has also been exacerbated by the vacancy levels, and has led to complaints by juniors of the high work load for the available number of doctors.

6.0 Conclusion

The Guardian role has been well received and supported by juniors and very senior ranks of management. We have been exceptionally well supported by the Chief Executive and Medical Director. There is still a level of distrust within clinical leads who often see the Guardians as interfering. Exception reporting has highlighted a number of rotas that need urgent work schedule reviews as defined by the 2016 contracts TCS. We are still in the bedding down phase, as educational supervisors adjust to the new reporting system and the implications it has on their workload (which has increased). The dynamic between Guardians, Director of Medical Education, Educational Supervisors and Clinical Supervisors is settling down. There is more education needed (despite considerable efforts so far) for Educational supervisors and Clinical supervisors to understand their significant contribution to the process. In time better communication will occur between educational and clinical supervisors to drive early work schedule reviews and thus prevent exception reports (with their associated fines). At this point however, we need the Board to support this drive for work schedule reviews until this occurs naturally.

It has been interesting to see that despite an early surge in exception reports that this trend has reduced despite the increased number of doctors transiting to the new contract.

Evidence from other trusts has shown that by targeting lower baseline work schedules at 45-46 hrs/wk has effectively removed fines. They however do not struggle with the high vacancy rate we do.

On the positive side the new contract (with the exception reporting mechanism) appears to be delivering a better set of working conditions for some of our trainees. It continues to deliver a more rapid dynamic system of highlighting areas of difficulty within our Trust. This can only serve to improve quality to our doctors in training and patient safety. However, how the Trust manages to support the gaps in the rotas that this 2016 contract has created will continue to

burden the Trust as it tries to find ways to acquire more doctors. This is reflected by our high locum and agency spend.

7.0 Recommendations and Requests based on this report

7.1 Acknowledge goals should be to target 45-46hr/wk average for the above rotas

7.2 Understand that the Guardian Admin support is approaching a vulnerable phase. Full support is needed in the area to continue this vital role effectively.

7.3 Recognize that exception reporting fines are considerably higher than locum and bank rates but that this process appears to be associated with lower cost than the previous banding system.

ESBT Update

Meeting information:			
Date of Meeting:	9th May 2017	Agenda Item:	11
Meeting:	Trust Board	Reporting Officer:	Catherine Ashton

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 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

As previously discussed an Alliance Agreement has been entered into with our Partners

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

None

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

Assurance that the Board are satisfied with the ongoing development of the Accountable Care Model in East Sussex

East Sussex Better Together (ESBT) Alliance
Accountable Care Development Group - Briefing no: 3

In July 2017 the ESBT Alliance partners will be recommending options for the best vehicle to deliver our ESBT objectives of high quality, effective care for the population covered by the ESBT footprint.

The ESBT Accountable Care Development Group has been tasked with carrying out an appraisal of the options available. The group brings together key stakeholders with leads from each partner within the ESBT Alliance: Eastbourne, Hailsham and Seaford & Hastings and Rother CCGs, East Sussex County Council, East Sussex Healthcare NHS Trust, and Sussex Partnership Foundation NHS Trust.

The purpose of this briefing is to share key actions agreed at the meetings of the Accountable Care Development Group in order to keep everyone informed of progress. Briefings are circulated following each meeting for use by ESBT Alliance partners.

April sees the start of an exciting year as we formally launch the East Sussex Better Together (ESBT) Alliance.

The ESBT Alliance, which aims to bring together primary prevention, primary and community care, social care, mental health, acute and specialist care, will begin a test year to look at the most effective ways of working together to provide the best and most sustainable services for local people.

The ESBT Alliance partners agreed to form an alliance arrangement in 2017/18 as a test year to operate 'as if' we are an accountable care system, while remaining separate organisations. An alliance agreement, together with an integrated strategic investment plan and governance structure, is being put in place to test new ways of working and improve services for residents in 2017/18 and in the longer term.

Forming an alliance partnership will help us to spend our funds more wisely and target our resources and services more effectively. It will also help us to progress development work to understand what the best vehicle will be to deliver our aims in the future.

The next steps for April are:

- Commence the alliance arrangement and adoption of the new governance structure.
- Take our collaboration to new levels to further improve and deliver services, test the new approach and understand the impacts.
- Begin an appraisal of the options for organisational form for the future ESBT accountable care model after the 2017/18 test year. This will go to our individual sovereign organisations in July 2017, together with an understanding of what the staff arrangements are likely to look like, and a roadmap for implementation.

For more information please contact: Vicky Smith, Accountable Care Strategic Development Manager, ESBT / Vicky.smith@eastsussex.gov.uk
Date: 6th April 2017

NHS Hastings and Rother Clinical Commissioning Group
NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Group
Sussex Partnership NHS Foundation Trust
East Sussex Healthcare NHS Trust
East Sussex County Council

Quality and Safety Strategy

Meeting information:	
Date of Meeting: 9 May 2017	Agenda Item: 12
Meeting: Trust Board	Reporting Officer: Alice Webster

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

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

Executive Summary:

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

Our East Sussex Healthcare NHS Trust Quality and Strategy provides a framework through which improvements in the services we offer to patients can be focused and measured. We have taken time to listen to our patients, public and staff about the things that really matter to them and within this strategy, address those issues through clear objectives over a four year period.

The Quality and Safety strategy is supported by a strong organisational philosophy of changing culture and improving services to meet our patient's needs, thus continuing to make our Trust, the healthcare provider of choice both for commissioners and the patients and communities we serve.

The aim of this strategy is to detail the quality and safety plans for the next 3 years to ensure the achievement of the trust ambition to become an outstanding organisation by 2020. This strategy will cover the 3 years (2017 – 2020) but will be reviewed on an annual basis.

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

Patient Safety and Quality Group – 15 February 2017
Quality and Safety Committee – 28 March 2017

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

To approve the Quality and Safety Strategy and that the monitoring of this programme will be through the Quality and Safety Committee

East Sussex Healthcare NHS
NHS Trust

Quality and Safety Strategy

2017 - 2020

Vision statement

"ESHT combines community and hospital services to provide safe, compassionate, and high quality care to improve the health and wellbeing of the people of East Sussex."

Our East Sussex Healthcare NHS Trust Quality and Strategy provides us with a framework through which improvements in the services we offer to patients can be focused and measured. We have taken time to listen to our patients, public and staff about the things that really matter to them and within this strategy, address those issues through clear objectives over a four year period. The Quality and Safety strategy is supported by a strong organisational philosophy of changing culture and improving services to meet our patient's needs, thus continuing to make our Trust, the healthcare provider of choice both for commissioners and the patients and communities we serve.

1. Purpose of this Quality and Safety Strategy

The aim of this strategy is to detail the quality and safety plans for the next 3 years to ensure the achievement of the trust ambition to become an outstanding organisation by 2020. This strategy will cover the 3 years (2017 – 2020) but will be reviewed on an annual basis. This will be implemented across all the Divisions which are Out of Hospital, Medicine, Diagnostics Anaesthetics and Surgery, Women Children and Sexual Health.

To be rated as an outstanding organisation by the Care Quality Commission we need to continually improve our quality of care and safety for our service users. Lord Darzi defined quality within the NHS as having three domains which are:

- Safety (avoiding harm from the care that is intended to help);
- Effectiveness (aligning care with science and ensuring efficiency);
- Patient-experience (including patient-centeredness, timeliness and equity).

This strategy will detail specific aims and objectives along with plans to improve quality and safety for each of the domains.

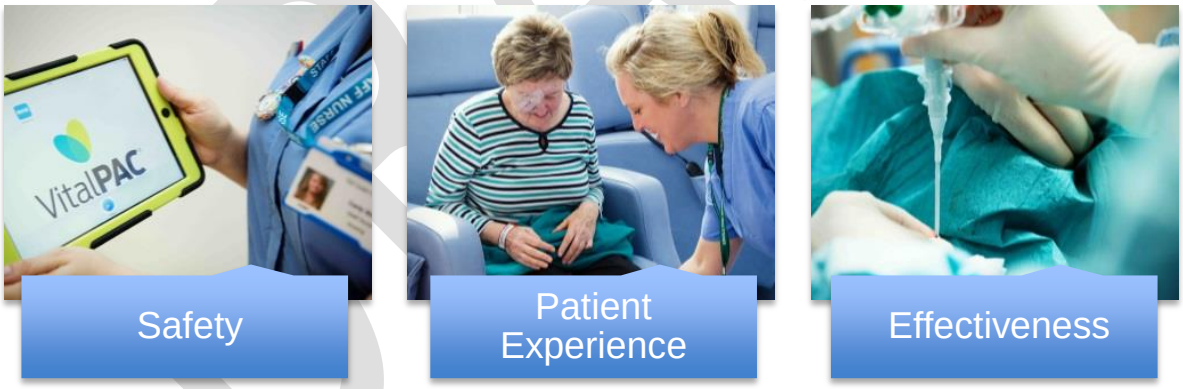


Figure 1 – Quality is made up of three components: Safety, Patient Experience and Effectiveness

2. Strategic Objectives

To support the Trust vision there are 5 Key Strategic Objectives (KSO's):

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 fulfill 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.

Although aspects of all the Key Strategic Objectives will be supported through this strategy, the specific safety and quality area identified within the 2020 Strategy (see diagram below) will be addressed. This strategy will detail actions and ensure they are measured in order to drive forward the delivery of quality and safety. Other strategies will cover the four other areas but there will be some crossover between them.

Figure 2 - Five key areas to support delivery of ESHT 2020

3. Safety principles to deliver this strategy and improve quality and safety

The aims and subsequent actions for the domains will require investment from the following approach as outlined within the Don Berwick report "A promise to learn– a commitment to act":

Safety Principle	Trust Actions
Learning	We need to be a listening and learning organisation to act on findings swiftly to reduce potential for harm and therefore improve quality and safety. We will learn from incidents, complaints, claims external reviews, audits, service changes and clinical reviews and act on findings.
Leadership	Investment in the trust values and development for trust leaders
Patient and Public Involvement	Development of an effective Public Engagement and patient experience Strategy that involves patients and public with strategy and ongoing service delivery from the floor to Board.
Staff investment and training	Ensuring recruitment and retention effective and provides the right number of staff to deliver safe care. Develop staff across the organisation and embed a positive culture through listening and engagement. Provide staff with improvement skills and support to embed a culture of continuous improvement across the organisation.
Measuring progress	Establish robust measuring of quantitative and qualitative data and act on findings.
Structures and monitoring	• Trust Integrated Performance Dashboard that incorporates key performance indicators within each of the five key areas. These are reported to the Trust Board; • Within the Quality and Safety area the dashboard monitors the same indicators at ward/department, Division and Trust level providing the opportunity to analyse progress and identify hot spots. This is known as the Floor to Board Dashboard; • An effective committee structure with regular progress reports for all aspects of quality and safety (see the Risk and Quality delivery strategy) • Each Division has Risk and Governance meetings with a monthly performance review with the Executive Team to review all their performance data including their quality KPIs; • Collaborative work with our Clinical Commissioning Groups with performance and quality groups in place to review and test quality. • Tracking and reporting progress through the Quality account priorities and the 2020 high level metrics

4. Delivery of the Strategy

This section describes the core aims and the deliverables to achieve outstanding Quality and Safety by 2020. This has been split into Safety, Patient Experience and Effectiveness.

4.1 Safety

Strategic Ambition
1. No preventable deaths 2. Continuously recognise and reduce harm
High Level Key Deliverables
1. Reduction in Trust preventable infections 2. Reduction in complications e.g. Sepsis, Acute Kidney Infection, pressure sores, VTE. 3. Improve Patient Flow (developing the Red2Green programme) (QA Priority) 4. Achieve 7 day working standards 5. Improve identification and management of deteriorating patients 6. Implement safety huddles (QA Priority) 7. Full compliance with medication reviews and controlled drug checks 8. Continue to create open culture for incident reporting and Duty of Candour 9. Clinical reviews conducted by Consultant for all new admissions within 14 hours 10. Improved incident reporting for Junior Doctors and Consultants 11. Improved learning from death reviews (QA Priority) 12. Reduction in harm (Sign up to safety) 13. Develop Quality Improvement Hub 14. Leadership and management training and support

4.2 Patient Experience

Strategic Ambition
1. Work in partnership with patient and public to develop and improve services 2. Learn and respond from feedback with patients and public
High Level Key Deliverables
1. Reduction in patient complaints through learning from previous experiences 2. Respond to timescales for patient complaints within 30 and 45 days (QA Priority) 3. No mixed sex breaches or privacy and dignity complaints 4. Minimised number of patients transferred from ward to ward 5. Increase Friends and Family Response rates for all areas 6. Increase Friends and Family score for all areas 7. Empower women to remain independent, active partners in their maternity care 8. Deliver End of Life Care Strategy to ensure compliance with “Priorities for care of the dying person” (QA Priority) 9. Develop and enhance public and patient engagement strategy 10. Establish patient feedback forums (QA Priority) 11. Patients receive senior review 7 days per week (Red2Green)

4.3 Effectiveness

Strategic Ambition
1. Outcome measures developed for each specialty and used for clinical improvement 2. Establish and embed clear improvement and tracking programme for clinical departments 3. Listen and learn from incidents and complaints
High Level Key Deliverables
1. Monitoring of clinical performance 2. Service based job planning 3. Deliver consistent high evidence based quality care 4. Establish a department accreditation programme (QA Priority) 5. Develop outcome measures for each specialty 6. Review appropriateness of local clinical audit programme and link to ESHT accreditation 7. Ensure compliance with NICE guidance appropriate to ESHT 8. Learning from Incidents and complaints

4 Where does the Quality and Safety Strategy sit in the Trust's quality structures?

The Quality and Safety Strategy needs to be understood and embraced by everyone within the organisation. The table below demonstrates the relationship between this strategy and the other related quality documents within the Trust. The key feature of the Quality Strategy is that it is the high level plan of how ESHT is going to improve the quality of services it provides to its population.

ESHT 2020 Strategy	Sets out the direction for clinical services provided by ESHT
ESHT Trust Objectives	Set the overall strategic direction of the Trust
Quality Strategy	Sets out the strategic patient safety, clinical effectiveness and patient experience aims for the Trust
Divisional, service, team and individual staff quality objectives	Sets out the annual quality objectives throughout the Division down to individual staff level
Quality Account	Evaluates progress made against annual objectives and defines the annual quality objectives for the year ahead
Risk and Quality Delivery Strategy	This will describe the Trust governance processes that will support the delivery of the programme
Workforce Strategy	This will ensure we commission training to develop staff who are skilled to deliver new models of care, and we have enough staff with the right skills
Leadership and OD strategies	This will ensure Quality and Safety underpins the values and culture of ESHT

5 Roles and Responsibilities to deliver the Strategy

Role	Responsibility
Chief Executive	The Chief Executive has overall responsibility for Quality Governance, continuous quality improvement and the delivery of high quality care for all. The Chief Executive has delegated this responsibility to two Executive Leads for Quality, risk and patient safety; the Director of Nursing and the Medical Director. Both Executives are responsible for reporting to the Board of Directors on the progress of quality, safety and quality improvements and for ensuring the Quality Strategy is implemented and evaluated effectively. The Deputy Medical Directors, Associate Director of Governance, Deputy Directors of Nursing and their teams, support the Executive leads for Quality.
Medical Director	The Medical Director is the joint Executive Lead for Safety and Risk. The Medical Director leads on the delivery of domain one, two and three of the NHS outcomes framework, preventing preventable death and enhancing quality of life, helping people recover form illness. The medical director chairs the trusts Clinical Outcomes Group which contributes to the development of the quality strategy and achievement of the quality improvement plan.
Director of Nursing	The Director of Nursing is the joint Executive Lead for Safety, Risk and Patient Experience and is the trust Director for Infection Prevention and Control (DIPC). The Director of Nursing leads on the delivery of domain four and five of the NHS Outcomes Framework; ensuring a positive experience of care and providing a safe environment and protect from harm.
Executive and Non-Executive Directors	The Executive Directors are responsible and accountable for ensuring that the Directorates are implementing the Quality Strategy and related policies to provide assurance via key reports and indicators to the Quality and Safety Committee and Integrated Performance Review via the performance management process.
Non-Executive Directors	Non-Executive Directors have a responsibility as part of the Board of Directors to ensure the Quality Strategy, supporting structures and processes are providing them with adequate and appropriate information and assurances related to quality, safety and risks against the Trust's objectives
Executive Directors	Executive Directors provide leadership for the performance management of the systems in place for assuring the effective governance of quality and safety.

Role	Responsibility
Directorate Teams	Clinical and Non Clinical Directors, Service and General Managers and Matrons are accountable and responsible for ensuring appropriate quality governance processes are implemented within their clinical areas. Each is required to: • Lead and implement the Quality Strategy and annual quality report priorities, Risk Management Strategy and related policies. • Ensure activity is compliant with Care Quality Commission regulations and that services are; safe, effective, caring, well led and responsive to people's needs. • Develop a clear vision for service development and quality improvement which reflect the quality priorities of the trust and improves the management of risk and safety. • Maintain a Directorate risk register and escalate significant risks to the Executive team as per the Risk Management strategy and related policies. • Ensure a Directorate workforce, education & training, supervision, leadership development plan and appraisal system is in place and reviewed regularly. • Ensure the Directorate participates in the annual clinical audit plan to provide evidence of good patient outcomes and good practice. • Ensure all related policies, protocols and guidance are up to date in line with theTrusts document control procedure. • Report and monitor progress through the use of key quality indicators and performance measures which are reviewed and challenged at the performance meetings with the Executive team. • Ensure all patients receive a Friends and Family test (FFT) tool is completed on discharge, and demonstrate that they are actively seeking patient feedback through a variety of means, and listening and responding to this feedback.

Role	Responsibility
Matrons/Clinical leads and ward/departmental managers	Matrons/Clinical leads and ward/departmental managers are responsible for providing effective leadership and ensuring patients receive safe, effective, compassionate and dignified care in line with the CQC standards, the ESHT values and behaviours within the clinical area. • Develop good multidisciplinary team working and networks to ensure patients receive good quality care. • Progress will be monitored through meetings with line manager, accreditation, performance meetings and Executive Safety and Quality walkabouts • Lead and/ or implement ward and departmental accreditation quality development plans using information to analyse the quality of service provision acting upon this analysis to make improvements and learning from patient feedback.
Individual staff	• Our values are fundamental to how we undertake our work. They shape our beliefs and our behaviours and were developed by members of staff, and all staff are expected to work to them. • All staff are responsible for ensuring they provide high quality care to all patients and treat them with respect, dignity and compassion working in compliance with professional registration requirements and local standards of practice and in line with CQC standards, the ESHT values and behaviours within their area of responsibility • Work as part of a multidisciplinary team to ensure patients receive good quality care. • Contribute to the progress of the quality priorities, service development plans and comply with related policies to ensure patients receive good quality care reporting risks to quality and safety to the line manager. • Undertake mandatory training and education appropriate to role and have an annual appraisal and development plan meeting with the line manager. • Comply with Trust policies, procedures and guidelines to protect the safety and wellbeing of patients and contribute to the related audit programmes. • Understand key quality indicators, performance measures and patient feedback for their area and be involved in quality improvement initiatives and where appropriate clinical audit and research programmes.

Leadership and Talent Management Strategy

Meeting information:			
Date of Meeting:	9th May 2017	Agenda Item:	13
Meeting:	Trust Board	Reporting Officer:	Monica Green

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 is a new strategy that will provide a systematic approach to Leadership and Talent Management across the Trust. Links to the recently published national leadership strategy, consideration of the anticipated requirements of the well led domain and also the overall vision and short, medium and long term objectives of the Trust have been reflected in the strategy.

The strategy outlines:

- The Trust's expectations of all leaders now and in the future linked to Trust values and key leadership behaviours
- Provides a pathway of development and support for all leaders to lead effectively
- Outlines the approach to talent management and succession planning to enable identification of existing and emerging talent

The strategy is supported by an action plan to ensure delivery and once approved, the Staff Engagement team will be working with the Communications team to ensure that the key components of the strategy are shared and understood throughout the Trust.

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

People and Organisational Development Committee (POD) 30/03/17

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

The Board are asked to approve the Leadership Development and Talent Management Strategy.

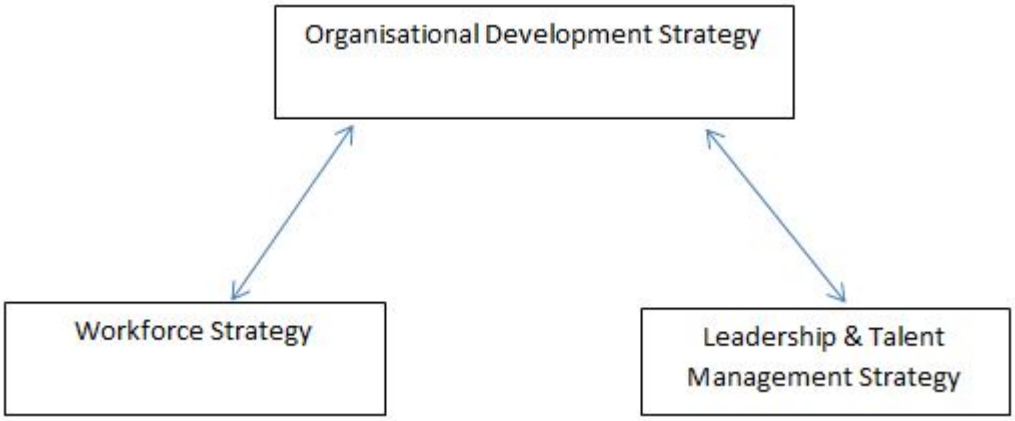
East Sussex Healthcare NHS
NHS Trust

LEADERSHIP DEVELOPMENT
&
TALENT MANAGEMENT STRATEGY
2017 – 2020

Contents

Introduction

The Leadership and Talent Management strategy sets out a framework that will provide a systematic approach to Leadership Development and Talent Management. It provides a route map, identifying our expectations and the support and development available for our leaders in order to deliver the overall vision and objectives of the Trust in the short, medium and longer term. It will form a key part of our Organisational development strategy alongside our Workforce strategy



EAST SUSSEX HEALTHCARE CONTEXT

East Sussex Healthcare NHS Trust (ESHT) employs almost 6,500 committed, skilled, caring and professional staff who deliver healthcare to a population of approximately 525,000 people. We are an integrated Trust that provides health services from two large hospitals, several smaller community hospitals and a number of local clinics, health and children's centres in addition to GP surgeries. We also provide community nursing and therapy services within patients' homes

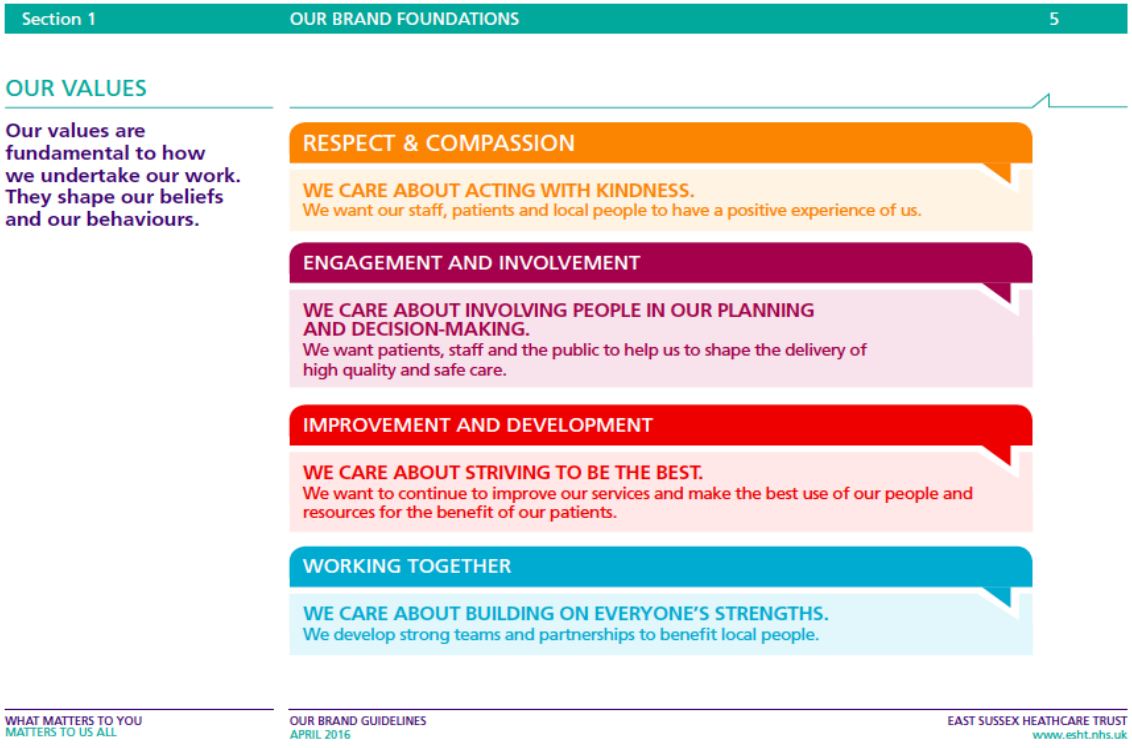
Core Principles

Our core principles or ways of working are:

- We are ambitious and aspire to excellence;
- We state clearly what we do and achieve high standards in delivering it;
- We work closely with our commissioners and social services in planning and delivering health and care;
- Services are provided seamlessly across our hospital and community settings;
- We have robust operational and financial systems.

Our Values

We must live by our values and make sure they underpin and characterise our work. If we live by our values, and make decisions and judgements based on them, we know we will be heading in the right direction. People across our organisation came together to develop these. They are the common core that binds us, whatever our role within ESHT.



ESHT 2020

ESHT 2020 sets the framework of objectives and actions that we must undertake to make ESHT into the high performance organisation that we want it to be by 2020. We have refreshed our vision and strategic objectives that were published in 2015 as follows:

- 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.
- 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.
- We will work with Commissioners, Local Authority, and other partners to plan and deliver services that meet the needs of our local population in conjunction with other care services.

- We will operate efficiently and effectively, diagnosing and treating patients in a timely fashion and expediting their return to health.

- We will use our resources efficiently and effectively, diagnosing and treating patients in a timely fashion and expediting their return to health.

This framework will be adopted across the organisation and translated into the individual work programmes in divisions, clinical units, corporate services, and cross-organisation initiatives. It will be the reference document for personal objectives, internal communications, and external communication with partner organisations and other stakeholders.

Our Trust's overarching aim is to provide safe and high quality healthcare for the people of East Sussex. We also aim to make ESHT a place in which staff are proud and happy to work and to achieve a CQC rating of 'Good' by 2017 and 'Outstanding' by 2020. The ESHT 2020 Programme provides the robust framework to deliver the outcomes to achieve these subsidiary aims within our five key areas for improvement:

- Quality and Safety
- Leadership and Culture
- Access and operational delivery
- Clinical strategy
- Financial Control and capital development

ESHT 2020 – Leadership & Culture

There will be good leadership throughout our organisation:

- A healthy, open culture of trust and confidence;
- Pride and satisfaction in our work
- Our values running through all we do
- Opportunities for development and progression for all.

We will deliver this by:

- Continuing to embed our vision, mission and values;
- Holding each other to account for our behavior, making sure we stick to our values;
- Supporting better leadership and communication within teams;
- Delivering a strategy to develop talent and leadership;
- Training line managers to deliver improved appraisals and communication;
- Giving higher priority to recruitment, linked to our values.
- Developing our medical leadership;
- Making sure our governance and management structures are clear and people understand what they are accountable for;
- Developing specific action plans to respond to issues raised in our staff surveys.

NATIONAL APPROACH TO LEADERSHIP DEVELOPMENT

In December 2016, a national framework for action on improvement and leadership development in NHS funded services was published; "Developing People – Improving Care"

The document is an evidenced based national framework to guide action on leadership development and talent management at national and local level. It calls for thoughtful action to build skills, develop current and future leaders and manage talent.

In summary, the framework identifies critical capabilities to develop as follows:

- **Systems leadership skills**
- **Improvement skills** for staff at all levels
- **Compassionate, inclusive leadership skills** for leaders at all levels.
- **Talent management** to fill current senior vacancies and future leadership pipelines with the right numbers of diverse, appropriately developed people.

It identifies five core conditions common to high quality systems that interact to produce a culture of continuous learning and improvement.

The five conditions are:

1. Leaders are equipped to develop high quality local health and care systems in partnership. Leaders of organisations in local health and care systems are able to collaborate with partners including patient leaders across organisational, professional and geographical boundaries in trusting relationships to achieve the same clear, shared system goals for their communities.

2. **Compassionate, inclusive and effective leaders at all levels**. Leaders demonstrate inclusion and compassion in all their interactions. They develop their own and their staff's skills and capacity to improve health services. They also have the specific management skills they need to meet today's challenges. Leadership is collective, in the sense that everyone feels responsible for making their bit of the system work better.

3. Knowledge of improvement methods and how to use them at all levels. Individuals and teams at every level will know established improvement methods and are using them in partnership with patients, communities and citizens to improve their work processes and systems. There are enough people able to lead improvement project teams to release the full benefits of this knowledge.

4. Support systems for learning at local, regional and national levels. There is sufficient training, coaching and organisation development capacity to meet development needs and support learning and improvement. Data and knowledge-sharing systems to support improvement and leadership development are in place and there are networks for sharing improvement knowledge and experience locally, regionally and nationally.

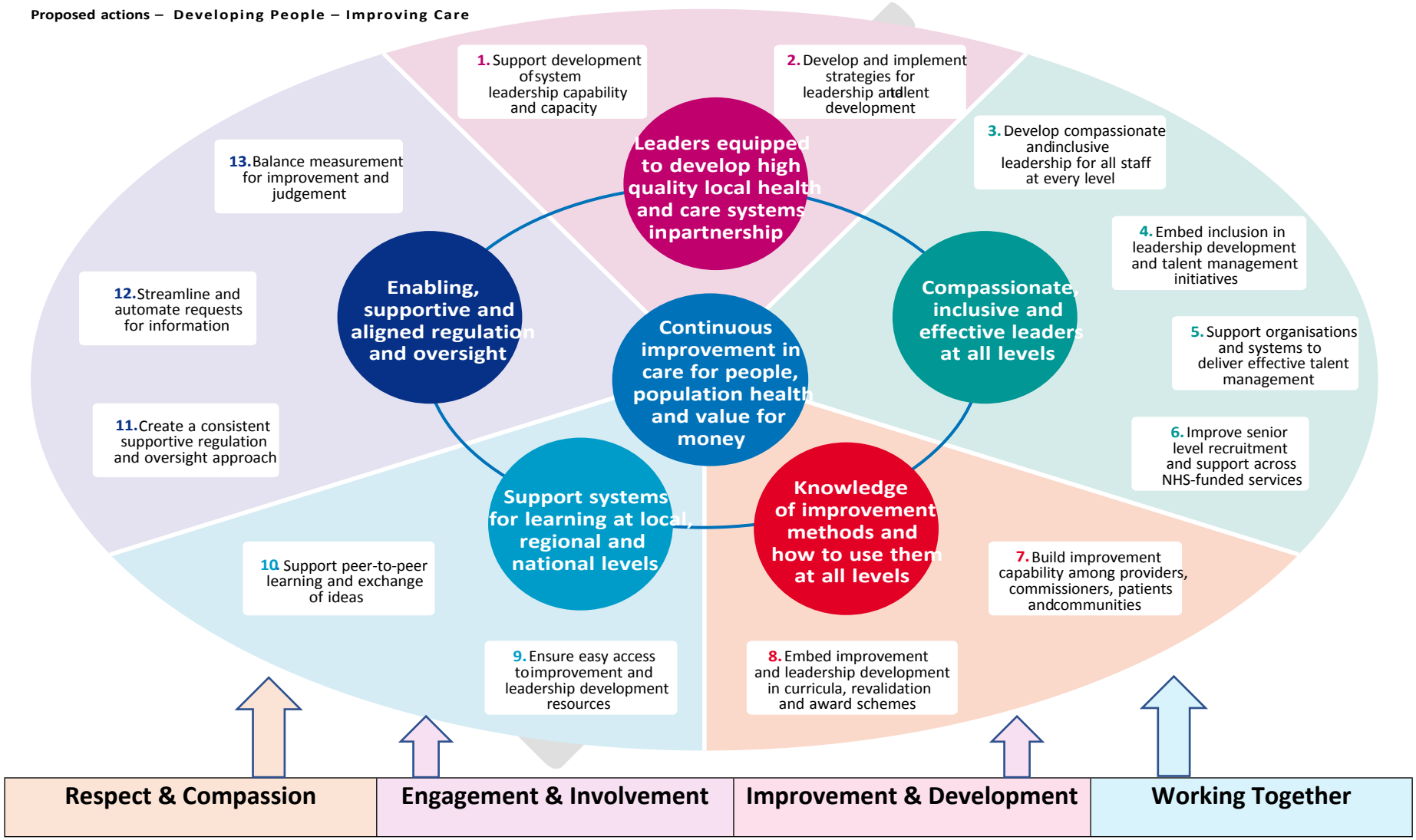
5. Enabling, supportive and aligned regulation and oversight. The regulation and oversight system gives local organisations and systems control of driving learning and improvement. At the same time, national organisations help local systems find the support and resources they need. The constituent parts of the regulation and oversight system behave consistently and 'speak with one voice'.

To create conditions 1, 2 and 3 of the framework, all teams directing NHS-funded work, from partners in the smallest general practice to boards of the largest national organisation, need to review their people development strategies and revise priorities, systems and budgets.

The principals outlined in the "Developing People – Improving Care" framework will be at the heart of our leadership and talent strategy at ESHT, together with our Trust values.

The following diagram illustrates the key drivers for delivering the "Developing People – Improving Care strategy:

Proposed actions – Developing People – Improving Care



AIMS AND OBJECTIVES OF ESHT LEADERSHP DEVELOPMENT AND TALENT MANAGEMENT STRATEGY

Aims and Objectives	What does this mean in practice
Define the leadership skills and behaviours needed to deliver sustainable services and successful transformation and innovation.	• Skills and behaviours that are based on and uphold our values. • Aligning ESHT strategy with national "Developing People – Improving Care framework
Ensure capability and capacity to lead effectively	• Training • Support • Mentoring • Management of workloads and role design
Ensure diversity in our approach and willingness to explore and embrace difference.	• Not just how we traditionally view diversity (eg. Characteristics such as race, gender etc), but also diversity of thought, extrovert/introvert etc.
Develop multi-disciplinary leadership capabilities to work across boundaries.	• Developing confidence and breaking down silos.
Identify existing and emerging talent.	• Greater use of appraisal system, feedback, and seeking out those with something to offer not just through traditional routes. • Developing talent at all levels • Developing robust successions plans
Identify appropriate resources for effective leadership and talent development.	• Ensure funding meets our aspirations. • Creating time and space to think and plan.

KEY DRIVERS FOR LEADERSHIP AND TALENT DEVELOPMENT:

- CQC Findings
- Staff Survey Findings
- Development of Values
- The move towards an Accountable Care Organisation and the need to work in a different way
- Cultural Audit Output
- Staff Feedback
- ESHT Clinical and Organisational Development strategies
- Better developed staff to have the skills to provide better patient care and services

The most recent CQC report published in January 2017 has commended the progress and substantial improvements that have been made within the Trust since the last inspection.
However there is still work to do to ensure we consistently provide high standards of care across all of our services. We must embed the improvements that have been made, and seek out every opportunity to make further improvements to achieve our ambition of being rated 'Outstanding' by 2020.

We will continue to focus on our key priorities - which include recruiting and retaining more permanent clinical staff; improving the management and flow through our hospitals of patients requiring urgent care; reducing waiting times for investigations and planned surgery; continuing to develop our community services; and achieving financial sustainability.

We will continue to develop better engagement with the people of East Sussex who use our services and with the people who work for us

The Trust will continue to collaborate closely with the County Council and our local Clinical Commissioning Groups (CCGs) in the East Sussex Better Together Alliance. Working together will enable us to develop health and care services that are designed to enable oversight of the whole health and care system from both a commissioning and delivery perspective, supporting us to act collectively in a way that delivers improvements for our local population.

It is therefore essential that we have a coordinated approach to Leadership Development for all our leaders

LEADERSHIP LEVELS:

The table below indicates the levels of leadership, and the suggested roles at these levels. It is just a general guide as to how we might stratify our staff to ensure we focus the right interventions at the right level.

Level	**Role**
Executive	CEO/Chair Board Directors Non-Executive Directors
Senior Leaders	Deputy/Associate/Assistant Directors General Managers Head of Nursing Division and Clinical Unit Chiefs/Deputy Chiefs Consultants *(Generally Band 9/8d/8c level or equivalent)*
Middle Management Level	Service Manager Department Manager Deputy Head of Nursing Ward Matron New Consultant Trust/Staff Grade Doctor *(Generally Band 7/8a/8b level or equivalent)*
Supervisory Level	Ward Sister Senior Team Leader Adviser/Officer (eg. HR Adviser/Project Officer) Senior Secretary/Administrator/Executive Assistant Senior Technician Junior Doctor *(Generally Band 5/6 level or equivalent)*
Junior Level	Junior Team Leader Healthcare Support Worker Staff Nurse Administrator Secretarial Porter/Housekeeper etc Maintenance Craftsperson Technician *(Generally Bands 1-4)*

KEY LEADERSHIP RESPONSIBILITIES:

The following diagram illustrates the key roles at the different levels of leadership throughout the Trust. The ESHT leadership development strategy will focus on ensuring that all of our managers and leaders have appropriate and timely development and support to ensure that they are equipped with the skills, knowledge and confidence to perform well and contribute fully in their roles. This will also lead to the identification of those who have the motivation and desire, together with the potential ability, to move into more complex and senior roles.

KEY LEADERSHIP BEHAVIOURS FOR ESHT:

We recognise that development of leadership skills must also be supported by ensuring that our leadership culture and behaviours at all levels in the Trust are consistent with our values. Therefore, we will ensure that:

- *ESHT values based leadership behaviours are developed, shared and embedded into our everyday practices*
- *Our leadership and management development programmes are centred around our ESHT values as well as the National Healthcare Leadership behaviours (see appendix I) and the core principals set out in the* new national Developing People – Improving Care framework

Distributive leadership will become increasingly important in the changing face of NHS organisations and for us at ESHT as we develop new models of working with the wider health and social care economy.

The traditional view of leadership tends to assume a tough, charismatic and "heroic" leader, who utilises a dictatorial approach and operates within a single organization. Recently, new 'post-heroic' ideas have emphasised the value of more collaborative and less hierarchical practices, enacted through fluid, multi-directional interactions, networks and partnerships. While these ideas about "shared", "distributed", "collaborative" and "networked" leadership are not necessarily interchangeable, they all imply a more collaborative and shared notion of power and authority.
(Centre for Excellence in Leadership, Distributed and Shared Leadership 2008)

"From a distributed perspective, leadership involves mortals as well as heroes. It involves the many and not just the few. It is about leadership practice, not simply roles and positions. And leadership practice is about interactions, not just the actions of heroes." (Spillane 2006).

We will therefore need to work closely with KSS and the national Leadership Academy as programmes emerge to support NHS organisations and in particular, the senior leaders who will work across boundaries and traditional structures to lead our NHS in the future.

ESHT Leadership Development Pathway

The following diagram outlines a draft leadership development pathway that incorporates the content, style and approach for leadership development and talent management in ESHT. This pathway is by no means exhaustive – it simply gives an indication of what type of development is considered essential for ESHT leaders, together with opportunities for development at various levels of leadership throughout the careers of our staff working in the Trust. More detail can be found in appendix

ESHT Leadership Development Pathway	Aspiring Leaders / Emerging Talent Any staff in non-management roles	New Managers Typically, Band 5-7	Experienced Leaders Typically, Bands 7-8a managers who have significant experience in management roles who have undertaken core skills training previously	Developing Leaders / Emerging Talent Any manager who is exceeding performance goals and showing potential for senior leadership roles	Senior Leaders Typically, Band 8b – 9	Senior Medical Leaders Clinical Unit Chiefs & Deputy Chiefs	Director level (including development for leading Accountable Care Model organisations)
All Managers	• **Essential /Mandatory Training and Development for all staff with line management responsibility, including medical leaders** • **All internal new and existing programmes to be underpinned by ESHT Values Based leadership and Compassionate, Inclusive leadership skills.**			• Leading the ESHT way – our values and culture (new) • Developing Capability for Quality Improvement (appropriate level programme) • Core People Management • Governance & Quality • Appraisal Skills • Management Essentials (new programme) • Budget Management/Financial Awareness			
Additional Courses/ in-house programmes	• LEAP programme • Career development workshops • Aspiring Leaders/Future Stars Programme (new) • Management Apprenticeships	• New Managers Induction (New) • First 100 days (new) • Core People Management • Appraisal Skills • Recruitment and selection	• HR conversations • Leadership Skills Masterclasses e.g. Leading change and transformation (new)	• Career Development workshops (new) • Aspiring Senior Leaders (new) • Leadership Skills Masterclasses e.g. Leading change and transformation (new)	Bespoke Development focused on individual & senior divisional team needs e.g. • Collective leadership • Accountability & responsibility • Understanding roles • Effective team work • Internal and external leadership	Bespoke Development focused on individual & senior divisional team needs (for examples – see senior leaders) • Core Workforce issues • Financial awareness & budgets	• Board coaching and mentoring • Bespoke individual and Board team development • Distributive leadership – leading for transformation across systems and boundaries
National programmes	• Edward Jenner e-learning	• Mary Seacole • Edward Jenner e-learning	• EGA	• Elizabeth Garrett Anderson (EGA) • Systems leadership	• The Director Programme • Nye Bevan • Systems leadership	• Nye Bevan	• CEO Programme
Other development	• Shadowing • Self-managed e.g. reading, research	• Shadowing • Mentoring	• Shadowing • Mentoring/Coaching • Leading change projects	• Coaching • 360 feedback • Action Learning • Leading projects	• Secondments • Leading Systems-wide projects	• Leading Systems-wide projects • Coaching/leadership mentors	• Coaching/ • Mentoring • Systems wide projects

ESHT - Talent Management Strategy

The sustainability and success of the Trust is dependent on having the right people with the right skills in the right roles – with the right behaviours and values. Managing talent within the Trust means supporting individuals who can make a positive difference to organisational performance and drive improvements in patient care. The Smith and Rose reviews recently published both point to the need for increased talent management in the NHS

Rose report (Oct 2014)

Lord Rose's report "better leadership for tomorrow", concluded that there is insufficient management and leadership capability to deal effectively with the challenges associated with the scale of change in the health service. Also, that there is a need for proper overall direction of careers in management across medical, administrative and nursing cadres.

Smith report (March 2015)

Findings in the Smith report, reviewing centrally funded improvement and leadership development functions, suggest that the current arrangements for improvement and leadership development do not meet the needs of the health and care system both now and into the future. It states the need to identify and nurture our best people to contribute fully to local and national priorities over their careers with us.

Developing People – Improving Care (Dec 2016)

The recently published framework calls for leadership development and talent management systems to be sufficiently inclusive and organised to make the pool of people equipped to lead continuously improving teams big enough and diverse enough to fill critical leadership roles. Leadership at every level of the system should truly reflect the talents and diversity of people working in the system and the communities they serve.

In developing the leadership and talent strategy at ESHT, we need to ensure that our leaders have the skills, knowledge and expertise to lead in an ever changing and developing environment and we need to train, develop, stretch and challenge our leaders in safe ways to prepare them for this new context; to ready them for the new challenges they face; and equip them to lead with compassion through expertise, competence and confidence.

The Benefits of Talent Management

There are three clear benefits from undertaking talent management in the NHS**.**

1. Delivering against organisational priorities – better quality services and care delivered by talented and well-developed people.
2. Reducing operational risk – key people doing critical work. Succession planning, a key component of talent management, reducing the operational impact of core roles remaining vacant for long periods when key people leave organisations.
3. Increasing value for money - improved appraisal processes, particularly where the quality of 1:1 conversations is improved and expectations are clear can go a long way to promoting a high-performance culture within the Trust

Roles and responsibilities for Talent Management in ESHT

As with most management activity, talent management practices work better when there are clear roles and responsibilities. The following groups are key to enabling ESHT to embed a systemic approach to talent management.

The Board and Executive Team

The Board is accountable for ensuring that talent management and succession planning strategies are effectively implemented. Regular agenda time should be scheduled to review organisation wide activity and individuals should role model and promote the behaviours they are expecting from their direct reports and all staff throughout ESHT in nurturing and developing their teams.

Line Managers

The direct reports to the Executive Team and their own management teams have a crucial role in owning talent management practices to ensure that it is not seen as a one-off or annual event but becomes the natural way of doing things. This will be achieved by embedding talent practices into appraisals, investing time for nurturing and coaching conversations, helping staff to understand what is expected of them and that their contribution is valued.

HR/OD Professionals

HR & OD professional have a role in supporting executives and line managers by developing and promoting tools and processes to embed effective talent practices throughout the organisation including recruitment, learning & development, retention and redeployment. There is a need for maintaining the confidentiality of the underpinning management information generated from the processes and ensuring it is put to good effect rather than being sought for its own sake; and networking with peers from other organisations to keep abreast of latest thinking and help share good practices.

Understanding Talent Management & Succession Planning

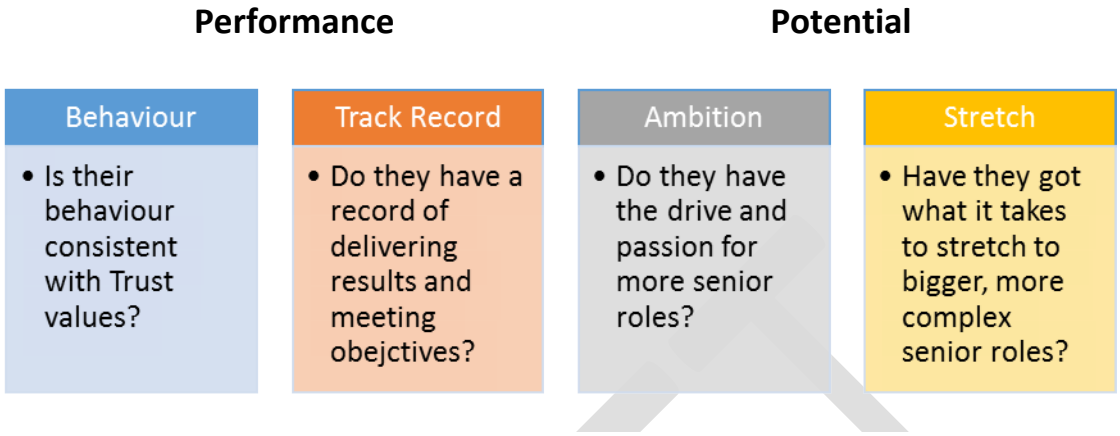
Talent Management

Talent management could be described as: *A systemic approach to selecting, managing, developing and retaining individuals who make an organisation successful and can lead it into the future.*

At ESHT, there will be many examples of good talent management practice; however, a strategic and systematic approach needs to be developed to ensure it is fair, transparent and motivational to all staff, not just those in very senior or business critical roles. Through good talent management, ESHT will seek to better inspire people to reach their potential, identifying the “shining stars” that will work and lead here and in the wider health economy in the future.

We want everyone working at ESHT to have clear expectations of what is required of them to do their job well and to have access to the learning and development needed to help them to grow. Where individuals meet, and exceed these performance levels and if they have both the desire and

the potential ability to progress into more senior or complex roles, their career progression should be supported by our talent management practices, regardless of grade or profession.



Succession Planning

Succession Planning is a strategic talent management process to identify potential future leaders for key roles and the associated actions needed to develop these people to be ready to fill these roles to help ensure future success. It should take account of both strategic and operational requirements and emerging talent, and be flexible enough to handle changing priorities and the workforce challenges facing the NHS today.

Succession planning works well when there is clarity about which roles and which people are involved.

- **Roles:** Succession Planning generally covers the most senior leadership positions in an organisation and other critical roles that are pivotal to organisational success. Often these roles are hard to fill if they require specialist skills and/or qualifications.
- **People:** Succession Planning discussions need to include all current role holders identified above plus at least their direct reports and 'high flyers' below that level

Implementing Talent Management & Succession Planning in ESHT

The Kent, Surrey and Sussex Leadership Collaborative have developed a comprehensive support toolkit for organisations seeking to maximise talent management suggesting that there are four duties that organisations should play when undertaking Talent Management.

Organisations should:

- Attract and select talented people by being an employer of choice and ensuring that recruitment processes are robust, effective and values based.
- Manage and motivate people to perform at their best, supported by engaging, fair and consistent processes, such as appraisal, talent management and succession planning.
- Develop and nurture people to realise their potential by ensuring development opportunities are available and accessible to staff at all levels and staff feel involved and engaged in their own development

- Retain talented staff, supporting them to build fulfilling careers within the Trust and the local health economy.

ESHT Summary actions/recommendations

All actions/recommendations below need to be reviewed and discussed to engage key stakeholders in agreeing them as actions for ESHT to take forward. All agreed actions, together with others identified through the engagement process, would then need to be prioritised and scheduled into a work plan for 2017 – 2020. See appendix 3

Leadership Development

- Engage with key stakeholders to establish an agreed framework for leadership development and behaviours across ESHT.
- Agree and implement a leadership development strategy including a more clearly defined pathway of development for ESHT leaders
- Ensure that all development activity aligns with:
  - ESHT values and leadership behaviours
  - National "Developing People – Improving Care framework, keeping abreast of developments at national, regional and local levels to ensure ESHT plans are flexible
  - National Healthcare Leadership Model behaviours
- Review existing leadership development interventions to ensure they are in line with national frameworks and ESHT values
- Work closely with KSS leadership collaborative to identify regional support for leadership development including interventions created that are linked to "Developing People – Improving Care" framework.
- Review all funding streams and internal resources to ensure that leadership development is prioritised and provides value for money
- Implement leadership development pathway ensuring there is an exciting and multi-channel communication strategy to engage and inform staff of the opportunities open to them.
- Review processes for identifying when new managers start in a management role for the first time to ensure they have access to robust and consistent "new managers" development.
- Design and deliver an ESHT management induction programme to incorporate essential/mandatory training for all new managers
- Establish core management and leadership development requirements across key roles and management grades throughout the Trust, ensuring that ESHT training provision meets the needs identified.
- Design and deliver an internal programme for all current ESHT leaders, to promote, develop and embed "leading the ESHT way" *through the Management Essentials Programme*
- Coaching/mentoring – strengthen links with KSS coaching/mentoring register.
- Develop further coaches, mentors and action learning set facilitators to grow internal capacity for provision of these development interventions throughout ESHT.

- Consider options for developing "coaching style conversations" training.
- Establish links between Developing Capability and Quality Improvement programmes and other leadership development programmes to ensure there is a consistent route for managers to access quality improvement training as part of their essential leadership development
- Explore options for developing a bespoke, in-house 360 feedback tool to incorporate into senior managers' appraisal
- Ensure that talent management and succession planning processes inform a more consistent and strategic approach to selecting staff to attend national development programmes.
- Establish a regular forum for all ESHT leaders to come together to engage with Executive and Senior Leaders to engage in key Trust priorities and develop leadership skills through masterclass type interventions
- Embed ESHT values and ensure these behaviours are role modeled by all staff, particularly those in leadership roles

Talent Management & Succession Planning in ESHT - actions/recommendations

Exploration/Engagement

- ESHT Talent lead to attend regional talent management development programme
- ESHT to connect all planned talent activities to wider OD and workforce strategies
- Explore different talent management and succession planning approaches
- Define ESHT current position using NHS talent engagement and evolution grid
- Set clear objectives to achieve fair, transparent, inspiring and engaging talent practices throughout ESHT

Succession Planning

- ESHT Talent lead to work with divisional management teams to introduce succession planning tools to support the establishment of clinical divisional succession plans that feed into overall ESHT plan. Each division should:
  - Review and agree the key roles and skill sets needed for future organisational success ensure that each senior team has awareness of their critical roles and the pipeline of potential future talented individual to move into these roles in the future.
  - Review the skills, capabilities and aspirations of staff to identify the depth of current potential successors in the short and medium term
  - Identify retention risks and potential gaps in the talent pipeline
  - Plan individual development activities to enable people to be serious contenders for key roles in the future, e.g. stretch responsibilities, coaching, mentoring, shadowing, secondments etc.

Attracting/Recruiting Talent

- Plan recruitment campaigns to regenerate talent pools, particularly in "difficult to recruit to" roles.
- Ensure all plans support the Trust's commitment to employing and developing a diverse, talented workforce who share the ESHT values.
- Introduce and embed values based recruitment
- Strengthen recruitment and selection processes, particularly for management roles
- Define ESHT brand – why do people really want to work here

Managing Talent

- Identify and develop ESHT talent champions who promote ESHT values and have a nurturing and developing style
- Embed regular appraisal for all staff to include engaging conversations identify and measure talent, both performance and potential.
- Hold regular talent forums to engage with staff to seek their views on how ESHT can build on talent management opportunities and continuously improve systems and processes for identifying and developing talent.
- Consider opportunities and flexibility for growth and development when designing new roles reviewing existing roles

Developing Talent

- Explore options for an internal career development service including continuation of career development workshops.
- Consider the provision of an "aspiring leaders" programme to prepare staff in non-management posts for future roles
- Establish clearer career pathways – e.g. apprenticeships, working with education providers to design new and evolving roles

Retaining Talent

- Strengthen exit interview procedures to gain honest and open feedback from staff about their reasons for leaving the Trust, acting on feedback as appropriate
- Implement and embed the ESHT OD strategy, capturing feedback, engaging with staff on their views of working here through staff survey.
- Continue to recognise staff achievement through ESHT awards, encouraging local teams to celebrate success and build team and oranisational pride
- Build networks with ESHT alumni e.g. Management Trainees and graduates of national leadership programmes such as Mary Seacole, Nye Bevan etc.
- Build networks with partner organisations to encourage talent to flow between organisations

Review and impact

- Establish clear measurement of the impact of talent management in ESHT
- Ensure that an organisational talent management review is a regular agenda item at appropriate Executive / Board level meetings
- Share best practice with KSS talent community and other industries

Appendix I – *National Healthcare Leadership Model – Nine dimensions of leadership behaviour:*

The Healthcare Leadership Model is to help those who work in health and care to become better leaders. It is useful for everyone – whether you have formal leadership responsibility or not, if you work in a clinical or other service setting, and if you work with a team of five people or 5,000. It describes the things you can see leaders doing at work and is organised in a way that helps everyone to see how they can develop as a leader. It applies equally to the whole variety of roles and care settings that exist within health and care.

Inspiring shared purpose

What is it? Valuing a service ethos; curious about how to improve services and patient care; behaving in a way that reflects the principles and values of the NHS
Why is it important? Leaders create a shared purpose for diverse individuals doing different work, inspiring them to believe in shared values so that they deliver benefits for patients, their families and the community

Leading with care

What is it? Having the essential personal qualities for leaders in health and social care; understanding the unique qualities and needs of a team; providing a caring, safe environment to enable everyone to do their jobs effectively
Why is it important? Leaders understand the underlying emotions that affect their team, and care for team members as individuals, helping them to manage unsettling feelings so they can focus their energy on delivering a great service that results in care for patients and other service users

Evaluating information

What is it? Seeking out varied information; using information to generate new ideas and make effective plans for improvement or change; making evidence-based decisions that respect different perspectives and meet the needs of all service users
Why is it important? Leaders are open and alert to information, investigating what is happening now so that they can think in an informed way about how to develop proposals for improvement

Connecting our service

What is it? Understanding how health and social care services fit together and how different people, teams or organisations interconnect and interact
Why is it important? Leaders understand how things are done in different teams and organisations; they recognise the implications of different structures, goals, values and cultures so that they can make links, share risks and collaborate effectively

Sharing the vision

What is it? Communicating a compelling and credible vision of the future in a way that makes it feel achievable and exciting
Why is it important? Leaders convey a vivid and attractive picture of what everyone is working towards in a clear, consistent and honest way, so that they inspire hope and help others to see how their work fits in

Engaging the team

What is it? Involving individuals and demonstrating that their contributions and ideas are valued and important for delivering outcomes and continuous improvements to the service

Why is it important? Leaders promote teamwork and a feeling of pride by valuing individuals' contributions and ideas; this creates an atmosphere of staff engagement where desirable behaviour, such as mutual respect, compassionate care and attention to detail, are reinforced by all team members

Holding to account

What is it? Agreeing clear performance goals and quality indicators; supporting individuals and teams to take responsibility for results; providing balanced feedback

Why is it important? Leaders create clarity about their expectations and what success looks like in order to focus people's energy, give them the freedom to self-manage within the demands of their job, and deliver improving standards of care and service delivery

Developing capability

What is it? Building capability to enable people to meet future challenges; using a range of experiences as a vehicle for individual and organisational learning; acting as a role model for personal development

Why is it important? Leaders champion learning and capability development so that they and others gain the skills, knowledge and experience they need to meet the future needs of the service, develop their own potential, and learn from both success and failure

Influencing for results

What is it? Deciding how to have a positive impact on other people; building relationships to recognise other people's passions and concerns; using interpersonal and organisational understanding to persuade and build collaboration

Why is it important? Leaders are sensitive to the concerns and needs of different individuals, groups and organisations, and use this to build networks of influence and plan how to reach agreement about priorities, allocation of resources or approaches to service delivery.

Research has shown that all nine dimensions of the model are important in an individual's leadership role. However, the type of job you have, the needs of the people you work with, and the context of your role within your organisation will all affect which dimensions are most important to use and develop.

Appendix II - ESHT Leadership Development Pathway – What development opportunities can our staff expect?

	Development Options	Status	Timescale	Resource required
All Managers (mandatory)	Management Essentials	Available	Spring 2017	Funded by ESHT internal budget
	Appraisal skills	Available	Now	Funded by ESHT training budget
	Developing Capability for Quality Improvement	Available	Now	Funded by Quality Improvement team
	Budget Management and Financial Awareness	To be developed	Autumn 2017	Explore options for Finance team to deliver
	Health and Safety for managers	Available	Now	Training delivered by H&S team
New Managers	New Manager's Induction Programme (Initial half day followed by 2 x review sessions over 6 months)	To be developed	Autumn 2017	Explore options for internal deliver by L&D team and subject experts
	First 100 days checklist	To be developed	Summer 2017	Funded by ESHT HR budget
	First Line Management skills	Available – subject to content review	Now	Annual CPD funding allocation
	On line HR tool	Available	Launched 2017	Funded by HR budget
	Edward Jenner e-learning programme	Available	Now	NHS Leadership Academy - free
Experienced Managers	HR conversations	Available	Now	Annual CPD funding allocation
	Leadership Skills Masterclasses	To be developed	Launch 2018	Funding source to be established – subject to business case
	Mary Seacole/Elizabeth Garett Anderson/Ready Now (Band 8 & above) National Leadership Progs	Available	Now	NHS Leadership Academy - cost £1700/ £6000/free
	Management Apprenticeship qualification	Available	Now	Apprenticeship funding available – refer L&D
	Shadowing (internal & external	To be developed	Summer 2017	Internal and external voluntary resources
	Coaching / Mentoring	HE KSS register, available now. Explore options for developing more	Summer 2017	HE KSS & NHS Elect & internal ESHT coaches

		in house coaches and mentors		
	360 feedback	Additional feedback facilitators to be trained	Summer 2017	Facilitator training funded by HE KSS? Cost per person c£45 from dept. budget
Senior Managers	Leading Excellence Programme (LEP)	To be developed	Autumn 2017	HE KSS funding approved £150,000
	Leadership Skills Masterclasses	To be developed	Launch Spring 2018	Funding source to be established – subject to business case
	Action Learning for senior clinical leadership teams	To be developed	Launch Spring 2018	Funding source to be established – subject to business case or part of LEP
	Coaching/Mentoring	HE KSS register, available now. Explore options for developing more in house coaches and mentors	Summer 2017	HE KSS & NHS Elect & internal ESHT coaches – coaching will be part of (LEP)
	360 feedback	Additional feedback facilitators to be trained	Summer 2017	Facilitator training funded by HE KSS? Cost per person c£45 from dept. budget
	Elizabeth Garrett Anderson/Nye Bevan National Leadership Programmes	Available	Now	NHS Leadership Academy - cost £6000/£7000
Senior Medical Leaders	Leading Excellence Programme	To be developed	Autumn 2017	HE KSS funding approved £150,000
	Leadership Skills Masterclasses	To be developed	Launch Spring 2018	Funding source to be established – subject to business case
	Action Learning for senior clinical leadership teams	To be developed	Launch Spring 2018	Funding source to be established – subject to business case or part of LEP
	Coaching/Mentoring	HE KSS register, available now. Explore options for developing more in house coaches and mentors	Summer 2017	HE KSS & NHS Elect & internal ESHT coaches – coaching will be part of (LEP)
	Core workforce issues	To be developed	Autumn 2017	Explore options for ESHT HR team
	Financial awareness and budget management	To be developed	Autumn 2017	Explore options for Finance team to deliver

	Leading Service development	To be developed	Early 2018	Funding source to be established – subject to business case
	360 feedback	Additional feedback facilitators to be trained	Summer 2017	Facilitator training funded by HE KSS? Cost per person c£45 from dept. budget
Executive Leaders	Executive coaching	Options to be explored	2017/18	Funding source to be established – subject to business case
	Bespoke Board Development	Options to be explored	2017/18	Funding source to be established – subject to business case
	Leading Accountable Care Organisations	Options to be explored	2017/18	Funding source to be established – subject to business case
	Distributive Leadership – leading for transformation across systems and boundaries	Options to be explored	2017/18	Funding source to be established – subject to business case
	CEO Development Programme	Available	Now	NHS Leadership Academy
Aspiring Leaders	LEAP	Available	Now	Funded by ESHT internal training budgets
	New Stepping Up programme aimed at BME staff	Available	Now	NHS Leadership Academy - free
	Aspiring Leaders Programme	To be developed	Spring 2018	Funding source to be established – subject to business case
	Management Apprenticeships	To be developed	Autumn 2017	Apprenticeship funding available
	Edward Jenner E-learning	Available	Now	NHS Leadership Academy - free
	NHS Graduate Management Scheme	Available	Now	Funded by NHS Leadership Academy
Aspiring Senior Leaders	Talent Management and succession planning in all clinical units	To be developed	Early 2018	Internal management supported by HR & Engagement teams
	Aspiring Senior Leaders Programme	To be developed	Spring 2018	Funding source to be established – subject to business case

	Ready Now programme for Band 8 and above	Available	Now	NHS Leadership Academy
	Elizabeth Garrett Anderson/Nye Bevan National Leadership Programmes	Available	Now	NHS Leadership Academy - cost £6000/£7000
	360 feedback	Additional feedback facilitators to be trained	Summer 2017	Facilitator training funded by HE KSS? Cost per person c£45 from dept. budget
	Coaching/Mentoring	HE KSS register, available now. Explore options for developing more in house coaches and mentors	Summer 2017	HE KSS & NHS Elect & internal ESHT coaches – coaching will be part of (LEP)

All staff	• All staff should be provided with meaningful feedback and the support to fulfil their potential • As a minimum, all staff will have regular high quality performance appraisals and career development conversions with their line manager – it will be seen as unacceptable for these not to happen • This will be back up with support for all staff to pursue their career ambitions through personal development. • The career paths open to people and the skills, experience and attributes they will need to acquire in order to progress will be clear and visible. • There will be equality of access to both opportunities for career progression and the development support needed to pursue these and line managers will be expected o specifically identify, encourage and support those from under-represented groups • There will be a corresponding expectation placed on every member of staff to take ownership for his or her own personal development and career progression • Ensuring that people have high quality appraisals and career development conversations is a joint responsibility between line manager and team member and while not everyone will necessarily want to rise to ever more senior levels, those that do must also be prepared to invest the necessary time and effort.

Appendix III – High level action plan & progress report

Leadership Development Actions	Status - March 2017	Feb - April 2017	Q1 - 2017	Q2 2017	Q3 2017	Q4 2017-18
• Engage with key stakeholders to establish an agreed framework for leadership development and behaviours across ESHT.	Underway - in progress					
• Agree and implement a leadership development strategy including a more clearly defined pathway of development for ESHT leaders	Complete - awaiting final approval					
• Ensure that all development activity aligns with: 1) ESHT values and leadership behaviours, 2) national "Developing People - Improving Care" framework, 3) National Healthcare Leadership Model.	Underway - in progress					
• Review existing leadership development interventions to ensure they are in line with national frameworks and ESHT values	Underway - in progress					
• Work closely with KSS leadership collaborative to identify regional support for leadership development including interventions created that are linked to "Developing People – Improving Care" framework.	Underway - in progress					
• Review all funding streams and internal resources to ensure that leadership development is prioritised and provides value for money	Underway - in progress					
• Implement leadership development pathway ensuring there is an exciting and multi-channel communication strategy to engage and inform staff of the opportunities open to them.	Action planned to liaise with ESHT communications team					
• Review processes for identifying when new managers start in a management role for the first time to ensure they have access to robust and consistent "new managers" development.	Action planned to liaise with ESHT recruitment lead					

• Design and deliver an ESHT management induction programme to incorporate essential/mandatory training for all new managers	Initial stakeholder engagement commenced. Early design underway					
• Establish core management and leadership development requirements across key roles and management grades throughout the Trust, ensuring that ESHT training provision meets the needs identified.	To be commenced Q1					
• Design and deliver an internal programme for all ESHT leaders, to promote, develop and embed "leading the ESHT way" **Management Essentials course**	Workshops commenced Feb 2017					
• Coaching/mentoring – strengthen links with KSS coaching/mentoring register.	Action planned to liaise with HEKSS					
• Develop further coaches, mentors and action learning set facilitators to grow internal capacity for provision of these development interventions throughout ESHT.	Action planned to explore options for building internal coaching capacity at ESHT					
• Consider options for developing "coaching style conversations" training.	Action planned to explore options and potential funding streams building on coaching module of management essentials workshop					
• Establish links between Developing Capability and Quality Improvement programmes and other leadership development programmes to ensure there is a consistent route for managers to access quality improvement training as part of their essential leadership development	Initial stakeholder engagement commenced					
• Explore options for developing a bespoke, in-house 360 feedback tool to incorporate into senior managers appraisal	To be commenced Q2-3. 360 feedback may be part of Leadership Excellence Programme					
• Ensure that talent management and succession planning processes inform a more consistent and strategic approach to selecting staff to attend national development programmes.	To be commenced Q1					

• Establish a regular forum for all ESHT leaders to come together to engage with Executive and Senior Leaders to engage in key Trust priorities and develop leadership skills through masterclass type interventions	Leadership Convesrsations in place - consider options to develop further					
• Embed ESHT values and ensure these behaviours are role modelled by all staff, particularly those in leadership roles	ESHT way included in Management Essentials training for all managers.					
Talent Management Actions						
Exploration/Engagement						
• ESHT Talent lead to attend regional talent management development programme	Head of Wellbeing & Engagement attending					
• ESHT to connect all planned talent activities to wider OD and workforce strategies	Underway - in progress					
• Explore different talent management and succession planning approaches	Action planned to explore approach to introduce talent management & succession planning in divisions, working with HR managers to support					
• Define ESHT current position using NHS talent engagement and evolution grid	Underway - in progress subject to update					
• Set clear objectives to achieve fair, transparent, inspiring and engaging talent practices throughout ESHT	Action planned to explore approach to introduce talent management and succession planning in divisions, working with HR managers to support					
Succession Planning						
• ESHT Talent lead to work with divisional management teams to introduce succession planning tools to support the establishment of clinical divisional succession plans that feed into overall ESHT plan. Each division should:	Action planned to explore approach to introduce talent management and succession planning in divisions, working					

	with HR managers to support					
• Review & agree the key roles & skill sets needed for future organisational success ensuring each senior team has awareness of their critical roles & the pipeline of potential future talented individuals to move into these roles in the future.	To be commenced Q1					
• Review the skills, capabilities and aspirations of staff to identify the depth of current potential successors in the short and medium term	To be commenced Q1					
• Identify retention risks and potential gaps in the talent pipeline	To be commenced Q1					
• Plan individual development activities to enable people to be serious contenders for key roles in the future, e.g. stretch responsibilities, coaching, mentoring, shadowing, secondments etc.	To be commenced Q2					
Attracting/Recruiting Talent						
• Plan recruitment campaigns to regenerate talent pools, particularly in "difficult to recruit to" roles.	To be commenced Q2					
• Ensure all plans support the Trust's commitment to employing and developing a diverse, talented workforce who share the ESHT values.	Action planned to liaise with ESHT recruitment lead					
• Introduce and embed values based recruitment	Action planned to liaise with ESHT recruitment lead					
• Strengthen recruitment and selection processes, particularly for management roles	Action planned to liaise with ESHT recruitment lead					
• Define ESHT brand – why do people really want to work here	To be commenced Q3					
Managing Talent						
• Identify and develop ESHT talent champions who promote ESHT values and have a nurturing and developing style	To be commenced Q3					

• Embed regular appraisal for all staff to include engaging conversations identify and measure talent, both performance and potential.	To be commenced Q3					
• Hold regular talent forums to engage with staff to seek their views on how ESHT can build on talent management opportunities and continuously improve systems and processes for identifying and developing talent.	To be commenced Q4					
• Consider opportunities and flexibility for growth and development when designing new roles reviewing existing roles	To be commenced Q4					
Developing Talent						
• Explore options for an internal career development service including continuation of career development workshops.	To be commenced Q4					
• Consider the provision of an "aspiring leaders" programme to prepare staff in non-management posts for future roles	To be commenced Q4					
• Establish clearer career pathways – e.g. apprenticeships, working with education providers to design new and evolving roles	To be commenced Q4					
Retaining Talent						
• Strengthen exit interview procedures to gain honest and open feedback from staff about their reasons for leaving the Trust, acting on feedback as appropriate	Actions have commenced to review systems to enable more effective exit interview processes.					
• Implement and embed the ESHT OD strategy, capturing feedback, engaging with staff on their views of working here through staff survey.	Underway - in progress					
• Continue to recognise staff achievement through ESHT awards, encouraging local teams to celebrate success and build team and oranisational pride						
• Build networks with ESHT alumni e.g. Management Trainees and graduates of national leadership programmes such as Mary Seacole, Nye Bevan etc.	To be commenced Q2					
• Build networks with partner organisations to encourage talent to flow between organisations	To be commenced Q2					

Review and impact						
• Establish clear measurement of the impact of talent management in ESHT	To be commenced Q3					
• Ensure that an organisational talent management review is a regular agenda item at appropriate Executive / Board level meetings	To be commenced Q2					
• Share best practice with KSS talent community and other industries	To be commenced Q3					

Organisational Development Strategy

Meeting information:			
Date of Meeting: 9th May 2017		Agenda Item:	14

Purpose of paper: (Please tick)			
Assurance	☐	Decision	☒
Meeting: Trust Board		Reporting Officer: Monica Green	

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 new strategy provides a framework to align our people, strategy and processes to deliver the overall vision and objectives of the Trust.

The strategy brings together the work in the Workforce, Leadership and Talent management and other strategies as well as identifying a number of key OD interventions that will act as enablers as we continue to transform as an organisation. In writing the strategy we have taken into account the feedback we have received from the cultural review and other external feedback.

The key OD interventions (some of which are already underway) which will equip the workforce with the capability and confidence to achieve our objectives are:

- Creating a Clear vision and strategy
- Embedding our values and behaviours
- Inspiring and consistent leadership
- Developing a skilled , productive workforce
- Aligning and developing our teams
- Staff and stakeholder engagement
- Promoting well being
- Implementing learning and improvement

Once the strategy has been agreed a delivery plan will be further developed with key leads in the organisation.

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

People and Organisational Development (POD) Committee.

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

The Trust Board are asked to approve the OD Strategy and Delivery Plan.

East Sussex Healthcare NHS
NHS Trust

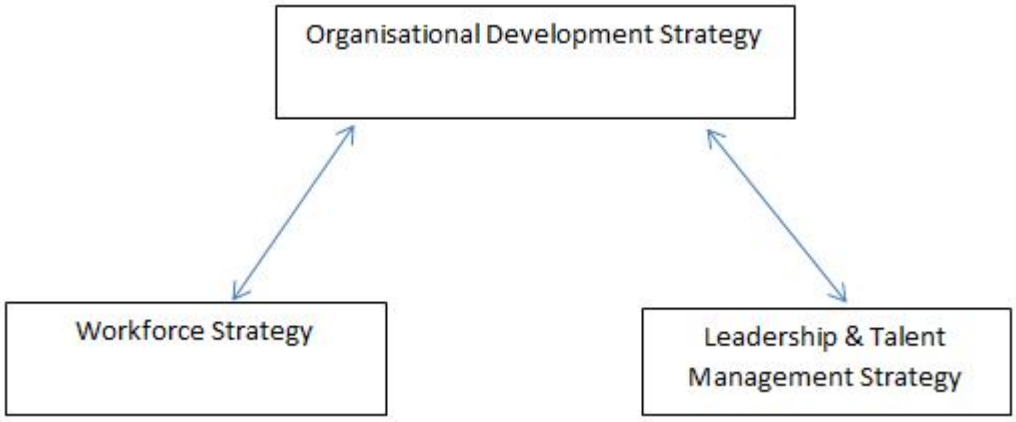
Organisational Development Strategy 2017 - 2020

1. Introduction

Organisational Development (OD) is an approach to making organisations more effective. It provides a route map, identifying areas for focus to help align people, strategy and processes in order to deliver the overall vision and objectives of the Trust in the short, medium and longer term.

OD is a key enabler of transformation and as such forms part of the transformation and improvement programs. It is constructed around a number of key interventions e.g. The Trust's clinical strategy and our quality improvement programme, our ambition to be outstanding by 2020 through delivery of ESHT 2020, our plans to move towards becoming an Accountable care organisation, our developing healthcare for the future across East Sussex which work together and will be supported by a range of other, interconnected activities.

The OD strategy will bring together the work outlined in our workforce strategy and leadership and talent management strategy



OD should be responsive to our priorities and flexible to the needs of the different parts of the Organisation. The OD strategy and plans will inevitably evolve as the Trust develops and relative needs and priorities change.

This Strategy outlines our approach in East Sussex Healthcare for the next three years – 2017 to 2020.

2. Purpose

The aims of this Strategy are to provide future recommendations for equipping our workforce with the capability and confidence to:

- accelerate the delivery of the ESHT 2020 programme
- enhance quality, safety and clinical outcomes across the system
- improve access and operational delivery whilst increasing effectiveness and efficiency
- maintain financial control and sustain capital developments

In turn, our OD plan aims to provide further detail about each of the Organisational Development interventions we will be implementing, in particular:

- what is involved and how long it will take
- who is involved and who is accountable
- the outcomes we are aspiring to and how we will measure them
- some of the potential risks and how we can avoid them becoming problems

3. Principles

Our guiding principles are to ensure that the interventions outlined within our OD strategy are integrated into day to day activities and that they are interconnected. We will recognise the power of conversation and will ensure that staff and stakeholders have the opportunity to contribute throughout its development and implementation. We will also maintain a future focus to ensure the outcomes we are aspiring to are delivered.

4. Organisational Context

East Sussex Healthcare NHS Trust (ESHT) employs almost 6,500 committed, skilled, caring and professional staff who deliver healthcare to a population of approximately 525,000 people. We are an integrated Trust that provides health services from two large hospitals, several smaller community hospitals and a number of local clinics, health and children's centres in addition to GP surgeries. We also provide community nursing and therapy services within patients' homes.

The most recent CQC report published in January 2017 commended the progress and substantial improvements that have been made within the Trust since the last inspection.

However there is still work to do to ensure we consistently provide high standards of care across all of our services. We must embed the improvements that have been made, and seek out every opportunity to make further opportunities to achieve our ambition of being rated 'Outstanding' by 2020.

We will continue to focus on our key priorities - which include recruiting and retaining more permanent clinical staff; improving the management and flow through our hospitals of patients requiring urgent care; reducing waiting times for investigations and planned surgery; continuing to develop our community services; and achieving financial sustainability.

We will continue to develop better engagement with the people of East Sussex who use our services and with the people who work for us.

The Trust will continue to collaborate closely with the County Council and our local Clinical Commissioning Groups (CCGs) in the East Sussex Better Together programme. Working together will enable us to develop health and care services that most effectively meet the needs of the people of East Sussex and are fully coordinated around individual patients.

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

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

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

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

5. Strategic Aims

Our Trust's overarching aim is to provide safe and high quality healthcare for the people of East Sussex. We also aim to make ESHT a place in which staff are proud and happy to work and to achieve a CQC rating of 'Good' by 2017 and 'Outstanding' by 2020. The ESHT 2020 Programme provides the robust framework to deliver the outcomes to achieve these subsidiary aims within our five strategic priorities:

1. Quality and Safety
2. Leadership and Culture
3. Access and operational delivery
4. Clinical strategy
5. Financial Control and capital development

To achieve sustainable improvement in these areas, changes must be led by clinicians and colleagues across the health and social care system.

6. Our Vision – Leadership and Culture

The Trust Board Assurance Framework, the CQC Well-led domain and the ESHT 2020 programme identifies leadership and culture as one of its key priorities. The focus is to ensure that we have the right amount of people with the right skills working to deliver healthcare services in our Trust. Additionally, it looks at how we build relationships with people outside the Trust who have a deep interest in what we do and how we work, such as the local communities we serve.

Our goal is to develop an organisation where we have a highly trained and highly motived workforce who receives the right support to enable them to do what they do best: deliver high quality healthcare services.

To achieve this goal our staff have identified three trust-wide improvement initiatives, closely linked to the outcomes of the recent CQC inspections. These are:

6.1 Workforce Capacity, Capability and Engagement

This focuses on improving the quantity of staff employed by the Trust, ensuring they have the right skills and that they work in an environment that is supportive and allows them to be successful.

6.2 Stakeholder Engagement

This focus here is to improve and expand our relationships and our engagement with external stakeholders in the wider community. We aim to become more inclusive and consultative when improving and developing our services.

6.3 Cultural Review

In April and May 2016, we commissioned an in depth review of the organisation's culture to ascertain the difference between the aspirational behavioural statements aligned to the Trust's values and the everyday experiences of those working within it. We also wanted to gain a greater understanding of some of the feedback we received through the National staff survey. Where people's experience did not match the Trust's values, we asked what changes would be needed to move closer to them. Positive reflections and areas for improvement were highlighted to the Board.

A series of recommendations from this cultural review were made including actions to improve communication and engagement, enhance operational effectiveness and steps to be taken in order to achieve a sustainable cultural shift. These recommendations, coupled with those outlined within the improvement initiatives outlined under the leadership and culture strand of the ESHT 2020 programme will provide the foundation for our OD plan over the next three years.

7. The case for shifting our culture

Creating the right culture is critical in supporting every aspect of Trust performance. The quality of care, levels of safety, patient experience, workforce attitudes and efficiency are all shaped by our culture. We want to create and sustain a culture that accelerates our transformation plans and ultimately delivers the highest quality care for our patients.

Professor Michael West's research into leading culture change in the NHS concludes there is a need for an inspirational vision, clear aligned goals and objectives at every level, patient and carer engagement, good people management, employee engagement and proactivity, team and inter-team working, learning and innovation and values based leadership at every level.

The King's Fund recommends that Boards focus on five areas to ensure their organisation is well led. These are developing a compelling vision and narrative, developing open and transparent cultures focused on improving quality, ensuring clear accountabilities and effective processes to measure performance and address concerns, focusing on engaging all staff and valuing patient's views and experience and focusing on continuous learning, innovation and improvement.

The Engage for Success Report (MacLeod and Clarke 2009) also makes reference to the need for visible, empowering leadership providing a strong strategic narrative, engaging managers who focus, coach and stretch their people, employee voice throughout the organisation and integrity, with no 'say-do' gap between the values on the wall and day to day behaviour.

This overwhelming body of research, along with recent organisation findings through various reviews and inspections provides ESHT with a compelling case for change.

8. Taking a values based approach

We carried out a significant engagement exercise in relation to the Trust values with patients, staff and our service users. A new set of values were developed based on their feedback and input and these have been widely shared with both the public and our staff. Our values are:

- **Respect and compassion** - We are compassionate and kind and treat people with dignity so our patients have a good experience and our staff feel valued

- **Working together** - We work as a cohesive and focused team, who are individually valued for our contribution to the provision of safe patient care and an excellent patient experience

- **Engagement and involvement** - We involve our patients, staff and the public we serve in making decisions about our services so that we can achieve our vision of being the provider of choice for our local population

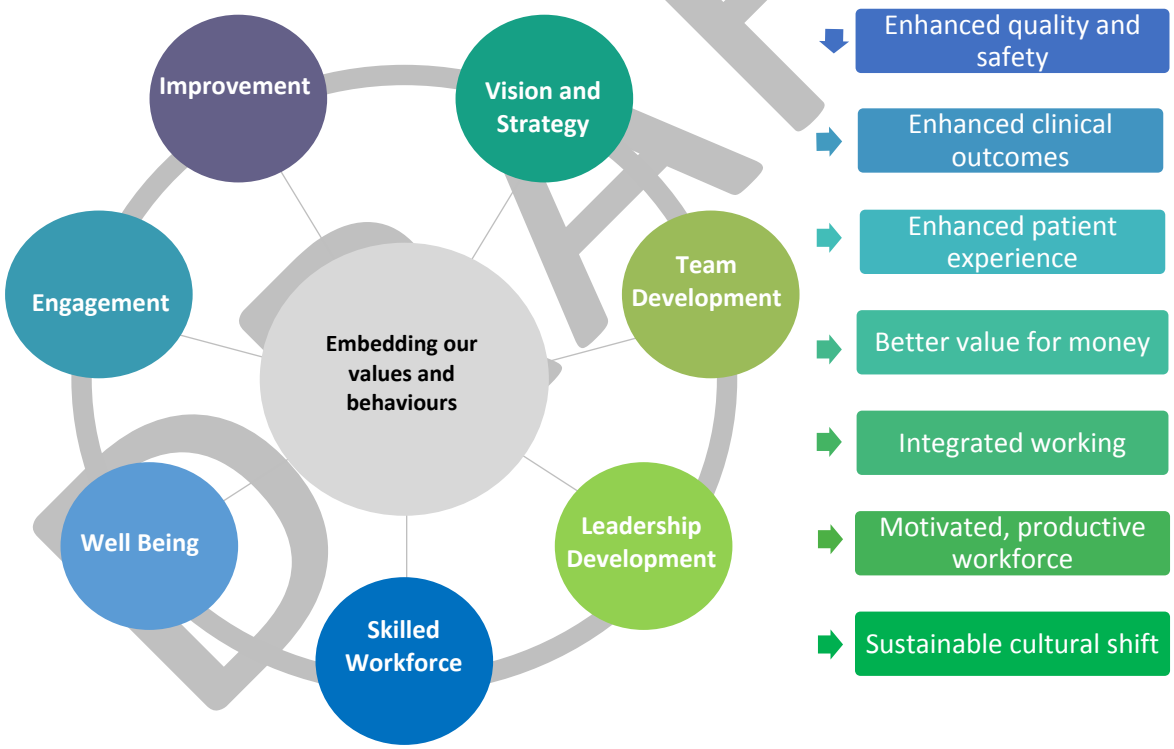
- **Improvement and development** - We continue to develop and transform our services and make the best use of the resources we have for the benefit of our patients

It is essential as we move forward that these values are embedded into our everyday practices and behaviours, so that they are integral to the way we do things at East Sussex Healthcare.

The first step to embedding values into the culture is to create a behavioural framework that describes excellence at every level. Behavioural indicators provide staff with clarity about ***how*** they are expected to perform in addition to ***what*** they deliver. These in turn provide the foundation to drive/enable a range of interconnected OD interventions all of which are designed to reinforce the values and behaviours at the centre (see illustration on Page 7) and form the currency by which staff are recruited, managed, supported and developed.

9. Our Organisational Development Priorities

Co-dependencies between different interventions and the potential benefits



Having reviewed our current position in relation to relevant research and the findings of recent inspections and reviews, the focus of our strategy is to build on work that has already started to ensure that we have the right infrastructure and culture in place to improve the quality of our services. With this in mind, our priorities will be:

- **Vision and strategy –** having a clearly articulated vision and strategy where staff at all levels are motivated by a common goal and understand that supporting the strategy is part of their role.

- **Embedding the values –** ensuring that our values and the behavioural frameworks which underpin these are fully integrated into everything we do.

- **Inspiring and consistent leadership –** to provide this at all levels of the organisation, ensuring that leaders and managers are visible, approachable, are appropriately skilled and act as role models to the wider workforce.

- **Developing a skilled, productive workforce -** having the right staff with the right skills to deliver our transformation plans and a clear accountability structure that supports the delivery of key outcomes linked to patient safety and experience.

- **Team development –** developing and nurturing engaged teams who are empowered to innovate, make decisions and deliver high quality services.

- **Staff and stakeholder engagement –** ensuring meaningful methods are in place which results in improved relationships and increased partnership working with all staff and stakeholders.

- **Promoting well-being –** focusing on developing a healthy workforce and safe, supportive working environment.

- **Implementing a learning and improvement culture –** creating a learning organisation and an environment that promotes improvement.

These priorities are described in more detail below and in the OD delivery plan.

9.1 Creating a clear vision and strategy

- Create and communicate a clear, strategic narrative and long term vision to ensure all staff and stakeholders understand the direction and priorities of the organisation.
- Agree the revised clinical strategy for ESHT
- Agree the brand of East Sussex Healthcare NHS Trust
- Communicate EHST 2020 vision, priorities and improvement plan
- Ensure a line of sight from the 2020 programme to business plans, service redesign, team and individual objectives

9.2 Embedding our values and behaviours

- Development of behavioural frameworks that describe excellence at every level of the Trust
- Develop a values based approach to recruitment
- Integrate behavioural frameworks into the Trust appraisal process
- Ensure values and behaviours are the foundation for further people focused interventions such as development, talent management, reward and communication.

9.3 Inspiring and consistent leadership

- Develop trust wide Leadership and Talent Management strategies
- Continue to develop the leadership and management population across the Trust
- Agreeing on an approach to leading change that assists the Trust to transform expediently and effectively whilst supporting those affected in the best way possible
- Instill a culture where issues are led and managed proactively rather than reactively and where staff feel empowered to act and make decisions
- Strengthen training interventions to enhance the skills and capability of leaders and managers particularly in relation to people/relationship management, communication, change management and service improvement

9.4 Developing a skilled, productive workforce

- Develop robust workforce plans to address immediate resourcing requirements and succession plans with a view to nurturing the organisation's talent pipeline and achieving clarity about future organisational needs.
- Implement the recruitment and retention strategy
- Fully implement a values based appraisal process with a focus on the quality of the appraisal conversation
- Ensure equity in and promote existing learning opportunities and streamline existing mandatory training
- Create a culture of accountability to ensure all managers and staff understand their roles and responsibilities and take ownership of issues as appropriate

9.5 Aligning and developing our teams

- Define appropriate media and channels of communication across all areas of the Trust to include ease of access to corporate information, reduced reliance on email communication and increased leadership visibility.
- Focus on creating 'one ESHT' through opportunities (and allowing time) for staff to work together, increase their understanding of roles and services and develop true partnerships in order to expedite the full integration of sites, sectors and teams
- Development programmes in place which reflect the importance team working
- Roll out of Engaging Leadership for Teams model to ensure effective engagement at all levels through team meetings

9.6 Staff and stakeholder engagement

- Develop and implement a communication and engagement strategy with an action plan to bring about improvement
- Continue with a range of both staff and public engagement events
- Re-establish relationships with our local stakeholders
- Staff engagement and wellbeing to be regularly addressed by the Board.

- Corporate staff engagement issues to be addressed through the Trust's Staff engagement operational plan
- Each division/corporate area to have own staff engagement plan based on feedback and particular needs of their staff
- Involve staff in shaping and developing local business plans and innovation to ensure that the vision and objectives of the organisation are translated appropriately at service, team and individual level.
- Continue to provide engagement initiatives with a focus on communicating key priorities in relation to strategic vision, listening, action and feedback (e.g. the 'you said, we did' approach).

9.7 Promoting well being

- Continue to develop an open and transparent culture where staff are able to raise concerns and ensure they receive feedback about the subsequent actions that are taken
- Health and wellbeing action plan is in place
- Ensure HR policies and procedures support employee wellbeing
- Develop a framework on how we recognise and celebrate success
- Raise the profile of the organisation through celebrating positives and use examples of high performing teams, specialties or individuals to highlight desirable and replicable behaviours
- Reinforce the Trust's expectations in relation to equality and diversity and eliminating discriminatory behaviour to ensure staff at all levels clearly understand their role in supporting and modelling this.

9.8 Implementing a learning and improvement culture

- Embed Listening into Action methodology to empower staff and involve them
- Listen, learn from and act upon patient feedback
- Develop the improvement hub/service development team to support a systems approach to planning patient pathways
- Develop a culture that uses robust evidence to make improvements
- Promote the sharing of best practice through existing "Dare to Share", Leadership Conversations and "what have you done to make a difference" initiatives

10. Next Steps (Appendix 1)

The attached action plan outlines the key actions and timescales required to equip our workforce with the confidence and capability to

- Accelerate the delivery of ESHT 2020 project
- Enhance quality, safety and clinical outcomes across the system
- Improve actions and operational delivery whilst increasing effectiveness and efficiency
- Maintain financial control and sustain capital investment

East Sussex Healthcare NHS
NHS Trust

OD Delivery Plan 2017 - 2020

Work Stream 1: Creating and communicating a clear vision and strategy

- Accountable Director(s): Adrian Bull, Monica Green, Catherine Ashton
- Internal Lead(s): Lynette Wells, Simon Purkiss

Actions	2017				2018				2019				2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Agree Clinical Strategy for ESHT (TBC)																
Develop and agree the ESHT brand (TBC)																
Communicate ESHT 2020, priorities and improvement plan																
Integrate 2020 priorities into business and service redesign plans																
Translate 2020 priorities into team/individual objectives																

Work Stream 2: Embedding our values and behaviours

- Accountable Director(s): Monica Green
- Internal Lead(s): Greig Woodfield, Lorraine Mason

Actions	2017				2018				2019				2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Develop behavioural frameworks for every level of the Trust																
Develop a values based approach to recruitment																
Integrate behavioural frameworks into Trust appraisal process																
Implement training for managers on values based approaches																
Review links to values and behaviours in Trust communication																
Review links to values and behaviours in L&D interventions																
Review links to values and behaviours in reward interventions																

WHAT MATTERS TO YOU
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East Sussex Healthcare NHS
NHS Trust

OD Delivery Plan 2017 - 2020

Work Stream 3: Inspiring and Consistent Leadership

- Accountable Director(s): Monica Green
- Internal Lead(s): Edel Cousins/Lorraine Mason

Actions	2017				2018				2019				2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Develop a Trust wide Leadership Strategy																
Develop a Trust wide Talent Management Strategy																
Develop and embed leadership behaviours																
Refresh and implement Board/Executive Development Plan																
Agree organisational approach to change management																
Enhance leadership/mgt capability in the following areas: • People/relationship management (inc empowerment) • Effective communication (inc decision making) • Change management • Service improvement (inc proactive management)																

Work Stream 4: Developing a Skilled, Productive Workforce

- Accountable Director(s): Monica Green
- Internal Lead(s): Edel Cousins

Actions	2017				2018				2019				2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Define skills needed at individual, team, trust and system levels																
Develop local workforce plans to address resource requirements																
Develop succession plans aligned to the Trust's future needs																
Develop and implement a recruitment and retention strategy																
Promote existing learning opportunities for all staff																
Streamline statutory and mandatory training																
Create and promote a culture of accountability across the Trust																

WHAT MATTERS TO YOU
MATTERS TO US ALL

East Sussex Healthcare NHS
NHS Trust

OD Delivery Plan 2017 - 2020

Work Stream 5: Developing our Teams

- Accountable Director(s): Adrian Bull, Monica Green, Catherine Ashton
- Internal Lead(s): Lorraine Mason

Actions	2017				2018				2019				2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Create time for staff to develop understanding of others roles																
Integrate internal services to ensure consistent delivery																
Increase visibility of leaders across the Trust																
Implement development activities that emphasise team working																
Roll out engaging leadership for teams model across the Trust																

Work Stream 6: Engagement and Communication with Staff and Stakeholders

- Accountable Director(s): Monica Green
- Internal Lead(s): Jeanette Williams, Lynette Wells

Actions	2017				2018				2019				2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Define appropriate Trust wide standards of communication																
Improve ease of access to corporate information																
Develop and implement an engagement strategy																
Create annual programme of events for staff and stakeholders																
Create opportunities to seek regular feedback (introduce Go tool)																
Involve staff in shaping local business plans																
Carry out stakeholder mapping and re-establish relationships																
Provide updates to Boards/CCG on progress/actions required																

WHAT MATTERS TO YOU
MATTERS TO US ALL

East Sussex Healthcare NHS
NHS Trust

OD Delivery Plan 2017 - 2020

Work Stream 7: Promoting Well-Being

- Accountable Director(s): Adrian Bull, Monica Green, Catherine Ashton
- Internal Lead(s): Liz Lipsham/Kim Boorman

Actions	2017				2018				2019				2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Implement Health and Well Being action plan																
Ensure HR policies and procedures support the well-being agenda																
Develop a framework for recognising and celebrating success																
Raise profile of Trust through highlighting positive practice																
Ensure all staff understand their role in the E&D agenda																
Promote a culture where staff feel safe to raise concerns																

Work Stream 8: Implementing a Learning and Improvement Culture

- Accountable Director(s): Catherine Ashton
- Internal Lead(s): Jeanette Williams/TBC

Actions	2017				2018				2019				2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Embed Listening into Action methodology																
Listen, learn from and act upon patient feedback																
Develop the improvement hub/service development team																
Implement a systems based approach to pathway planning																
Develop a culture that uses evidence to drive improvement																
Create regular opportunities to share best practice																
Roll out “Dare to Share” initiative and Leadership Conversations																

WHAT MATTERS TO YOU
MATTERS TO US ALL

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Thursday 19th January 2017 at 10.00am in Committee Room, Conquest

Present: Mr Mike Stevens, Non-Executive Director (Chair)
Mrs Sue Bernhauser, Non-Executive Director
Mr Barry Nealon, Non-Executive Director

In attendance Mr Jody Etherington, Audit Manager, BDO
Mr Chris Lovegrove, Counterfraud Manager, TIAA
Mr Adrian Mills, Audit Manager, TIAA
Mrs Emma Moore, Clinical Effectiveness Lead
Mr Jonathan Reid, Director of Finance
Mr Pete Sheppard - Senior ICT Audit manager, TIAA
Mr Mike Townsend, Regional Managing Director, TIAA
Mrs Lynette Wells, Director of Corporate Affairs

Mr Pete Palmer, Assistant Company Secretary (minutes)

Action

001/17 Welcome and Apologies for Absence

Mr Stevens opened the meeting and introductions were made.

Apologies for absence were received from:

Janine Combrink, Director, BDO
Mr Stephen Hoaen, Head of Financial Services
Dr David Walker, Medical Director
Mrs Alice Webster, Director of Nursing

002/17 Minutes of the meeting held on 23rd November 2016

i) The minutes of the meeting held on 23rd November 2016 were reviewed. It was noted that Ms Howarth's name was incorrect on Page 6 of the minutes, but they were otherwise agreed as an accurate record.

ii) Matters Arising
The following verbal updates were provided:

052/16 i) – Theatres & Clinical Support Audit & Risk Register Review
Mr Reid updated that the decision to end PMO support to the VitalPAC project would be reviewed by the Digital Steering Group, due to the benefits to patient safety that were being realised. Rollout of VitalPAC to Urgent Care and Paediatric services had been delayed to enable the Trust to further upgrade the existing PAS infrastructure. He reported that work was being undertaken to identify whether implementing VitalPAC Doctor, at no additional cost to the Trust, would be beneficial.

Mrs Bernhauser noted that VitalPAC provided great benefit to the Trust in improving patient safety as well as data for audits and for investigating Serious Incidents.

065/16 – Out of Hospital Risk Register Review
Mr Reid explained he had met with Simon Badcott, and that the risk reported at the previous meeting of the Audit Committee concerning a lack of Chemocare administrator had been reduced following review from management team. He reported that contact had been established with partner Trusts about improving governance arrangements regarding Chemocare and that a business case was being completed.

Mrs Wells reported that the risk had been raised at the Quality and Safety (Q&S) Committee. Mrs Bernhauser explained that the potential for chemotherapy drugs being provided in an incorrect environment constituted a high risk to patients and felt that the risk should remain rated red until the business case had been completed. Mr Nealon agreed, commenting that he felt a risk should not be removed from the high level risk register until assurance was received that mitigating actions were fully embedded. Mr Reid agreed to ask Mr Badcott to attend the next meeting of the Audit Committee in order to provide an update. **JR**

053/16 – Clinical Audit Forward Plan Diabetes Audit
Mrs Bernhauser noted that the Trust's continued lack of participation in the National Diabetes Audit had been raised at the Q&S Committee. She said that she understood that the necessary software had reduced in cost to a level at which it could be purchased and asked that Dr Walker or a deputy provide an update at the next meeting of the Audit Committee. **DW**

068/16 – Internal Audit Progress Report
Mrs Bernhauser noted that Angela Colosi had attended the Q&S Committee to provide an update on End of Life Care (EOLC) the previous day. A full EOLC report would be completed once imminent National Guidance has been received, and PMO support was now in place to support EOLC. She explained that the Q&S Committee would be maintaining a close focus on the EOLC.

072/16 Pharmaceutical Write Offs

Mr Reid reported that Mr Hoaen had contacted other Trusts requesting comparative information about pharmaceutical write offs, and would report his findings back to the Committee in March. **SH**

003/17 Board Assurance Framework and High Level Risk Register

Mrs Wells presented the Board Assurance Framework (BAF) and High Level Risk Register. She explained that a large amount of work had been undertaken in reviewing high level risks within the organisation and a number of duplicated risks had been uncovered. As a result the risk register now contained 52 risks, with a further reduction anticipated. She noted that four risks were scored at 20.

She reported that two new risks had been opened on the risk register since November 2016, relating to:

- Conquest switchboard failure
- Temperature in pathology stores

Neither of these were strategic enough to be included on the BAF.

She noted that three areas of the BAF had areas that were rated as red:

- Emergency department reconfiguration/patient flow
- Patient transport
- Finance

Mrs Wells reported that discussions had taken place at the Q&S Committee about reducing the risk concerning patient transport from red to amber, but it was felt that sufficient assurance around this risk was not yet available.

She requested approval to change the rating of the risk concerning clinical administration from amber to green as satellite services had now been set up, and much greater assurance about the effectiveness of services was now available. She explained that once the changes were fully embedded that she would propose removing the risk from the BAF to become business as usual. Mr Mills noted that an internal audit of centralised administration within the Trust had recently been completed and had received reasonable assurance. He supported the proposed reduction in ratings.

Mr Nealon asked about the process for reducing ratings on the BAF and Mrs Wells explained that decisions were made by Board Committees before being recommended to the Board. Ratings could then be reduced with Board approval.

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.

004/17 Clinical Audit Update

Mrs Moore explained that the Trust was still unable to participate in the National Diabetes Audit due to a continuing lack of appropriate software. Mr Stevens noted his disappointment in lack of progress in resolving this issue, and said that he would escalate the issue at the following week's Trust Board meeting. **MS**

Mrs Moore reported that work continued on reducing levels of abandoned audits, noting that level 4 audits would no longer be approved if they did not have a named lead. Mr Stevens said that he felt that ensuring appropriate leads for audits was a small step towards resolving the issue of abandoned audits, and that he hoped increased levels of critical appraisal of audits prior to their approval would lead to further improvements.

Mrs Moore noted that the quality account audit list had recently been received by the Trust, and that this would be presented to the Audit Committee at the meeting in March. She advised that Trust Clinical Audit Awards would take place on 29th June.

Mrs Moore explained that she had held conversations with the Trust's revalidation lead about including audit within the medical appraisal process, but that no agreement had been reached. Mr Stevens said that he felt that linking audit and the appraisal process would greatly reduce incidents of abandonment and Mrs Moore agreed to continue discussions. Mrs Bernhauser suggested that the issue could be picked up by the People and Organisational Development Committee as part of their focus on the Trust's workforce.

Mrs Moore explained that the Trust would continue to focus on high priority audits while reducing the number of level four audits undertaken in order to prioritise resources. The Trust's Clinical Units had been invited to contribute to audit plans for the 2017/18, and national audit plans had been circulated Trust-wide.

Mrs Wells asked what measures were being taken to help departments undertaking insufficient audits to improve clinical effectiveness and Mrs Moore explained that concerns were raised in audit meetings with Clinical Units, and that support was offered to improve engagement. Mrs Wells noted that she had received a list of suggested audits from the CQC which she would send to Mrs

Moore.

005/17 Internal Audit Progress Report

i) Progress Report

Mr Mills reported that five audits had been finalised since November's Audit Committee meeting, with three at a draft stage.

He reported that the audit of nursing agency health roster controls had received limited assurance, with a priority 1 issue identified around the finalisation of work on wards where agency staff had not been deployed. Mr Reid explained that management of staffing within the Trust was a dynamic process where wards with sufficient staff and those with insufficient staff were constantly being balanced. He explained that paperwork had been filled out incorrectly due to operational pressures and that a business case had been approved the previous day to extend the size of the site management team. He hoped that this would provide additional resource to improve documentation.

Mr Nealon noted an increase in full time employees within the Trust by 8% during the previous year, asking why agency usage had not reduced in conjunction with this increase. He asked whether an audit of where this recruitment had occurred was planned and Mr Reid confirmed that the Finance and Investment Committee had asked for this information as it would influence the Trust's budget setting process.

Mr Mills reported that the audit into the Trust's charitable funds had been completed and evidence from the audit would be supplied to BDO, the Trust's external auditors, in order to support their audit of the charity's annual accounts and report. He reported that the audit of centralised outpatient administration had been finalised and the audit of staff appraisal satisfaction survey was being finalised.

Mr Sheppard reported that the ICT cybersecurity review had been completed with limited assurance given. He explained that fundamental issues had been identified which included a lack of a proactive approach to cybersecurity within the Trust and the fact that the decision about whether to utilise data loss prevention software had not been made using a defined decision making process.

Mr Reid explained that he agreed with the auditor's findings, and that a digital steering group had been set up within the Trust to oversee implementation of the Trust's emerging cybersecurity policy. He explained that a business case was being completed for putting auditor recommendations in place. Mr Sheppard noted the importance of increasing awareness amongst Trust staff of cybersecurity risks and agreed to meet with Mr Reid to discuss tools which other Trusts had successfully used to improve cybersecurity.

Mr Nealon asked whether cybersecurity had been added to the Trust's Risk Register, particularly in light of the recent cybersecurity breach at Barts Health NHS Trust. Mrs Wells explained that the risk would be added to the division's risk register in the first instance and would then feed up to the Board Assurance Framework and Trust Risk Register if appropriate.

Mr Sheppard explained that an audit had been started looking at the Trust's Information Governance (IG) Toolkit. A full report would be presented at the next audit committee meeting.

Mr Mills reported that an audit into the Trust's telephone systems was being undertaken, looking for evidence of misuse including unusual phone numbers and calls to foreign countries. Mr Reid explained that he hoped the audit would identify opportunities to make savings whilst also providing an assurance check on the Trust's spending on telephone systems.

Mr Nealon asked if the audit would review average response times for external phone calls to switchboard and Mr Mills explained that this was not included. Mr Reid noted that the switchboard technology was outdated, with a lack of a single consolidated switchboard leading to occasions when phone calls concerning outpatients appointments overflowed onto the main switchboard during busy periods causing delays in answering calls. Mr Reid agreed to ask Mr Bissenden to attend the next meeting of the Audit Committee in order to provide an update on the Trust's digital strategy, which would include plans for improving telephone systems. **JR**

Mr Mills proposed that tiaa undertook detailed follow up work to review audits which had received limited assurance during the previous year. The Audit Committee agreed to this proposal.

Mr Stevens asked if the auditors could produce a summary of the management response in future reports rather than a verbatim version. Mr Mills agreed to do this for future reports.

ii) <u>Follow Up Report</u>

Mr Mills presented tiaa's follow up report, explaining that good progress had been made in following up audit recommendations. He explained that his chief concern was about outstanding recommendations following the ICT audit where little progress had been made in implementing recommendations. There were 71 actions still to be completed following the audit, and Mr Mills reported that he had requested an update on progress by the end of February which would enable him to report on progress to the Audit Committee in March.

Mr Mills raised concerns about the Trust's progress with consultant job planning, reporting that he had spoken to the Trust about the issue and that further work would be undertaken to improve this process. Mrs Bernhauser noted that the Trust's relationship with medical staff had greatly improved since Dr Bull joined the Trust. She explained that consultant clinical excellence awards would no longer be considered if an agreed job plan was not in place and hoped that this would realise improvements.

Mr Nealon explained that he felt that the Trust was not consistently aligning appraisals with business plans, noting that he would like greater insight into any quality issues that may exist around appraisals. Mr Mills agreed to present a draft auditor plan on appraisals at March's meeting. **AM**

006/17 Local Counter Fraud Service Progress Report

Mr Lovegrove presented the Local Counter Fraud Service (LCFS) progress report, noting that he was concerned that he had not received any referrals regarding misuse of Trust mobile phones and that this would be reviewed in new financial year as part of his work plan. Mr Reid explained that the devolved nature of the organisation meant that it was difficult to acquire usable data on mobile phone usage. He hoped that the scrutiny from LCFS and the Trust's auditors would lead to a single database of users. Mrs Bernhauser noted that this would provide the opportunity to move users to a single provider, with an associated cost saving.

Mr Lovegrove noted that many staff within the Trust had not received counterfraud presentations for a number of years and that these had been commenced for new staff during the induction process. He explained that fraud alerts were circulated to staff and that cybersecruity awareness presentations were being made at staff meetings in order to promote greater awareness.

Mr Lovegrove reported that LCFS were supporting the Trust's finance team in recovering overpayments of salary, although recent alterations had been made to the way in which cases could be pursued, limiting the help that LCFS could offer.

He reported that seventeen Trusts had been involved in a nurse agency benchmarking exercise, ensuring that all agency staff received appropriate pre-employment checks. Six action points were recommended at the end of the report into the benchmarking exercise and, while the organisation already had adequate processes in place, these had been accepted by the Trust.

Mr Stevens noted the need for staff to be told that they were eligible for tax refunds if they participated in wider access training, asking that staff were informed about this in a proactive fashion.

The Committee noted the Local Counter Fraud Service Progress Report

007/17 External Audit Progress Report

Mr Etherington reported that a formal audit plan would be presented at the Audit Committee meeting in March.

Mr Stevens explained that, following the decision to change external auditors to Grant Thornton, he hoped that BDO would regard the 2016/17 audit as a chance to impress in order to come back to work with the Trust in the future. He said that he was concerned that partners at BDO were no longer attending Audit Committee meetings.

The Committee noted the External Audit Progress Report

008/17 Information Governance Toolkit Report

Mrs Wells reported that preparation for second part of tiaa's audit of the IG Toolkit was progressing well, praising the work that Ruth Paine did in monitoring IG compliance within the Trust. She explained that incidents reported during 2016/17 had reduced from 2015/16, noting that no incidents had been reported to the Information Commissioner's Office.

The Committee noted the Information Governance Update Report.

009/17 Registration Authority Report

Mrs Wells reported that the RA report would be amalgamated into IG report in the future, noting that it was a statutory requirement for the report to be presented to a Board committee.

Mr Stevens asked whether all staff in the Trust needed to be issued a smart card, asking for the report to include information about the percentage of staff who should and shouldn't have cards for greater context in the future. **CCJ**

010/17 Audit Fees for 2017/18

Mr Reid presented a breakdown of the Audit fees agreed for 2017/18 with Grant Thornton. He explained that these figures were aligned to those agreed during the tendering process.

011/17 Tenders and Waivers Report

Mr Reid reported that a substantive head of procurement had been recruited, and that work was underway to build up the procurement

team. He noted that the procurement team would challenge any purchase where a single provider was identified to ensure that the Trust received value for money, and that these purchases required approval by either the Director of Finance or Chief Executive.

Mr Nealon asked how often the Trust benefited from the NHS' national procurement programme. Mr Reid replied that the NHS' aspiration had been for 100 standardised products to be available during 2016/17 but that currently only ten products were available, all of which were used by the Trust.

012/17 Review of Losses and Special Payments

Mr Reid presented a report on losses and special measures, noting that benchmarking information from comparative Trusts about pharmaceutical losses was being sought. He reported that the Trust's Pharmacy lead was very focussed on reducing potential waste within the Trust.

Mr Stevens explained that he was concerned that the Trust was holding too much pharmaceutical stock, and that processes could be made more efficient in order to reduce losses. Mr Reid explained that a number of changes had already been made by the pharmacy team to improve performance in this area, and that work was being undertaken to improve dialogue between pharmacy and the wards in order to realise further improvements.

The Committee noted the Review of Losses and Special Payments

013/17 Date of Next Meeting

The next meeting of the Audit Committee will be held on:

Thursday 23rd March 2017 at 1000 in the St Mary's Boardroom, EDGH.

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on
Wednesday 29th March 2017 at 9am – 11.30am
In the Committee Room, Conquest

Present	Mr Barry Nealon, Non-Executive Director (Chair) Mr Mike Stevens, Non-Executive Director Mrs Jackie Churchward-Cardiff, Non-Executive Director Dr Adrian Bull, Chief Executive Mr Jonathan Reid, Director of Finance Mrs Joe Chadwick-Bell, Chief Operating Officer Mrs Lynette Wells, Director of Corporate Affairs Miss Tracey Rose, Associate Director of Planning & Business Development (representing Catherine Ashton)
In attendance	Mr David Clayton-Smith, Chairman Mr Chris Hodgson, Associate Director for Estates & Facilities Miss Chris Kyprianou, PA to Director of Finance (minutes)

037/17	**Welcome and Apologies for Absence** Mr Nealon welcomed members to the Finance & Investment Committee. There were no apologies.	**Action**
038/17	**Minutes of the Meeting of 1 March 2017** The minutes of the meeting held on 1 March 2017 were agreed as an accurate record.	
039/17	**Matters Arising/Action Log** <u>(i) EBITDA Quarterly Report</u> Mr Reid reported that Mrs Brandt will be presenting the next EBITDA quarterly report to the June F&I Committee meeting. It was noted that the work that Mrs Brandt had been doing over the last year will form the foundation of the unidentified CIP gap. All Divisions have been receiving the SLR information as part of the monthly IPR meetings. Mrs Brandt will be working with Mrs Chadwick-Bell, Mrs Ashton, Mrs Watts and Mr Miller to turn this into something which will form part of the efficiency plan for next year. <u>(ii) Future Provision of Laundry Service</u> This was discussed under minute item 052/17 below.	

	(ii) Refreshing the 16/17 Forecast Mr Reid reported that mediation remains an option and had suggested this to the CCG. A robust meeting with the CCG took place the previous week where Mr Reid re-informed them of the number required to get to £46.5m. A further meeting is due to take place on 30 March 2017 to establish whether this is an achievable number. Dr Bull reported on a recent letter that had been received from the NHSI financial special measures team, a copy of which will be circulated to the Committee for information. An appropriate response will be sent in due course. In the meantime the Trust will develop a financial plan for 17/18 which addresses the underlying financial challenge of its cost base.	
040/17	**Integrated Performance Report/Finance Report – Month 11** Mr Reid presented the month 11 Finance Report. The Committee noted that the full Integrated Performance Report had been presented to the Executive Directors meeting the previous day. It was noted that the financial run-rate had reduced again in M11 to £3m deficit/month, reflecting a concerted effort to deliver a strong year end outturn. The Trust continues to forecast £46.5m deficit against a financial plan of £41.7m deficit, a shortfall driven by delays in delivery of the Financial Recovery Plan and operational pressures. The Committee reviewed the year on year comparisons. Mr Nealon queried the total inpatient activity which was showing as 5.2% lower than last year's level. Mr Reid reported that total outpatients were 5.9% higher than the previous year and total income was £19.0m (5.8%) up on the same period last year. Dr Bull explained that the difference on inpatient activity has been due to the length of stay as this has gone up from 4.8% to 6.3%. Mr Reid reported that a summarised version of the finance report would be included in the next Board Report. It was reported that there had been some significant improvements in coding, the main focus had been around outpatients. There was still some more work to do around the A&E and T&O coding. Mrs Churchward-Cardiff queried the high medical agency spend. It was noted that recruitment to Consultant vacancies and middle grades remained challenging, however Dr Bull explained the actions in place to try and address this. The Committee noted that nurse agency costs were reducing as a result of the measures put in place. Mrs Churchward-Cardiff queried the graph on the financial recovery	

	plan slide, which showed that the gap was getting bigger. Mr Reid confirmed that there was a degree of backloading in the plan however good progress was being made and the Trust was reasonably confident in getting to the £12.5m position. Mr Reid gave a brief update to the Committee on the position of the capital programme for the year. A review of forecast capital expenditure was continuing and this includes a review of the over-planning margin to ensure that the Trust does not exceed its capital resource limit at financial year end. **Action** **The Committee noted the financial performance for Month 11 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.**	
041/17	**Financial Recovery Plan – Update** The Committee received a report on the Financial Recovery Plan (FRP) update. The Trust recognises that it has focused on income recovery in 16/17. The £3m run-rate improvement achieved in year is not sufficient and has not reduced costs – the focus of the FRP is now moving toward cost reduction. The FRP shows progress and 'grip and control' has been extended. However, the Trust is facing two key challenges: - system capacity is impeding progress on key FRP schemes, and - waiting list/escalation costs are not being fully captured within 'grip and control measures.' The Trust is acting to address both issues. The Trust is forecasting £4.8m variance from the control total deficit of £41.7m. At Month 11, the Trust improved the run-rate by £300k to £3m deficit/month. The Trust needed to improve by £900k in Month 11. The month 12 requirement is a run-rate reduction of £1.5m. It was noted that the Trust has plans to address this. The risk to the forecast is £2.5m in total. This includes the estimated impact of contract income risks. **Action** **The Committee noted financial recovery plan update**	
042/17	**Contracts – Monthly Review** Mr Reid gave an update on the Trust income position at month 11. It	

	was noted that the Trust had set an ambitious income plan for the year and at month 11 remained ahead of plan. Levels of activity growth in the year to date are significant and the Trust expects this to be reflected in income performance, both against the commissioners (CCG & NHSE) contract values and plan. There are a number of schemes which have been identified in the work the Trust has undertaken and these schemes are detailed in the Financial Recovery Plan. The Committee noted the detail on the month 11 position and the latest projection of income to the end of the financial year. Mr Reid reported that the new Head of Contracting and Income will join the Trust on 12 June 2017. **Action** **The Committee notes the current position regarding NHS income and the steps being taken to ensure the best outcome for the year.**	
043/17	**Cashflow – Monthly Review** Mr Reid presented the Committee with an update on the cash position. It was noted that cash remains particularly challenging. At month 9 a revised income and expenditure forecast was declared to NHSI. The paper presented was based on a projected net deficit for the year of £43.9m, although consideration was also given to the implications of the outturn being worse than that projected. It had been predicted in previous reports that the liquidity position would reach critical levels without additional financing in excess of the agreed £31.3m working capital loan. The change in forecast enabled the Trust to apply for the movement in cash – the remaining £4.6m being received in March. The Trust's latest monthly cash flow forecast showed the movements for month 11 and the position for the year to date. Cash held at the end of February was £4.3m and Creditors were just under £31m at the end of February. The value of creditors continued to put a huge strain on relationships with suppliers, with many accounts on 'Stop' and a risk of this number increasing. Late payment interest charges were also being incurred. Creditor balances remained virtually unchanged in February but significantly above the £24m level previously identified as high risk (red rated). In March they were projected to increase again to £37m, a level that remained extremely challenging and will remain during 2017/18.	

	Mr Reid reported that in future, the cash report will contain a bit more detail about the rolling short term cashflow forecast, and detail around the cash in and out over the next three months and then over the next 12 months. Mr Nealon asked if the Committee could have further details on Insurance costs to enable them to gain a better understanding of this. Mrs Wells said she would provide an update for the next meeting. **Action** **The Committee noted the ongoing management of cash and capital within the Trust.**	LW
044/17	**Capital Programme – monthly review** This was discussed under minute 040/17 above. The Committee noted that at the end of month 11, the year to date capital expenditure incurred amounted to £9.9m. The programme currently forecasts expenditure of £12.2m which exceeds the available resource. A review of the schemes was ongoing to ensure that the programme was controlled, the risk mitigated and the programme delivered as planned. **Action** **The Committee noted the current performance of the capital programme and the risks associated with limited capital.**	
045/17	**Review of Financial Governance** Mr Reid reported that a recent review led by the Director of Finance and the Executive Team set out a number of key recommendations which had been discussed with the Executive Team in respect of the overall governance of the Financial Recovery Programme. This was aligned with a review undertaken jointly by the Trust, NHSI and PA Consulting as they exited the Trust. The recommendations were proposed and agreed by the Financial Improvement and Sustainability Committee (FISC). Mr Nealon queried whether the Trust had 'real time' live reporting of activity. Dr Bull explained that the Trust does not have this at the moment but that one of the targets for next year is to get to 'real time' tracking of activity and converting that to revenue. It was noted that the Finance team recognises the need to strengthen the process of monthly forecasting, and this is a key priority. Dr Bull explained the governance structure for the FISC Committee. It was reported that the PMO has been strengthened and was aligning	

	more closely to the Quality PMO. He reported that there were three key groups, the Vacancy Control Group, the Non Pay Review Group and Temporary Workforce Board. The Trust is also tracking the performance requirements, which is as an explicit part of the monthly Integrated Performance Review meetings. An additional review would be put in of the emerging plans before the next FISC meeting. Mrs Chadwick-Bell reported that there was an additional urgent and planned care financial PMO group set up which she chairs. Dr Bull reported a paper would be put together for the next meeting that addresses the governance architecture, and will include detail around the terms of reference and frequency of meetings for each of the groups. The Financial Improvement Director will also be working with Mr Reid to review the governance structure. Mr Nealon reported that the combination of this and the activity that is going on gives the Committee a greater assurance around grip and control. **Action** **The Committee noted the proposed options to strengthen FISC governance and the further changes required.**	**JR**
046/17	**Budget Setting update – 2017/18** Mr Reid circulated some slides showing the position of the Financial Plans for 2017/18. The Trust set a draft Annual Plan in December 2016, reflecting key assumptions and the signed contract. Draft budgets were issued in December to business units for agreement. The Trust is resubmitting a draft plan to NHSI to refresh trajectories in March 2017, but it is anticipated that the plan will be revisited in April 2017 following Financial Special Measures (FSM) review. The Committee reviewed the key planning assumptions, the current status of the Clinical Unit and Divisional sigh-off and the management of the unidentified FRP of £4.8-£6.8m. It was noted that further work was underway in respect of the Trust capital plan. Clinical Unit and Divisional Finance Business Partners have been working with operational teams to identify the funding required for 2017/18. Once funding for unapproved business cases has been taken out to hold centrally, then the gap between Divisional positions and the Trust issued budgets narrows significantly. The Committee reviewed the initial budget values for 17/18 with a comparision with 16/17 for headline review. Work was continuing to ensure agreement at the CU/Divisional level on each of the key budget lines.	

	The balance of the unidentified FRP was under development through the FSM process, supported by the Finance Team, PMO and the Director of Financial Improvement. This is a new workstream within the FRP and is under development. The presentation received was a high level refresh of the ESHT LTFM, which takes into account the latest draft plans for both the Trust and the CCG. Clinical Units will present their draft plans at the Board Seminar 5 on April 2017, and formal sign-off will be completed during the IPR sessions in w/c 3 April, following discussions between the CUs and the finance department. The Committee asked for a greater level of assurance that the Trust had robust enough plans to deliver the control total before signing off the plan for 17/18. Mr Reid reported that part of this would be addressed at the Board Seminar on 5 April, and the development of the detailed FRP over the next 4-6 weeks with the help of the new Director of Financial Improvement was also key. Mrs Chadwick-Bell explained that there were now more robust plans in place and these were owned by the General Managers, and there was a more robust PMO in place. She reported that the Trust was in a very different place, compared to last year, as an organisation. **Action** **The Committee noted the Budget Setting update – 2017/18**	
047/17	**Business Planning Update 2017/18** The Committee received an update on the Business Planning Process which is aligned with the two year operational plan that was submitted to NHS Improvement (NHSI) on the 23 December 2016. It was noted that the Planning, Strategy, Finance and Knowledge Management teams have a programme of engagement with Clinical Divisions and corporate areas in place for the development of the clinical unit 5 years strategies and annual business plans. Each division and corporate area was in the process of developing their plans which will be presented and signed off at the Board Seminar on the 5 April 2017. The Committee noted the progress to date and the timelines and next steps. **Action.** **The Committee noted the progress of the business planning**	

	round for 017/18.	
048/17	**Efficiency Programme 2017/18** The Committee received a report on the Efficiency Programme for 17/18 which highlighted the plans in development for £16m of efficiency savings. Given the exit run rate and the non-delivery of the £41.7m 16/17 Control Total, the efficiency requirement had increased from £16m to £22m. It was proposed that the shortfall would be addressed through a new Clinical Services Review workstream which will use detailed SLR information and the outcomes of Carter workstreams, including benchmarking. The 'opportunity' identified for cost reduction is £11m/year. The newly appointed Financial Improvement Director will help to develop this workstream, aimed at supporting delivery of the 2017/18 control total, and the Trust proposes to present the refreshed plans to the FSM team in April 2017. **Action.** **The Committee noted the challenge for 2017/18 and support the proposal for addressing the shortfall**	
049/17	**Alliance Executive Financial Plan 2017/18** Mr Reid reported that work was still ongoing on shaping the Alliance Executive Financial Plan 2017/18. Once this is finalised it will be presented to the Committee for information. **Action.** **The Committee noted that work was ongoing in shaping the Alliance Executive Financial Plan 2017/18.**	
050/17	**Sussex and East Surrey STP Financial Plans** Mr Reid presented a paper, for information, setting out the latest financial position for the STP moving into 2017/18, and the actions in train across the STP to move to financial balance across the local health economy. As the acute services realignment work comes to a conclusion, the outcomes will be shared with the Committee for review. The Trust continues to participate fully within the Sussex and East Surrey STP workstreams, including the Finance Sub-Group, the Digital Group, and the Acute Services Alignment workstream.	

	The ESBT financial plans remain aligned with the STP plans **Action** **The Committee noted the ongoing work within the STP to support a move to collective financial balance**.	
051/17	**Commercial Strategy and Market Developments** The Committee received an update on the current status of business cases and tenders. 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 fortnightly basis. The process is being reviewed and will be updated to ensure alignment with revised operational and corporate structures and incorporates the monitoring of benefits realisation and Key Performance Indicators (KPIs). **Action** **The Committee noted the update on tenders and service developments.**	
052/17	**Laundry Business Case - update** Mr Hodgson gave an update on the position of the Laundry service. This was previously discussed at the January Finance & Investment Committee meeting and it was felt that the decision to outsource or otherwise should be agreed by the Executive Team. Since then, there has been ongoing discussion at the Estates & Facilities Integrated Performance Review and also with Salisbury who have improved their offer through negotiation. The Committee noted that outline legal and procurement advice is that tenders should be sought in order to avoid a potential legal challenge. Mrs Wells explained the legal position. Mr Hodgson reported that Brighton were going back out to the market again and this was an opportunity that should be explored within the wider STP context with Brighton and Western Sussex. Mr Hodgson was commended by the Committee for negotiating a better deal with Salisbury. It was agreed that both options with Brighton and with Western should be explored, and that a short timetable should be put together. In the meantime, the Trust would prepare the ground for a tender.	

	Action **The Committee noted the position of the Laundry Service.**	
053/17	**Draft 2017/18 Work Programme** The Committee reviewed the draft work programme for 2017/18. Mr Nealon asked to discuss this further with Mr Reid outside of the meeting. **Action** **The Committee reviewed the draft work programme for 2917/18**	**BN**
054/17	**Minutes to note – for information only** The Committee received the minutes of the following meetings for assurance and information: • Financial Improvement & Sustainability Committee – 28.2.17 • Business Case Approval Group – 15.3.17 • Digital Steering Group – 3.3.17 The Committee felt it was helpful to have sight of these minutes.	
055/17	**Date of Next Meeting** The next meeting will take place on Wednesday 26 April 2017, 9am – 11.30am, St Mary's Board Room, EDGH	

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

Minutes of the People and Organisational Development (POD) Committee meeting held on
Thursday 15th December 2016, 10.00am – 12.00pm
Committee Room, Conquest v/c to Sara Hampson 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)
Mr Jamal Zaidi, Associate Medical Director – Workforce (JZ)

In attendance: Mrs Lorraine Mason, Head of Staff Engagement & Wellbeing (LM)
Mrs Jo Gahan, Head of Operational HR (JG) *Deputy for MT*
Mrs Anne Watt, Learning & Development Manager (AW) *from 10.30am*
Mr Christian Bennett, Education Business Manager (CB) *Deputy for EC*
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 introductions were made. Apologies for absence were received from: Mrs Joe Chadwick-Bell, Chief Operating Officer (JCB) Mrs Edel Cousins, Asst. Director of HR – Workforce Development (EC) Dr Sally Herne, Improvement Director (SH) Mrs Jan Humber, Staff Side Chair (JH) Mrs Moira Tenney, Deputy Director of HR (MT) Dr David Walker, Medical Director (DW) Mrs Lynette Wells, Director of Corporate Affairs (AW)	
2)	**2.1 Minutes of the last meeting held on 15 September 2016** The minutes were reviewed and agreed as an accurate reflection of the meeting. **2.2 Matters Arising and review of Action Tracker:** The Action Tracker reviewed and the following updates noted: Healthroster – SG to invite Ruth Merrick to attend the next meeting in March 2017 and provide a paper around Safecare. Medical Engagement – Item deferred to March 2017 agenda. SG to invite Mike Dickens to attend to present GMC survey feedback. Schwartz Rounds – LM agreed to circulate the evaluation of	**SG** **SG** **LM**

Schwartz Rounds to members.

Long-term sickness – MT to be asked to circulate a paper to the Committee. **MT**

BME applicant shortlisting – KN advised she was awaiting data from HR and agreed to provide an update at March meeting. **KN/MT**

AHP numbers - MG presented data from end of November 2016, which shows vacancies are reducing. MG agreed to provide further data for all staff groups for the next meeting. **MG**

3) Feedback from sub-groups of HR Senior Leaders Meeting:

3.1 – Staff Engagement Ops Group

LM provided an update following the last meeting held on 21 November 2016. LM outlined work being undertaken to review and evaluate the "Walking in your Shoes" and Quality Walk programmes at the Trust and look at combining these in the future. A "Celebrating Success" paper was being drafted to present to the Board which would pull together the different awards ceremonies across the Trust to ensure a more uniformed approach.

The staff survey was also discussed and LM confirmed the response rate was 46% for the Trust which was lower than expected and felt in part to be due to staff not believing the survey is anonymous. It was noted the Staff Survey report would be presented at the Trust Board Seminar on 8 February 2017.

JCC raised whether there would be any feasibility for a staff surgery/open door session being held regularly for staff to answer any general queries and build trust. LM agreed to look into this and update at the next meeting in March 2017. **LM**

3.2 – Education Steering Group

MG provided an outline of discussions held at the last Education Steering Group (ESG) meeting held on 28 November 2016.

MG highlighted that finance tariffs for 2017-18 were changing for education and training. The impact of this is still unclear, however it is expected that there would be 2% less funding. The next meeting would look at mapping out the impact of that change.

Updates around medical training, including GMC survey, forums for staff grade and AS doctors and sharing best practice workshop. Nurse training were also discussed. The Doctors Assistant pilot would be commencing in January 2017 with six fixed-term roles working in the medical and surgical assessment units at the Trust.

3.3 – Workforce Resourcing Group
MG advised this group has not met since the last meeting, however a meeting would be held next week with the Chief Executive to look at taking this work forward.

3.4 – HR Quality & Standards Group
The Group last met on 30 September 2016. Since that time Capsticks have undertaken a detailed review of the HR risk register and work was ongoing to update this.

It was agreed by the Committee that the most recent notes of each sub-group would be circulated with the minutes of this meeting; however, a summary report for each of the sub-groups would be provided for all future meetings. **MG/MT/ LM**

4) OD, Leadership & Culture Update

LM provided an update around the OD Strategy. She advised that adding in examples of the improvement work being undertaken at the Trust were being added into the Strategy. Further detail would also be included around the strategic work being undertaken with East Sussex Better Together (ESBT), Sustainability Transformation Plan (STP) and the Accountable Care Organisation (ACO).

It was agreed the Strategy would be sent to the Executive Team for review and would then to be forwarded to Committee members for virtual approval once agreed by the Executive Team. **MG**

LM also outlined work being undertaken around a behavioural framework relating to the Trust values and agreed to present this at the next meeting. **LM**

<u>Leadership Development & Talent Management Strategy</u>
MG confirmed that this strategy had now been drafted and provided detail for each of the different leadership groups within the Trust and outlined development opportunities for each level of staff. The appraisal process would be utilised to identify talent within the Trust, looking at potential, track record and performance of staff. The strategy also reflects the same focus as the National Leadership Strategy.

It was agreed the draft strategy would be discussed by the Executive Team and would then be circulated to members of the POD for comment. **MG**

5) Q2 Staff FFT Results
LM outlined the recent presentation to the Trust by Cometrica, who run the quarterly Staff FFT process. Since the Trust commenced this, average response rates have ranged between 11 – 13.5%, which is in line with the national average. The national average for the recommendation for care and treatment is 79% and as a place of

work is 65%. It was noted the Trust is not far off both of these figures however, further work to needed to be undertaken to increase the responses.

One of the key recommendations from the presentation was to consider providing the staff FFT and staff survey electronically as this would encourage a higher response rate. LM agreed to circulate the Cometrica presentation with the minutes of this meeting. **LM**

6) Junior Doctors Contract Update

MG outlined the update paper which had been presented at Trust Board yesterday around the junior doctors new contract implementation. It was noted that two guardians of safe working hours have been appointed one on each site. Monthly junior doctor forums had now been set up. A large number of junior doctors have successfully transitioned onto new contract following the December intake. MG highlighted that the Emergency departments were noticing the impact of the junior doctors working less hours as a result and confirmed that Trust was looking at offering an opt out clause to allow junior doctors to work more hours if they wished. The financial impact of the contract implantation is currently being assessed.

It was agreed this item would be reviewed again at the June 2017 Committee meeting. **SG**

7) Apprenticeships & Integrated Education

Integrated Education

CB outlined an integrated education management group was being set up in January to take forward integration of the education functions within the Trust. This would report into Education Steering Group.

An integrated education business case had been drafted which would be reviewed by the Education Steering Group early next year. CB confirmed that the integrated education business case would be linked to the strategic work being undertaken via ESBT, ESHT 2020, ACO and STP. JCC suggested talking to Southampton and other Trusts that have successfully implemented integrated education and CB agreed to follow this up. **CB**

Apprenticeships

AW provided an update around the apprenticeship levy being introduced next year. Funding is anticipated to be in the region of £92-£95k per month. AW advised the apprenticeship route would be utilised for existing staff who wanted to undertake further training as the remit of apprenticeships has evolved to include upskilling. There would also be a targeted approach to recruit new apprentices to the Trust. Nursing apprenticeships have also been approved.

AW agreed to circulate the draft Apprenticeship Policy with the minutes. **AW/SG**

The Committee noted the update.

8) HR Quality Metrics

MG presented a paper outlining methods of measuring HR performance including staff sickness, turnover, vacancy rate and engagement. Table 1 shows a reduction in sickness and turnover across the Trust over the last year. Table 2 shows an improvement in the Staff FFT response rate over the last year.

MG outlined work being undertaken with recruiting managers to remove bottlenecks in the recruitment process and confirmed similar work would be undertaken within the operational HR team shortly around the application of policies.

The Chair commented that the metrics are the responsibility of line managers and not just HR. JCC asked how the Trust equips line managers to manage workforce issues effectively and whether areas were identified and targeted for improvement. MG confirmed the Leadership Strategy would provide detail around the responsibility of managers and this would also be covered by the "Back to Essentials" training being rolled out to managers. MG advised monthly Integrated Performance Review (IPR) meetings were held with each Division and a performance report was produced for this which included workforce metrics. The Chair agreed to review a performance report to consider whether there would be any merit in a regular review at this Committee. **MK**

MG considered whether workforce metrics could be added into the Floor to Board dashboard to highlight particular areas of the Trust where there were problems or areas of good practice. MG to further discuss with AW to implement this and update at the next meeting. **MG/AW**

9) Items for Information:

9.1 - HR Incident Report

MG outlined the HR incident report which details activity related to disciplinary, Dignity at Work and grievance cases, suspensions and Employment Tribunals covering the period April – September 2016. It was noted there had been an increase in the number of cases being raised attributed to the Trust's zero tolerance of bullying and harassment.

JG highlighted actions being undertaken to improve the time taken to resolve issues including undertaking telephone interviews to obtain witness statements rather than a face to face meeting. The senior operational HR team had also recently visited Western Sussex Hospitals Trust who have implemented a more informal route and

work is now being undertaken to look at upskilling managers to provide them with the confidence and tools to resolve matters in an informal way where appropriate with less HR involvement.

The Committee noted the report.

9.2 - Workforce Report
The Committee noted the report.

10) Questions from observers
No observers were present.

11) Any other business

Quality & Safety Committee (QSC) deep dive
MG reported that she had presented a paper to the QSC which had provided assurance that all workforce items previously reviewed at that Committee were now within the POD Committee remit.

Staff vouchers
LM confirmed all staff would be receiving a £5 Costa Coffee voucher with their December payslips as a token of appreciation from the Trust Board.

Meeting dates
The committee reviewed the 2017 meeting dates and agreed the meetings would need to inform the following Board meetings:

- 30th March – to inform Trust Board meeting on 9th May
- 15th June – to inform Trust Board meeting on 25th July
- 28th September – to inform Trust Board meeting on 28th Nov
- 14th December - to inform Trust Board Meeting in January 18

12) The next meeting of the Committee will take place on:

Thursday 30 March 2017, 11.00am – 1.00pm in the Princess Alice Room, EDGH with v/c to Room 3, Education Centre, Conquest

Quality and Safety Committee

Minutes of the Quality and Safety Committee Meeting

Wednesday 18 January 2017
St Mary's Board Room, EDGH

Present:
Sue Bernhauser, Chair
Jackie Churchward-Cardiff, Non- Executive Director
Dr James Wilkinson, Assistant Medical Director, Quality
Lynette Wells, Company Secretary
Ashley Parrott, Associate Director of Governance
Joe Chadwick-Bell, Chief Operating Officer
Hazel Tonge, Deputy Director of Nursing
Angela Colosi, Assistant Director of Nursing
Moira Tenney, Deputy Director of HR

In attendance:
Lesley Walton, Programme Manager
Jackie Thomas, Senior Project Manager
Nicky Hughes, Executive Office Support Secretary (notes)

1.0 Welcome and Apologies for Absence

Sue Bernhauser welcomed participants to the Quality and Safety Committee meeting and introductions were made.

Apologies for absence were noted:

Alice Webster, Director of Nursing
Dr Adrian Bull, Chief Executive
Monica Green, Director HR
Janet Colvert, Ex-Officio Committee Member
Dr David Walker, Medical Director
David Clayton-Smith, Chair, ESHT
Anne Wilson, Director of Infection Prevention and Control
Miranda Kavanagh, Chair of People and Organisational Development Group
Catherine Ashton, Director of Strategy

2.0 Patient Story

Ashley Parrott informed the meeting that as a patient would not be present today he would share 2 Serious Incident reports, which were circulated.

2015/34437
Ashley Parrot gave a verbal overview of the incident. This report demonstrated how long ago this incident was reported and the Pathway delay around an 85 year old patient with a bowel obstruction admitted to the Emergency Department at Eastbourne Hospital with the decision to treat and transfer to the Conquest Hospital. JCB confirmed that all pathways were being reviewed.

Datix: WEB48326
Ashley Parrott gave a verbal overview of the incident. The report related to a 77 year old patient who attended the Emergency Department at Eastbourne Hospital. The patient had been brought in by the Ambulance crew, treated then sent home with a diagnosis of postural hypertension. The patient collapsed at home and sadly died of aortic aneurysm.

Action: Sue Bernhauser stated that it would be useful to see examples worthy of noting (evidence, actions and conclusions to be available) to monitor processes in place for reassurance, themes and lessons learnt.

Action: Karen Salt to add as Agenda item twice a year.

3.0 **Minutes of the Previous Meeting**

The minutes of the 23rd November 2016 meeting were agreed to be an accurate record of the meeting.

3.1 **Matters Arising**

Item 4.1 – Chemotherapy system – Jackie Churchward-Cardiff stated that this had not been added to the risk register. Ashley Parrott replied that the risk could have been downgraded but will investigate and add to risk register.
Action: Ashley Parrott to investigate and add to the risk register.

Item 6.1 – It was confirmed that the Deep Dive had been on falls within the wards.

3.2 **Action Log**

Updates to the Action Log were noted:

QSC 37, QSC 48, QSC 49, QSC 53, QSC 54, QSC 55, QSC 56 – agreed to close.
QSC 57 – Ashley Parrott suggested producing a spreadsheet of TIA audits and a review of actions. It was agreed to bring back to The Quality and Safety Committee for review.

Action: Ashley Parrot to liaise with the team producing the spreadsheet of TIA audits and bring back to the next meeting for sign off.

4.0 **Compliance and Risk**

4.1 Patient Safety and Quality – Board Assurance Framework

Lynette Wells gave a verbal overview of the Board Assurance Framework paper.

4.2 Patient Safety and Quality – High Level Risk Register

Lynette Wells gave a verbal overview of the High Level Risk Register. 2 new risks had been opened since November 2016 that related to Conquest switchboard failure and the temperature in pathology stores. Ashley Parrott confirmed that further risks were being followed up with the target of end January 2017.

4.3 ESHT 2020 Improvement Programme

Lesley Walton gave a verbal overview of the ESHT 2020 Improvement Programme stating that the 4 main programmes within the Improvement Programme were:

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

An additional project had been agreed to focus on patient driven improvements in 2017, Expert Patient, elective Care Board and associated improvement project to be initiated.

5.0 Safety and Quality

5.1 Governance Quality Report

Ashley Parrott summarised the report and stated the key areas were:

- Risk register, which is continuing to improve.
- FFT inpatient data shared monthly with Divisions and individual departments.
- Deep dive had commenced on falls. A deep dive on pressure ulcers to commence this week.
- It was noted that the biggest issue had been the backlog of complaints; further improvements to be undertaken.

Sue Bernhauser questioned whether investigations were in place on time/process of complaints. Ashley Parrott replied that Divisions would be expected to take more ownership and the process would need to be more specific to individuals of what would be required.

Jackie Churchward-Cardiff questioned the Quality Account Priorities and asked what efforts would be required to resolve by end of January 2017. Ashley Parrott replied that in his opinion things could have been done better but going forward there would be monthly reporting to be tracked over the year.

Jackie Churchward-Cardiff questioned the incidents in MAUs and asked if the issue was around staffing etc. Ashley Parrott replied that there had been a high number of falls in Eastbourne but under the reporting analysis some were not necessarily clarified as a fall.

Jackie Churchward-Cardiff stressed the importance of a deep dive on pressure ulcers as they had been increasing.

Joe Chadwick-Bell reported that as part of the Urgent Care Programme they would be looking at the function of the assessment units (assessment and short stay) and the requirements of staffing to meet patient demand.

Jackie Churchward-Cardiff raised a concern around the National Adult Diabetes Audit. It had been noted that the Trust could not take part as do not have the software in place. This had not been resolved within the last year. It was agreed that Sue Bernhauser would raise at the Audit Committee on 19th January 2017.

ACTION: Sue Bernhauser to raise the National Adult Diabetes Audit at the Audit Committee on 19th January 2017.

5.2 **Patient Safety and Quality Group Report**

Ashley Parrott summarised the report and stated that a clear set of KPI measures had been written to show how the Trust was progressing.

5.3 **Quality Section of the Integrated Performance Report Month 8**

This paper was for information only.

5.4 **End of Life Care Update**

Angela Colosi gave a verbal overview of the submitted report. The report updates the progress of actions developed from national guidance, CQC recommendations and concerns. Further work to be undertaken on Key Performance Indicators. It was agreed that the End of Life Project would be shared with the Non-Executive Directors in April 2017.

Action: Angela Colosi to share the End of Life project with Non-Executive Directors

in April 2017.

6.0 **Deep Dive**

6.1 **Deep Dive – Urgent Care**

Joe Chadwick-Bell summarised the report and stated that clear actions and clear governance had been implemented. With the receipt of the CQC report there would be a need to cross reference including the clinical elements. The Urgent Care Programme was in place with good clinical engagement. The project was being delivered through 5 work streams: A&E improvements, revised medical model, discharge planning, capacity planning and governance arrangements.

Key highlights:

- Streaming and redirection. Dashboard monitoring urgent care was not picking up certain elements. A need to ensure the dashboard is matched to correct actions.
- Pathways in place; need reviewing, but not being followed by everyone.
- Focusing around what breaches are avoidable. Follow non-admitted pathway, very rare to have a breach – significant work going on.
- Need to complete nursing profiles for ED – changes in nursing leadership.
- No clear definitions of areas in Conquest.
- Put in place enhanced Co-ordinators (nurses in charge).
- ED tracker in place, trialing this non–clinical role, which involves observing the dashboard screen and reminding relevant staff of activity required.

- Two improvement leads in post for Conquest and Eastbourne. Their role is to advise, mentor, train, help to change the culture within departments and support with difficult conversations.
- Patient flow – now on 6 wards – taken off significant number of length of stays. Moving forward roll out quicker, need to progress. ECIP supporting some of the guidance.
- Assessment areas – started work linking into medical model. A need to be clear on functionality of assessment units and short stay units along with medical staff to support.
- Pilot started with one GP, one day a week, part of ESBT.
- Discussions taking place regarding re-commissioning of GP out of hours.

Joe Chadwick-Bell reported that the Back to Green week had been successful; a meeting due to take place on Friday 20th January to discuss feedback and issues.

Action: Karen Salt to add "Back to Green Update" on to the Agenda for 22nd March 2017.

7.0 **Deep Dive for next meeting**
It was agreed that the Deep Dive for the next meeting would be Falls.

8.0 **Any other business**
None.

9.0 **Date of Next Meeting**
Wednesday 22nd March 2017, 14:00 – 16:00, Room 2, Ed Centre, Conquest

Annual Self-Certification

Meeting information:			
Date of Meeting: 9th May 2017		Agenda Item: 17.	
Meeting:	Trust Board	Reporting Officer: Lynette Wells, Director of Corporate Affairs	

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

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

Executive Summary:

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

We received a communication from NHS Improvement (NHSI) at the end of April 2017 setting out that, for the first time, we will need as a Trust Board to self-certify against the NHS provider licence. NHSI has issued guidance that explains the relevant licence conditions and what they mean in terms of the assurance the Trust will need to carry out and when.

Providers are required to self-certify the following after the financial year end:

The Licensee shall take all reasonable precautions against the risk of failure to comply with:

(a) the Conditions of the Licence,
(b) any requirements imposed on it under the NHS Acts, and
(c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

This means as a provider of healthcare we are required to have in place effective systems and process to ensure compliance. We need to identify risks to compliance and to take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

Deadline 31st May 2017

- The provider has complied with required governance arrangements - Condition FT4(8)

Deadline 30th June 2017

The aim of self-certification is for providers to carry out assurance that they are in compliance with the conditions. Returns are not required – Trust boards are required to self- certify, but nothing needs to be sent to NHSI. The Trust will need to self- certify and secure sign off from the Board, and publish a statement of self- certification under Licence Condition G6.
NHSI will check compliance with spot audits from July.

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

None

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

Based on the evidence highlighted in Appendix A, it is recommended to the Board that the 'Condition G6' Self-Certification is formally signed-off as **"Confirmed".**

Based on the evidence highlighted in Appendix B, it is recommended to the Board that the 'Condition FT4 (8)' Self-Certification is formally signed-off as **"Confirmed".**

APPENDIX ONE

Compliance with the Provider Licence Conditions

SECTION 1: GENERAL CONDITIONS

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
G1.	Provision of information	This condition requires licensees to provide Monitor with any information they may require for licencing functions.	ESHT has robust data collection and validation processes and the proven ability to submit large amounts of accurate, complete and timely information to regulators and other third parties to meet specific requirements.	Director Finance Chief Operating Officer
G2.	Publication of information	This condition contains an obligation for all licensees to publish such information as Monitor may require, in a manner that is made accessible to the public.	ESHT is committed to operating in an open and transparent manner. The Board meets in public and agendas, minutes and associated papers are published on our website. The website also contains information and referral point details providing advice to the public and referrers who may require further information about services. Copies of the Trust's Annual Report and Accounts and Quality Account are published on the website and the Trust operates a publication scheme.	Chief Executive Director of Corporate Affairs
G3	Payment of fees to NHSI	The Health & Social Care Act 2012 ("The Act") gives NHSI the ability to charge fees and this condition obliges licence holders to pay fees to NHSI if requested.	No decision has yet been made by NHSI to charge fees. However, the obligation to pay fees is a condition and will be accounted for within the Trust's financial planning. ESHT pays fees to other parties such as the Care Quality Commission and the NHS Litigation Authority.	Director of Finance

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
G4	Fit and Proper Persons	This condition prevents licensees from allowing unfit persons to become or continue as Governors or Directors (or those performing similar or equivalent functions).	The CQC reviewed the Trust's Fit and Proper Persons compliance in October 2016 and found the Trust to be compliant. All members of the Board and their deputies who may 'act up' into a Board role have been subject to a Disclosure & Barring Service (DBS) check. Directors are required to sign an annual declaration that they remain a FPP.	Director of Human Resources
G5	NHS Guidance	This condition requires licensees to have regard to any guidance that NHSI issues.	The Trust has had regard to NHSI guidance through submission of required annual and quarterly planning requirements, declarations and exception reporting.	Director of Finance Director of Operations
G6	Systems for compliance with licence conditions and related obligations	This requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements.	The Trust has a robust governance framework in place as outlined in the Annual Governance Statement. The Board and its sub Committees (Audit Committee, Quality and Safety Committee, People and Organisational Development Committee and Finance and Investment Committee) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance. All Committees undertake a review of their annual work programme and effectiveness and revisions are made as required.	Chief Executive Director of Corporate Affairs

			The Trust has a Risk Management Strategy and processes are in place to enable identification, management and mitigation of current risk and anticipation of future risk. The Risks are identified through incident reporting, risk assessment reviews, clinical audits and other clinical and non- clinical reviews with a clearly defined process of escalation to risk registers. The Board Assurance Framework is reviewed by the Board and its sub committees. The Board has regard to the NHS Constitution, compliance with access targets has been challenging in 2016/17 but actions are in place to support delivery and achievement of trajectories.	
G7	Registration with the Care Quality Commission	This licence condition requires providers to be registered with the Care Quality Commission and to notify NHSI if registration is cancelled.	The Trust is registered with the Care Quality Commission without condition. The Trust was inspected in October 2016 and its rating moved from 'Inadequate' to 'Requires Improvement'	Chief Executive Director of Corporate Affairs
G8	Patient eligibility and selection criteria	This condition requires licence holders to set transparent eligibility and selection criteria for patients and to apply these in a transparent manner.	The Trust publishes descriptions of the services it provides and who the services are for on the Trust website. Eligibility is defined through commissioners' contracts and the choice framework. Assurance is gained through the assessment stages to ensure that the appropriate services are provided.	Chief Operating Officer

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
G9	Application of Section 5 (Continuity of Services)	This condition applies to all licensees. It sets out the conditions under which a service will be designated as a Commissioner Requested Service. Licensees are required to notify NHSI at least 28 days prior to the expiry of a contractual obligation if no renewal or extension has been agreed. Licensees are required to continue to provide the service on expiry of the contract until NHSI issues a direction to continue service provision for a specified period or is advised otherwise. The conditions when Commissioner Requested Services (CRS) shall cease is set out. Licencees are required under this Condition, to notify NHSI of any changes in the description and quantity of services which they are	Requested Services are set within the contracts agreed with commissioners. Trust has strong working relationships with its commissioning partners within the local health economy. Finance director is responsible for leading on contract negotiations and Chair and executive team continually work on developing and improving stakeholder engagement. The Trust works with partners to deliver service transformation, efficiency and quality improvement to meet the needs of the local population.	Chief Executive Director of Finance Chief Operating Officer

		under contractual or legal obligation to provide.		

SECTION 2 PRICING

	Licence Condition:	Explanation:	Board Assurance	**Lead Director**
P1.	Recording of information	Under this condition, NHSI may oblige licensees to record information, particularly information about their costs, in line with Monitor guidance.	The Trust records all of its information about costs in line with current guidance.	Director of Finance
P2.	Provision of information	Having recorded the information in line with Pricing condition 1 above, licensees can then be required to submit this information to NHSI.	The Trust intends complies with any requirements to submit information to NHSI.	Director of Finance
P3.	Assurance report on submissions to NHSI	When collecting information for price setting, it will be important that the submitted information is accurate. This condition allows NHSI to oblige licensees to submit an assurance report confirming that the information that they have provided is accurate.	The Audit Committee receives and monitors all Internal Audit reports	Director of Finance

P4.	Compliance with the national tariff	The Health and Social Care Act 2012 requires commissioners to pay providers a price which complies with, or is determined in accordance with, the National Tariff for NHS health care services. This licence condition imposes a similar obligation on licensees, i.e. the obligation to charge for NHS health care services in line with the National Tariff.	The Trust is on a PbR contract for acute provision and community services are on a block contract. Any local variation is in line with national guidance.	Director of Finance
P5.	Constructive engagement concerning local tariff modifications	The Act allows for local modifications to prices. This licence condition requires licence holders to engage constructively with commissioners, and to try to reach agreement locally, before applying to NHSI for a modification.	As above	Director of Finance

SECTION 3: CHOICE AND COMPETITION

	Licence Condition:	Explanation:	Board Assurance	**Lead Director**
C1.	Patient Choice	This condition protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. This condition applies wherever patients have a choice under the NHS Constitution, or where a choice has been conferred locally by commissioners.	The Trust complies with patient's right to choose and the choice framework	Chief Executive
C2.	Competition Oversight	This condition prevents providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. It also prohibits licensees from engaging in other conduct that has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	All licensed provider organisations will be treated as 'undertakings' under the terms of the Competition Act 1998. This means that all licensed providers will be deemed to be organisations engaging in an 'economic activity' for which the provisions of the Competition Act will apply. Licensed providers therefore need to comply with the Competition Act. The Board and Executive Management team has access to expert legal advice to ensure compliance with this condition.	Chief Executive

SECTION 5: CONTINUITY OF SERVICES

	Licence Condition:	Explanation:	Board Assurance	Lead Director
CoS1.	Continuing provision of Commissioner Requested Services	This condition prevents licensees from ceasing to provide Commissioner Requested Services, or from changing the way in which they provides Commissioner Requested Services, without the agreement of relevant commissioners.	As for condition G9 above.	
CoS 2.	Restriction on the disposal of assets	This licence condition ensures that licensees keep an up to date register of relevant assets used in the provision of Commissioner Requested Services. It also creates a requirement for licensees to obtain NHSI's consent before disposing of these assets when Monitor is concerned about the ability of the licensee to carry on as a going concern.	The Finance Department maintains a capital asset register. The Trust complies with requirements regarding disposal of assets.	Director of Finance
CoS 3.	Standards of Corporate Governance and Financial Management	This condition requires licensees to have due regard to adequate standards of corporate governance and financial management. The Risk Assessment Framework will be utilised by NHSI to determine compliance	The Trust has adequate systems and standards of governance, oversight by the Board and establishment and implementation of associated governance systems and processes including those relating to quality and financial management. Refer to the Trust Annual Governance Statement	

CoS 4.	Undertaking from the ultimate controller	This condition requires licensees to put in place a legally enforceable agreement with their 'ultimate controller' to stop ultimate controllers from taking any action that would cause licensees to breach the license conditions. This is best described as a 'parent/subsidiary company' arrangement. **If no such controlling arrangements exist then this condition would not apply.** Should a controlling arrangement come into being, the ultimate controller will be required to put in place arrangements to protect the assets and services within 7 days. Governors, Directors and Trustees of Charities are not regarded by NHSI as 'Ultimate Controllers'.	The Trust is a Public Benefit Corporation and neither operates or is governed by an Ultimate Controller arrangement so this licence condition would not apply.	Not applicable
CoS 5.	Risk Pool Levy	This licence condition obliges licensees to contribute, if required, towards the funding of the 'risk pool' – this is like an assurance mechanism to pay for vital services if a provider fails.	The regulatory Risk Pool Levy has not come into effect to date. The Trust currently contributes to the NHS Litigation Authority risk pool for clinical negligence, property expenses and public liability schemes.	Director of Finance

CoS 6.	Cooperation in the event of financial stress	This licence condition applies when a licensee fails a test of sound finances, and obliges the licensee to cooperate with NHSI and any of its appointed persons in these circumstances in order to protect services for patients.	The Trust has been place in Financial Special Measures and co-operates fully with NHSI.	Director of Finance
CoS 7.	Availability of Resources	This licence condition requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services.	As with the provision of Mandatory Services, the Trust has well established services in place and currently provides all of the Commissioner Requested Services to a high standard. The Trust has forward plans and agreements in place with commissioners that meet this condition.	Director of Finance

SECTION 6: NHS FOUNDATION TRUST CONDITIONS

	Licence Condition:	**Explanation:**	**Board Assurance**	**Lead Director**
FT1.	Information to update the register of NHS Foundation Trusts.	This licence condition ensures that NHS Foundation Trusts provide required documentation to NHSI. NHS Foundation Trust Licensees are required to provide NHSI with: • a current Constitution; • the most recently published Annual Accounts and Auditor's	The Trust is not an FT and therefore does not have a constitution. Annual Accounts, Auditors Report and Annual Report are all published.	Director of Corporate Affairs

		report; • the most recently published Annual Report; and • a covering statement for submitted documents.		
FT2.	Payment to NHSI in respect of registration and related costs.	If NHSI moves to funding by collecting fees, they may use this licence condition to charge additional fees to NHS Foundation Trusts to recover the costs of registration.	Not applicable. See G3 above.	Not applicable
FT3.	Provision of information to advisory panel.	The Act gives NHSI the ability to establish an advisory panel that will consider questions brought by governors. This licence condition requires NHS Foundation Trusts to provide the information requested by an advisory panel.	Not applicable as Trust does not have governors.	Not applicable

FT 4 Annual Corporate Governance Statement

Appendix B

1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	As evidenced in the Annual Governance Statement
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Board reporting cycle and seminars allows new guidance to be brought to the Boards attention as required
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Governance framework in place. Clarity of reporting and accountabilities, highlighted in 2020 document. Annual review of committee structure and effectiveness. CQC recognised improved governance.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	CQC inspection demonstrated significant improvement in well led domain. Trust remains in Special Measures as assurance required that systems and processes are embedded. Annual Governance Statement, Quality account along with Annual Report documenting compliance with regulatory requirements. Robust external and internal audit processes have escalate any concerns on key internal controls and processes. Regular board and sub-committee meetings undertaking reviews of planned work and including regular oversight of performance information, financial information and the corporate risk register. Compliance with NHS Constitutional standards has been challenging in 2016/17 but actions are in place to support delivery and achievement of trajectories. The Trust was placed in financial special measures and a Financial Recovery Plan is in place.

Use of Trust Seal

Meeting information:			
Date of Meeting:	9th May 2017	Agenda Item:	17
Meeting:	Trust Board	Reporting Officer:	Lynette Wells, Director of Corporate Affairs

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

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

Executive Summary:

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

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

5th April 2017 – Agreement between ESHT and Brighton and Sussex University Hospitals NHS Trust for annual rental of Bexhill Renal Unit.

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

Not applicable.

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

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