EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 28th November 2017, commencing at 09:30 in the St Mary's Boardroom, EDGH

	AGENDA		Lead:	Time:
1.	1.1 Chair's opening remarks 1.2 Apologies for absence 1.3 Monthly award winner(s)		Chair	0930 - 1030
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 26th September 2017	A		
4.	Matters arising	B		
5.	Quality Walks Board Feedback	C	Chair	
6.	Speak Up Guardian's Report	D	Ruth Agg	
7.	Board Committee Feedback	E	Comm Chairs	
8.	Board Assurance Framework	F	DCA	
9.	Chief Executive's Report	G	CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
10.	Integrated Performance Report Month 6 (September) 1. Quality & Safety 2. Access & Responsiveness 3. Sustainability 4. Leadership & Culture	Assurance	H	DN/MD COO HRD	1030 - 1150
11.	Learning From Deaths (Quarter 1)	Assurance	I	MD	

BREAK – 15 MINUTES

12.	Finance and Financial Special Measures Update	Assurance	J	DF	
13.	Capital Programme – Mid Year Review	Assurance	K	DF	

STRATEGY

					Time:
14.	ESBT Progress Report		L	CEO/ DS	1150 - 1205
15.	Clinical Strategy		M	DS	

GOVERNANCE AND ASSURANCE

					Time:
16.	Emergency Planning Core Standards and Emergency Preparedness, Resilience & Response (EPRR)		N	COO	1205 - 1230
17.	Annual Reports: 17.1 Infection Control 17.2 Health & Safety	Assurance	O		
18.	Review of Corporate Governance Documents	Assurance	P	DCA	
19.	Board sub-committee minutes: 19.1 Audit Committee 19.2 Finance & Investment Committee 19.3 POD Committee 19.4 Quality & Safety Committee	Assurance	Q	Comm Chairs	

ITEMS FOR INFORMATION

				Time:
20.	Meeting Dates and Planner for 2018	R	Chair	1230 - 1245
21.	Questions from members of the public (15 minutes maximum)		Chair	
22.	Date of Next Meeting: Tuesday 6th February 2018, Hastings (TBC)		Chair	

David Clayton-Smith

Chairman

1st November 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, 26th September 2017 at 09:30 in the Oak Room, Hastings Centre.

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

In attendance:
Miss Jan Humber, Joint Staff Committee Chairman
Mr Tony Humphries, Senior Manager, Estates (for item 087/2017)
Ms Katey Ma, Improvement Hub Manager (for item 079/2017)
Mr Pete Palmer, Assistant Company Secretary (minutes)

075/2017 **Welcome**

1. Chair's Opening Remarks
Mr Clayton-Smith welcomed everyone to the meeting of the Trust Board held in public. He welcomed Mrs Tonge to her first meeting and thanked her for acting up. It was noted the Vikki Carruth would be joining the Trust as Director of Nursing at the start of October.

2. Apologies for Absence
Mr Clayton-Smith reported that apologies for absence had been received from Ms Philippa Slinger, Improvement Director

3. Monthly Award Winners
Mr Clayton-Smith reported that July had seen joint winners of the monthly staff award. These had been the reception team at EDGH and the Outpatient managers and supervisors. August's winner was Laurie Smith, a PACS officer at EDGH.

076/2017 **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.

077/2017 **Minutes**

The minutes of the Trust Board meeting held on 25th July 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.

078/2017 **Matters Arising**

It was noted that all matters arising from July's meeting had been discharged and a summary of actions was included in the papers.

079/2017 **Improvement Hub**

Katey Ma joined the meeting and gave a comprehensive presentation on the Trust's work to develop an improvement hub. She highlighted the difference between improvement and innovation and outlined the improvements that the programme would bring to the organisation. Details of projects already in train were shared with the Board.

Mr Clayton-Smith thanked the team for the work that they had undertaken in putting a very impressive programme of work in place.

080/2017 **Feedback from Quality Walks**

Ms Kavanagh reported that she had visited various departments including A&E at the DGH and Health Visitors in Lewes. She found the teams to be welcoming, dedicated and hard working. She noted that teams had fedback concerns about not feeling that they were as involved as they could be in everything that went on in the Trust.

The Board noted the feedback on Quality Walks.

081/2017 **Board Committees Feedback**

1. Audit Committee

Mr Stevens noted that the Audit Committee was meeting on the 28th September. He advised that all outstanding end of year accounting matters had been resolved.

Mrs Churchward-Cardiff thanked the Audit Committee for resolving the issues with the Trust's compliance with the National Diabetes Audit. It was noted that the Audit was not on track.

2. Finance and Investment Committee

Mr Nealon reported that the Finance and Investment (F&I) Committee was meeting the following day. The Committee would be reviewing feedback following the meeting with NHSi on 22nd September and would ensure there was continued focus on the financial recovery planning.

3. People and Organisational Development Committee

It was noted that the Committee would be convening on 28th September. POD would be meeting bi-monthly next year.

4. Quality and Safety Committee

Mrs Bernhauser reported that the Committee had greater assurance in a number of areas including risk management, incident reporting and progress in meeting the CQC 'must' and 'should' do's. The Committee would be reviewing the End of Life Care Policy and requested an update on the plain film reporting.

Overall she commented that the meetings were well attended with a good level of debate and assurance received. Timeliness and quality of papers was being addressed.

The Board noted the Committee Reports.

082/2017 **Board Assurance Framework**

Mrs Wells confirmed that following the last Board meeting two items had been removed from the Board Assurance Framework (BAF) in respect of patient transport and mortality. The wording for the gap in assurance regarding seven day working (3.3.1) had also been revised.

The Board agreed with the proposed addition of 4.3.1 in relation to compliance with fire safety regulation, this related to compartmentation at the DGH site. The action plan was being reviewed and would be shared with the fire service.

It was noted that there was a concomitant risk in that completion of the fire compartmentation work at pace would require the decant of wards which would impact capacity. Mrs Chadwick-Bell was adding the risk to the register and this would be escalated to the BAF.

Mrs Wells advised that following the meeting of the Quality and Safety Committee it was proposed to remove the gap in assurance related to community paediatric appointments as there were now significant controls in place and this was reviewed at the Division's IPR meeting.

In response to a question Mrs Wells advised that gaps in control or assurance rated green were recommended to be removed from the BAF when there was sufficient assurance that they were embedded.

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

They approved the removal of the gap related to community paediatric appointments.

083/2017 **Chief Executive's Report**

Dr Bull praised staff for their professional response following the major incident involving a cloud of gas which saw over 130 patients attend A&E. He highlighted that this was one of the biggest decontamination exercises undertaken in the NHS and a system wide review of the response was being held to consider best practice and lessons learned.

A meeting was held with the leaders of the CQC regional team in September and presentations were made on key Trust initiatives along with poster presentations. The Trust was expecting a focussed inspection to take place early in the New Year.

Dr Bull provided an update on the Alliance Executive, advising that there was considerable work being undertaken to develop a consolidated system-wide financial position.

The Board noted and thanked Dr Bull for the report.

QUALITY, SAFETY AND PERFORMANCE

084/2017 **Integrated Performance Report Month 4**

Access and Responsiveness
Mrs Chadwick-Bell reported that in August the Trust achieved 87.7% performance against the four hour standard and, for the fourth month, over 90% for RTT, with a final position of 92.03%. Compliance with the two week wait standard had been maintained. Diagnostic performance had improved but remained just above 1% at 1.7%. The 62 day cancer target remained a challenge, achieving 73.4% with focussed work being done in all specialties to manage performance. Central funds have been secured for additional initiatives to improve the position. It was noted that the Board had received a presentation from the cancer team at the August seminar.

Quality & Safety
Mrs Tonge reported that in June, there had been one Never Event (misplaced naso-gastric tube) which had been investigated. A new system had been implemented requiring two people to check placement from x-rays. In May one never event occurred (wrong site surgery – wrong tooth). The report had been completed and submitted to the CCG.

The biggest trend for serious incidents was falls resulting in a fracture. A new multifactorial risk assessment had been produced and would be piloted on 4 wards, combined with a new simulation training session to ensure assessments conducted effectively identifying the correct prevention measures to put in place. The overall number of falls continued to fall over the last year. In July 2016 there were 152, whereas in July 2017 there were 125.

One MRSA case has been reported in July with no lapses in care identified.

Dr Walker provided an overview of the mortality metrics. SHMI was 1.09 (Jan – Dec 2016), which was within the Trust's expected range. The top diagnostic groups were pneumonia, septicaemia and acute cerebral disease. It was noted that SHMI was generally high in community hospitals and impacted the scores for integrated Trusts. There were a small number of Trusts in a similar position. It was noted that RAMI (currently 95 and performing better than last year which was 108) tended to be a much better indicator for integrated providers.

Leadership & Culture
Miss Green reported that workforce usage of staff in May had been 6663.43 full time equivalents (ftes), 164.44 below the budgeted establishment. Temporary staff expenditure in July had reduced by £245k compared to June. The Trust's vacancy factor in July was 10.57%, and annual turnover was 11.18%.

The monthly sickness had increased slightly to 4.42% in July, although annual sickness rates remained consistent with the previous year. The overall mandatory training rate within the Trust had increased by 0.74% to 89.34%.with increased compliance in all subjects except for Trust Inductions. Appraisal compliance had increased 81.53% and Mr Stevens explained that he was pleased to see the continued improvement in appraisals and training.

Miss Green advised the Board that the national staff survey had been launched and that all staff were being encouraged to give feedback of their views of working for the Trust. She explained that the Staff Family and Friends surveys

continues to show an upward trend in both recommending the Trust as a place to get treatment and also to work.

Miss Green explained that a process of workforce planning was underway linked to the business planning cycle whereby all Divisions are being asked to identify workforce needs and to think about the introduction of new roles. She then went on to update the Board about the leadership programme 'Leading Excellence' which had recently commenced.

The Board noted the IPR Report for Month 4.

85/2017 **Mortality Learning From Deaths Policy**

Dr Walker presented the Trust's Learning from Deaths Policy which met the requirements set out in the Care Quality Commission Learning from Deaths. The mortality database had been revised to reflect the reviewed process.

The report outlined the actions taken and those still outstanding, to embed the process along with the first report and classification of deaths recorded and reviewed during 2016/17 financial year. The classification for these deaths had been mapped from the old system to the new. It was noted that the importance of reviewing deaths within the 3 month timescale was critical to ensure that reporting was accurate and provided a useful overview on the number of deaths that were actually or potentially avoidable. This was the only risk remaining with the learning from deaths process changes and was highlighted to consultant staff a recent mortality summit.

The Board noted the significant progress in learning from deaths and adopted the Policy.

86/2017 **Financial Special Measures Update**

Mr Reid reported that The Trust had delivered the plan in the first 4 months of the year however at Month 5, there were emerging risks around continued delivery and careful action will be required. CIPs developed stood at £34.8m and a full review of deliverability was in train during September 2017.

The Acting Director of Nursing and the Medical Director, with the support of the Quality Improvement Director, had undertaken a full refresh of the Quality Impact Assessments and the risks to overall deliverability, rather than quality, were noted,

The Trust's income forecast was on plan and the forecast was above the CCG demand plan. The scope of the internal audit review on income capture had been reviewed and agreed with the FSM team and work would commence in September for presentation at the October checkpoint.

Jackie Churchward-Cardiff expressed continued concern about the impact of the availability of cash. Mr Reid acknowledged that it remained a significant challenge, with non-cash I&E movements and increases in debtors driving pressure on creditors. Immediate action had been taken to improve recovery and payment, and a review of the growth of debtors/creditors was in train. Discussions were being held with the CCG and NHS Improvement about the position.

It was noted that the Financial position would be considered in greater detail at the F&I Committee on 27th September 2017.

The Board noted progress in delivery of the Financial Recovery Plan and the requirements to review and respond to the emerging risks in depth

87/2017 **Annual Reports**

1. Safeguarding

Mrs Tonge tabled the April 2016 - 2017 annual report for corporate safeguarding children and adults. The report provided information about national changes and influences, local developments and activity including how statutory requirements were being assured, and how challenges to business continuity relating to safeguarding children were managed.

It was noted that the report had been scrutinised at a number of forums, including the Quality and Safety Committee.

The Board endorsed the Annual Safeguarding Report

2. Equality Delivery System 2 Annual Report

Mrs Novis joined the Board and highlighted the improvements made in equality and diversity across the organisation. EDS2 comprises 4 goals, leading to 18 outcomes. 2 goals focus on patient access to services, experience and communication. The further 2 goals focus on staff experience, fair recruitment, access and leadership. The report supported the Trust in meeting its statutory obligations and thanked Mrs Novis for leading the work.

The Board noted the Equality Delivery System 2 Annual Report

3. Fire Safety Annual Report

Tony Humphries joined the meeting to present the Annual Fire Report. It was noted that the Trust had in place the appropriately qualified and experienced fire safety advisors, systems, training and fire safety risk assessments according to the requirements of HTM 05-01 (2013). Clinical units continued to attend mandatory training sessions for fire safety and the attendance had steadily increasing post April 2016.

The level and number of risks were anticipated to decrease over the next 5 years through investment arising from the 2016-2021 Capital Plans, albeit the Trust would have in place a degree of risk related to fire safety during this period.

The Board discussed increased fire scrutiny following the Grenfell Tower tragedy and the Trust's obligations to comply with regulations. The Audit Committee would have oversight of compliance with the Trust's statutory fire obligations.

The Board noted the Fire Safety Annual Report

088/2017 **Winter Preparedness**

Mrs Chadwick-Bell provided an overview of the Trust's winter preparedness plans which were detailed and robust to address activity surges over winter. The plans had been developed in the context of the wider East Sussex system. The Board received assurance that the Trust's winter capacity plans will be

reviewed in full by the Quality & Safety Committee on 27th September 2017.

089/2017 **Board Subcommittee Minutes**

The following sub-committee minutes were reviewed and noted:

Audit committee 31st May 2017
Finance and Investment Committee 28th June 2017 and 26th July
Quality and Safety Committee 24th May 2017

090/2017 **Trust Seal**

It was noted that the Trust Seal had been used on two occasions since the last meeting of the Board. These were:

23rd August 2017 – Lease agreement between ESHT and Hastings and Rother CCG for occupation of part of the first floor at Bexhill Hospital.

23rd August 2017 – Licence agreement between ESHT and Sussex Community Trust for use of clinical treatment rooms at Crowborough Hospital, Hailsham Health Centre and Rye Memorial Hospital.

091/2017 **Questions from Members of the Public**

Questions from members of the public Mrs Walke and Mr Campbell were received.

It was agreed, following a request from Mrs Walke, that the Trust would review numbers of stillbirths within the organisation.

Due to IT issues it was not possible to record these in the minutes.

092/2017 **Date of Next Meeting**

Tuesday, 28th November 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 26th September 2017 Trust Board Meeting

Agenda item	Action	Lead	Progress
There were no matters arising from the Trust Board meeting on 26th September 2017			

Quality Walks July - October 2017

Meeting information:			
Date of Meeting:	28th November 2017	Agenda Item:	5
Meeting:	Trust Board	Reporting Officer: :	Chairman

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

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

Executive Summary:

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

22 services or departments have received visits as part of the Quality Walk programme by the Executive Team between 1st July and 31st October. The Chief Executive has also visited a number of departments and staff groups in addition to the formal programme. A summary of the observations and findings noted are detailed in the attached report.

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

None

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

The Board are asked to note the report.

Introduction
Quality Walks are carried out by Board members and can be either planned or on an ad hoc basis. They are intended to provide an opportunity to observe and review care being delivered, listen to feedback from patient's, visitors and staff, observe different roles and functions and afford assurance to the Board of the quality of care across the services and locations throughout the Trust. The process enables areas of excellence to be acknowledged, risks to be identified and allow staff the opportunity to meet and discuss issues with members of the Board.

Analysis of Key Issues and Discussion Points Raised by the Report

22 services or departments were visited as part of the Quality Walk programme by the Executive Team between 1st July and 31st October as detailed below. The Chief Executive also visited several departments and staff groups in addition to the formal programme.

Date	Service	Site	Visit by
19.7.17	Endoscopy	EDGH	Monica Green
21.7.17	Judy Beard Unit	Conquest	Monica Green
3.8.17	CCU & Cath Lab	EDGH	Jackie Churchward-Cardiff
3.8.17	Speech and Language Therapy	EDGH	David Walker
9.8.17	Speech and Language Therapy	Centenary House	Jackie Churchward Cardiff
5.9.17	Discharge Lounge	Conquest	Monica Green
6.9.17	Health Visitor Team Sidley	Sidley Children's Centre	Sue Bernhauser
13.9.17	Hailsham 4 & Urology Investigation Suite	EDGH	Sue Bernhauser
20.9.17	Crisis Response Team	Princes Park Health Centre	Monica Green
27.9.17	Emergency Department	EDGH	Miranda Kavanagh
29.9.17	Health Visitor Team Uckfield	Uckfield	Monica Green
4.10.17	Glynde Ward	EDGH	Jackie Churchward-Cardiff
11.10.17	Complex Rehabilitation Team	Conquest	Miranda Kavanagh
11.10.17	Emergency Department	Conquest	Miranda Kavanagh
16.10.17	JCR and Falls team	Bexhill	Monica Green
23.10.17	Baird Ward (MAU)	Conquest	David Walker
23.10.17	Occupational Health	EDGH	Catherine Ashton
24.10.17	EME	Conquest	Jackie Churchward-Cardiff
25.10.17	Radiology	EDGH	Barry Nealon
26.10.17	Pharmacy	EDGH	Catherine Ashton
27.10.17	Health Records	EDGH	Miranda Kavanagh
2710.17	JCR	Firwood	Miranda Kavanagh

The majority of these visits were pre-arranged and the Ward or Unit Manager notified in advance to expect the visit, other ad hoc visits may also have taken place.

Where feedback has been received this has been passed on to the relevant managers for information.

Key Themes and Observations

Communication and Engagement

- Generally communication was reported as good with evidence of some excellent practice within some teams such as Crisis Response, the Emergency Department at Conquest and the JCR team in Eastbourne where some innovative ways of communication and feedback were noted.
- One team that had recently undergone significant changes to their working environment felt that there had been insufficient consultation with staff beforehand, and the facility they now have does not entirely meet their needs.
- Another team commented that where there was an impact on individuals of ongoing change and uncertainty they felt staff needed to be more involved and communicated with on an ongoing basis.
- Positive views of the CEO, management team and Speak up Guardian were reported by staff
- Some staff felt that management could be more visible and one area commented that they would love Board members to stop by.
- Communicating electronically with some non NHS providers such as nursing homes is seen as a challenge due to unsecure IT processes, and this can delay communication and the need to use fax.
- Some community teams felt there is a need for further work and communications to raise awareness of their roles and the impact they can have in terms of caring for patients at home, avoiding admissions and facilitating discharge, particularly with GPs and acute based staff as there can be confusion regarding the different roles such as crisis response, falls prevention, JCR etc. and who does what and who to refer to.
- Some teams particularly those providing community services are successfully using social media to communicate and promote their service.

Incidents Risks and Safety Issues

- The environment of the Discharge Lounge at the Conquest site was noted to be poor.
- At a visit to the Glynde Unit earlier in the year various issues were raised particularly in regard to the environment, at the request of the unit a further Quality Walk has taken place, and the department was noticeably more ordered and de-cluttered. It was observed that the team had worked hard to establish and introduce improvements.

Other Issues

- Concerns were raised about the length of time it can take for essential items to be ordered and installed and some staff commented on the time it can take for minor repairs and changes to be implemented and that frustration and ambition may be constrained by the lack of estate and finances.
- Concerns were raised by staff regarding a lack of computers and workstations in a lot of areas, this makes their work more difficult as most staff information, training and clinical information is now electronic.
- Lack of available technology was also highlighted for some of the community services, some staff currently have to return to their base following visits to write up notes as they have no equipment available for using in the field.
- Storage of equipment continues to be problematic in many areas due to inadequate space.
- One health visiting team had recently been co-located with social services colleagues, but the staff felt this had not been successful as due to their work being in the community they were rarely in the office together. There were also issues with the location not being fit for purpose as it was too small with no rooms for staff to have conversations with families, leading to concern regarding confidentiality when discussing sensitive issues.

- Another health visiting team were very positive about the benefits of now sharing accommodation directly with the team of children's services key workers and felt it had resulted in a seamless service to children and families in the locality.
- At a visit to health records it was noted how the department is undertaking a transformational change in the way health records are kept.
- A visit to the EME department demonstrated a strong commitment they have for developing their service and how their forward thinking approach makes it a strong asset for the organisation.

Staffing

- It was noted that staff were very open in their discussions with Board members and were enthusiastic and passionate about what they were doing. They felt well supported by senior staff and put their patients at the centre of their work in an obvious way.
- Some areas reported a lack of experienced staff within certain specialities but they had a clear team approach and offered a supportive environment which presented as a positive and happy work place. Senior nurses are involved in considerable staff development and 'on the job' training for more junior staff.
- The use of Doctors Assistants to enhance care is valued.
- There is staffing issues nationally and in particular it was noted that recruiting to Band 6 posts in complex rehabilitation is a challenge, however recently staff have been recruited from Brighton and staff felt the reputation of ESHT as a nice place to work is growing.
- A general point was made about the difficulty in funding Continuous Professional Development for staff, and that where course costs are covered the travel and accommodation are not, which makes many opportunities unaffordable.

Patient feedback

- Patient feedback was reported in the cardiac unit as being consistently around 94% positive.
- A patient awaiting discharge provided very positive feedback on the treatment and care she had received during her stay, she had a chronic problem and had also been an inpatient before.
- There were positive comments about the food and that there was a good selection most days.
- A health visiting team provided comments that families had made when asked to evaluate the service and these were very positive.
- There were many examples of some excellent communications with patients which were supported by the considerable number of extremely complimentary plaudits that some areas received.

Risks and Implications

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

Speak Up Guardian Report April 2017 – September 2017 Quarter 1 and 2

Meeting information:			
Date of Meeting:	28th November 2017	Agenda Item:	6
Meeting:	Trust Board	Reporting Officer	Ruth Agg

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

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☐
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 Freedom to Speak up Guardian role is now mandatory within all NHS and Foundation Trusts and ensures that the needs of staff are met and the principles of Freedom to Speak up become part of everyday business at ESHT.

The National Guardian office recommends the Board regularly receives reports from the Speak up Guardian. Reassurance is given to staff and the public that Dr Adrian Bull meets monthly with the Speak up Guardian and has responded to any concerns that require support when needed. The Executive team are easily accessible for face to face discussions and support if needed.

Raising concerns and speaking up form part of the well led domain in CQC inspections.

The National Guardian Office recognises that the role is not an easy one and patient safety and staff wellbeing are the quality markers. The role requires Senior Leadership support and investment which is evident in the promotion and support of the role at Executive level. The number of staff coming forward may seem high but is evidence of a culture that encourages staff to raise concerns and not fear reprisal.

Current work being undertaken includes:

- Monitoring behaviours including bullying and harassment through Datix reviews and with the help of the HR department if needed. These incidents undergo robust investigation, resolution and action.
- Members of staff are supported and feedback is given to ensure learning.
- A tool to help staff manage level 1 and 2 incidents is due to be launched.

- A review of incidents involving violence and aggression review is being undertaken. New posters and ensuring that policy is followed in a robust fashion/Relaunch and understanding of policy and how to apply it for staff.
- Supporting staff wellbeing improves patient safety and reduces sickness and absence. The Speak Up Guardian has supported staff who returned to work with wellbeing concerns.
- Attending team meetings to ensure staff understand how to raise concerns and the resources available to them. Trust values are promoted and the behaviour we expect from staff is discussed.
- Recent training for "Chairing meetings" has been given to staff following concerns regarding meetings/culture. A Trust Charter is being developed in partnership with staff.

Speak Up Guardian Log for 2017/18 Quarter 1 & 2 – Categories

Categories	Quarter 1	Quarter 2
Behavioural / Relationship	11	23
Bullying / Harassment	22	14
Cultural	5	1
Infrastructure / Environmental	3	1
Leadership	10	2
Middle Management Issue	6	0
Patient Safety / Quality	5	2
Senior Management Issue	1	0
Staff Safety	1	5
System / Process	11	13
Total	75	61

An anonymous survey monkey feedback tool has been launched. 14 surveys have been completed and the collated results of these can be found in Appendix 1. A small number as just established.

Staff from throughout the organisation have used the service, including senior managers, Consultants, trainee Doctors, nursing staff, clinical administration staff and staff from estates and facilities. Members of the public have also contacted the Speak up Guardian.

The National Speak Up Guardian recently undertook a case review of speaking up processes, policies and culture of an NHS Trust. The results of this review can be found here:

http://www.cqc.org.uk/sites/default/files/20171115_ngo_southportormskirk.pdf
The outcomes of the review will be reviewed to see if any learning can be shared within the organisation.

The National Speak Up Guardian's Report for 2016/17 has recently been published and can be found here:

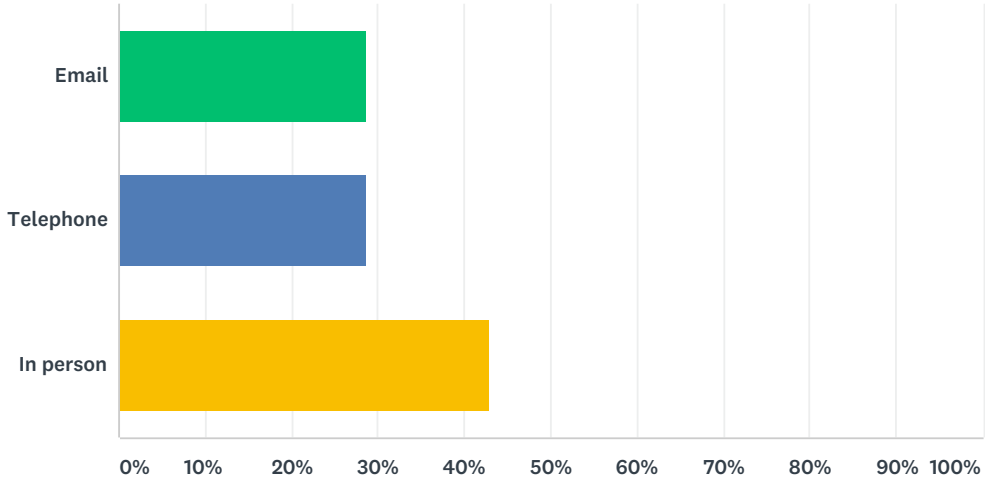
http://www.cqc.org.uk/sites/default/files/20171115_ngo_annualreport201617.pdf

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

The Board is asked to receive assurance the Speak Up Guardian's role is becoming fully embedded within the organisation. The Speak Up Guardian has open access to the Chief Executive and help and support from throughout the organisation.

Q1 How did you first make contact with the Speak Up Guardian?

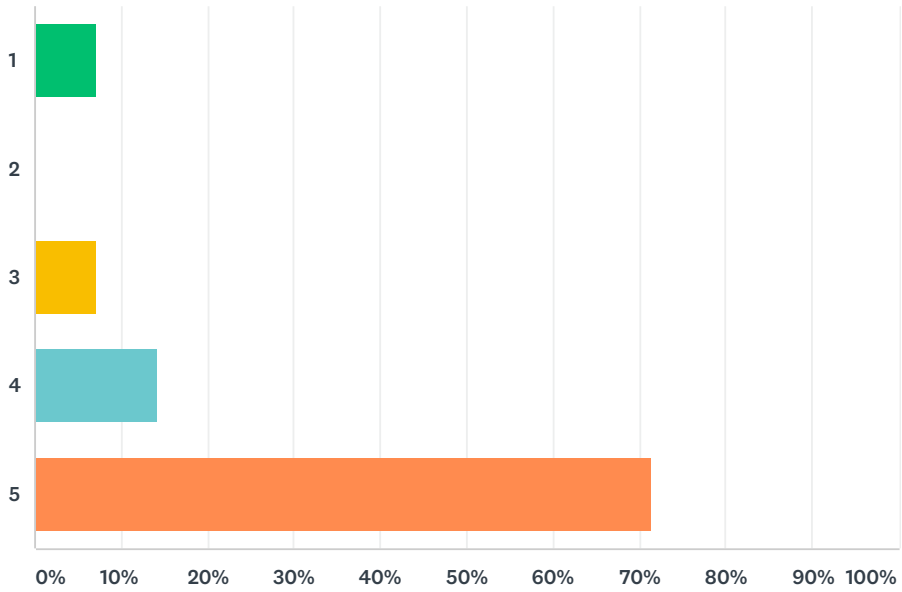
Answered: 14 Skipped: 0



ANSWER CHOICES	RESPONSES	
Email	28.57%	4
Telephone	28.57%	4
In person	42.86%	6
TOTAL		14

Q2 On a scale of 1 - 5, how easy did you find it to contact the Speak Up Guardian? (1=very difficult, 5=very easy)

Answered: 14 Skipped: 0

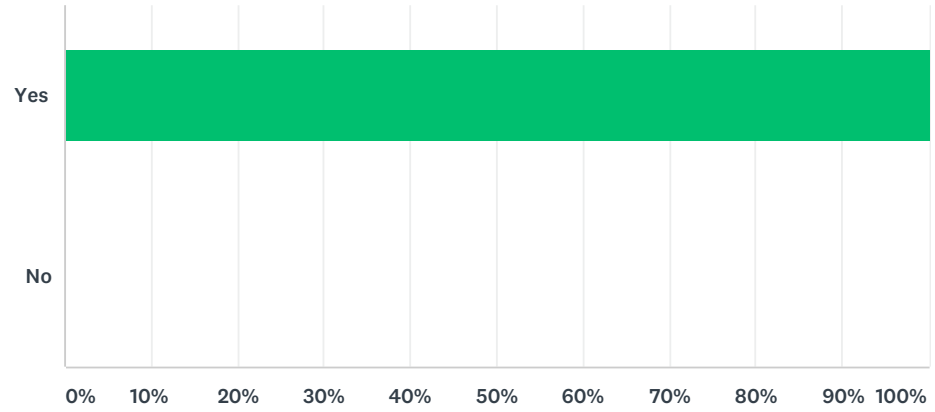


ANSWER CHOICES	RESPONSES	
1	7.14%	1
2	0.00%	0

3	7.14%	1
4	14.29%	2
5	71.43%	10
TOTAL		14

Q3 Did you receive a timely response from the Speak Up Guardian?

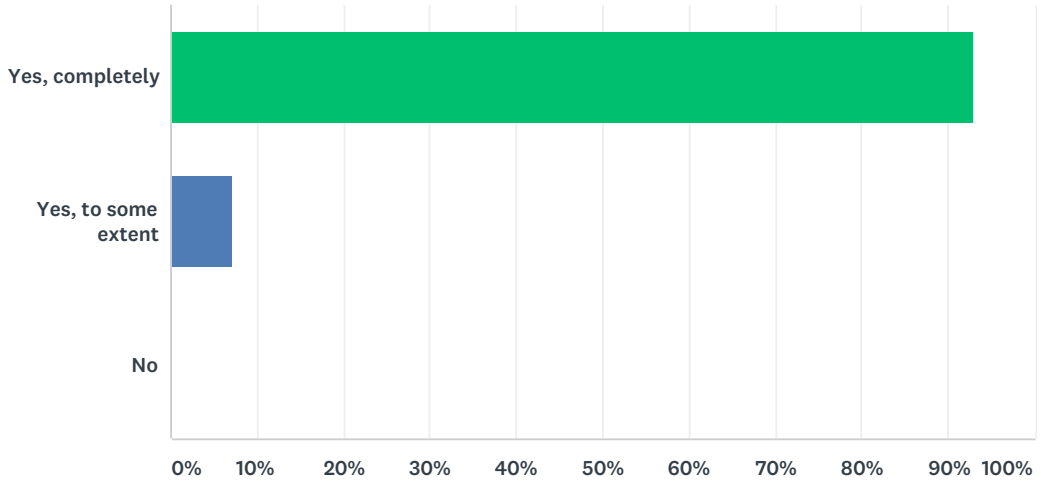
Answered: 14 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	14
No	0.00%	0
TOTAL		14

Q4 Do you feel that your concerns were listened to?

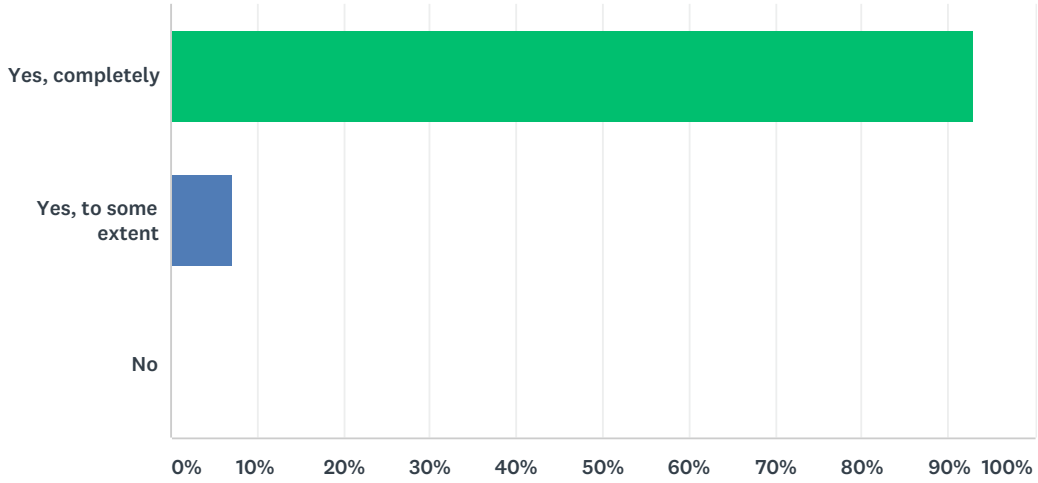
Answered: 14 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes, completely	92.86%	13
Yes, to some extent	7.14%	1
No	0.00%	0
TOTAL		14

Q5 Did you feel supported?

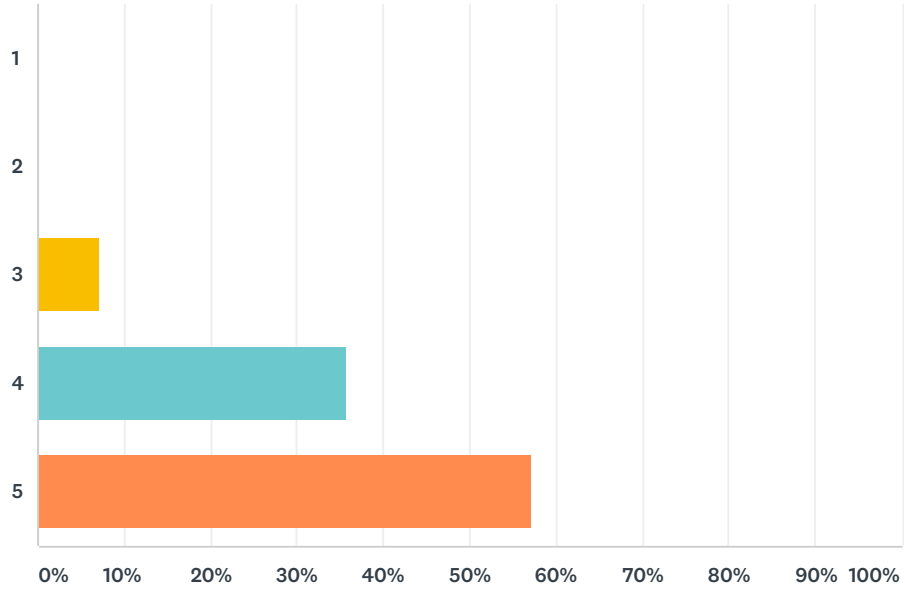
Answered: 14 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes, completely	92.86%	13
Yes, to some extent	7.14%	1
No	0.00%	0
TOTAL		14

Q6 On a scale of 1 - 5, to what extent do you feel that the Speak Up Guardian gave you the support/tools to resolve your concerns? (1=not at all, 5=completely)

Answered: 14 Skipped: 0

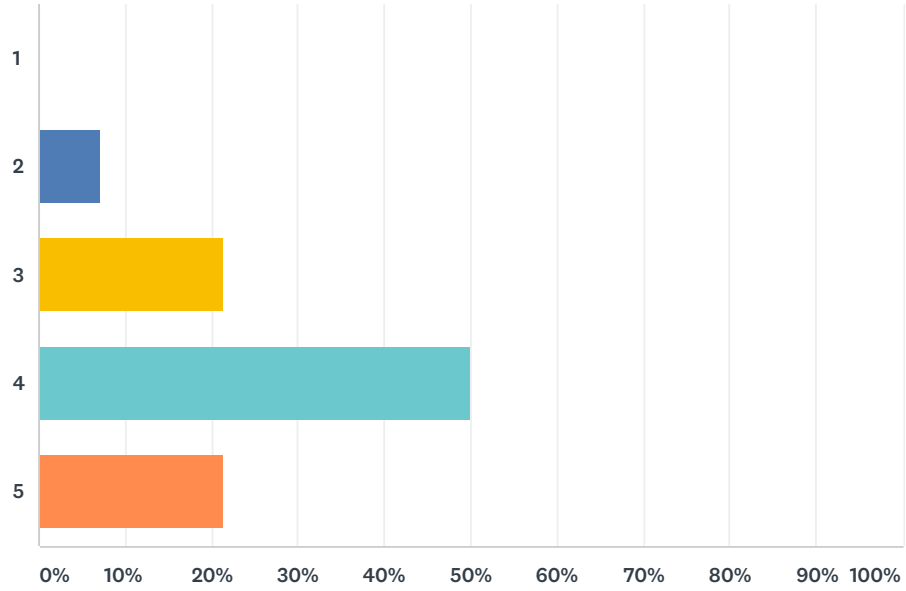


ANSWER CHOICES	RESPONSES	
1	0.00%	0

2	0.00%	0
3	7.14%	1
4	35.71%	5
5	57.14%	8
TOTAL		14

Q7 On a scale of 1 - 5, to what extent do you feel that your concerns have been resolved? (1=not at all, 5=completely)

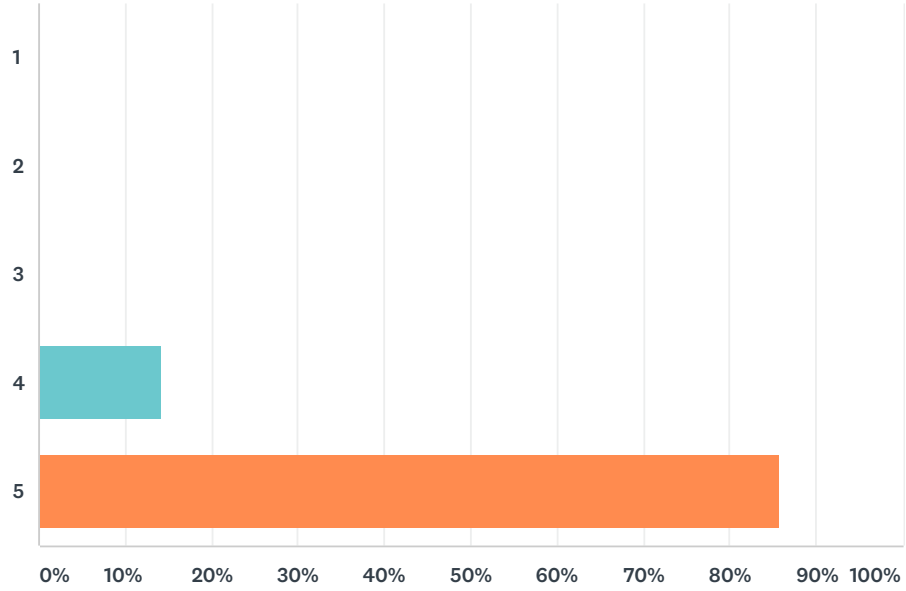
Answered: 14 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	7.14%	1
3	21.43%	3
4	50.00%	7
5	21.43%	3
TOTAL		14

Q8 On a scale of 1 - 5, how likely are you to recommend the Speak Up Guardian to a colleague? (1=not at all likely, 5=very likely)

Answered: 14 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	0.00%	0
3	0.00%	0
4	14.29%	2
5	85.71%	12
TOTAL		14

Q9 Do you have any further comments to make about the Speak Up Guardian (either positive or negative) or any suggestions on how the service could be improved?

Answered: 8 Skipped: 6

POD Committee Executive Summary Report 28 September 2017

Meeting information:			
Date of Meeting:	28th November 2017	Agenda Item:	7
Meeting:	Trust Board	Reporting Officer:	Miranda Kavanagh

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

Executive summary attached for POD Committee meeting held on 28th September 2017,

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

N/A

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

The Board are asked to note the contents of the attached executive summary.

East Sussex Healthcare NHS Trust

People & Organisational Development (POD) Committee

1. Introduction

Since the Board last met a POD Committee meeting was held on 28th September 2017. A summary of the items discussed at the meeting is set out below.

2. Review of Action Tracker

The outstanding items on the action tracker were reviewed and further updates would be provided at the next meeting.

3. Guardian of Safe Working Report

WY was welcomed to the meeting and provided background to the Guardian of Safe Working post remit. Many of the exception report issues raised previously had now been resolved. It was agreed that medical staffing issues would be discussed in relation to the winter plan to ensure that the plan included sufficient medical staffing. The Committee agreed that support available to junior doctors should be highlighted within the Divisions.

4. Feedback from sub-groups

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

5. Workforce Risk Register

The workforce risk register was reviewed by the Committee which included all risks scored at 9 or above. It was highlighted that the highest scoring risks related to staffing shortages. The Director of Corporate Affairs would be asked to ascertain the risk rating cut-off for the committee for future reports.

6. Risk Appetite

The Committee discussed the level of risk appetite assigned to the Leadership & Culture elements of the ESHT 2020 objectives. The Committee were mostly in agreement with the levels assigned, however, agreed that further information was required to understand how the decisions had been made to allocate the levels and this would be further reviewed at the next Committee meeting.

7. Retention Strategy

The Committee received a presentation from MT outlining the Trust's current position in relation to staff turnover and actions to be taken to increase the retention of staff, particularly within hard to recruit areas and staff groups. The presentation would be circulated with the minutes of the meeting.

8. Schwartz Rounds

The Committee welcomed Farida Malik (FM), Clinical Lead for Schwartz Rounds, who provided a presentation on the background of Schwartz Rounds and their implementation across the Trust from May 2015, and current arrangements for holding these. FM asked for committee members' support to attend future Schwartz Rounds and to champion Schwartz Rounds to their teams. The Committee were in agreement with this and chair thanked FM for an interesting presentation and commented on the importance of this within the Trust.

Approved minutes of the meeting held on 15 June 2017 are attached for the Board's information.

Miranda Kavanagh
Chair of POD Committee

20 November 2017

Board Assurance Framework

Meeting information:			
Date of Meeting:	28 November 2017	Agenda Item:	8
Meeting:	Trust Board	Reporting Officer:	Lynette Wells, Director of Corporate Affairs

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

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

Executive Summary:

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

Attached is the updated Board Assurance Framework. Following approval at the last Board meeting the gap in control related to ensuring children requiring an appointment with a community consultant paediatrician are seen in a timely manner has been removed as controls and assurance are now adequate. Other revisions to agree are:

4.4.1 An additional risk has been added in relation to ensuring there are adequate controls in respect of the threat of cyber security.

2.2.2 There is a proposal to increase the assurance levels in respect of clinical leadership from amber to green

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

Audit Committee – 22 November 2017 Quality and Safety Committee – 22 November 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.
- Agree the addition of the gap in control regarding cyber security.
- Agree to increase the assurance level to green for 2.2.2 clinical leadership.

Assurance Framework - Key

RAG RATING:

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

Status:

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

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

C indicated Gap in control
A indicates Gap in assurance

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

Strategic Objective 1: Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients

Risk 1.1 We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies

Key controls	Effective risk management processes in place; reviewed locally and at Board sub committees. Review and responding to internal and external reviews, national guidance and best practice. Feedback and implementation of action following "quality walks" and assurance visits. Reinforcement of required standards of patient documentation and review of policies and procedures Accountability agreed and known eg HN, ward matrons, clinical leads. Annual review of Committee structure and terms of reference Effective processes in place to manage and monitor safe staffing levels PMO function supporting quality improvement programme iFIT introduced to track and monitor health records EDM implementation plan being developed Comprehensive quality improvement plan in place with forward trajectory of progress against actions.
Positive assurances	Internal audit reports on governance systems and processes Weekly audits/peer reviews eg observations of practice Monthly reviews of data with each CU 'Quality walks' programme in place and forms part of Board objectives External visits register outcomes and actions reviewed by Quality and Standards Committee Financial Reporting in line with statutory requirements and Audit Committee independently meets with auditors Deep dives into QIP areas such as staff engagement, mortality and medicines management Trust CQC rating moved from 'Inadequate' to 'Requires Improvement'

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/milestone**	**RAG**	**Lead**	**Monitoring Group**
1.1.1	A	Quality improvement programme required to ensure trust is compliant with CQC fundamental standards.	March CQC inspection reports published Sept 15, trust in special measures. Quality Improvement plan developed Improvement Director working with the Trust. Mar-16 In depth review of all warning notice actions by exec team . QIP monitored by stakeholders, medicines management and incident deep dive took place Mar-16. May-16 to Sept-16 2020 Quality Improvement Priorities agreed and key metrics developed to support compliance and monitoring. Commenced preparation for Autumn CQC inspection. Mock inspection took place end June, further mock planned end of July. Continued monitoring of QIP and preparation for CQC inspection. Nov-16 CQC inspection took place October - draft report expect Dec 16. Continuing with quality improvement priorities eg end of life care and optimising patient pathways. Jan-17 Draft report expected this month Mar-17 Report published end of Jan 17. Trust rating moved to 'Requires Improvement' Good progress evidenced in a number of areas however 2 must do actions and 34 should do actions to address. Programme of improvements in place. May-17 Good progress in implementing CQC actions. Mock inspections planned for May-17 Jul-17 Action tracker in place and monitored with divisions and at Q&S. New CQC regulatory guidance being reviewed and communication plan developed to ensure Trust can evidence compliance. Sep-17 QIP in place. Continued monitoring of action tracker, internal inspection planned for 21 Sept. CQC progress meeting took place 22 Aug awaiting feedback on scope and timetable for inspection Nov-17 Inspection anticipated early 2018. Tracker being strengthened and prep group meeting. Community mock planned for Nov.	end Mar-18	◄►	DN / DCA	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-May 16 - TDA support 2 days per week to focus on sustainability and 62 day achievement. Ongoing review and strengthened processes supporting improved performance against cancer metrics. 2WW achieved Feb/Mar and 62 days improving. Jul-16 - Nov 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. 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 - Mar-17 Continued achievement of 2WW and 31 day standards. 62 days 84.1% off trajectory but improving. Number of programmes in place to support improvement including joint PTL tracking with both Brighton and Guys. May-17 Performance of 62 days below trajectory at 69.9% (latest data Feb 17) Greater focus on patient tracking with Guys being set up to run weekly in order to replicate the scrutiny on 38 day transfers currently in place with MTW and BSUH. Refer to monthly IPR for details of ongonig programmes of work to improve cancer metrics. Jul-17 Continued focus on 62 day achieved 76% (latest data Apr 17) trajectory 85% Sep-17 Presentation to Board Seminar in Aug. Continued progress in improving performance particular focus on achieving 62 day performance by end of Sept 17 Nov-17 Meeting 2 week wait target despite continuing increase in referrals. 62 day standard remains a challenging target. Daily telephone conferences held to ensure patients are seen within timescales. New reporting system being developed to provide a live view/dashboard anticipate this monitoring will assist in delivering improvements to cancer performance	end-Dec 17	◄►	COO	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.1.2	C	Emergency departments require reconfiguration to support effective patient assessment-treatment time and subsequent discharge to other specialist/bed areas. CQC report identified privacy and dignity issues.	Meet SECAMB monthly to review on going issues and joint working to resolve. Action plan and escalation process in place Capital bid with TDA for review to support expansion; outcome awaited, planning permission being sought in advance. Dec-15 Capital bid to be considered by ITFF at end of Feb. Mar-16 AHSN developing proposal to support the Trust with patient flow in A&E areas which will have a positive impact on privacy and dignity. Risk remains red as reconfiguration still required. May-16 Finance application being redeveloped for submission to ITFF to support capital plans. Jul-16 Trust prioritising reconfigurations from own capital programme to support effective patient pathways and address privacy and dignity issues. Finance application being redeveloped for ITFF. Sept-16 Urgent Care Programme Board established. Multi-disciplinary summit being planned to further support improved patient flow. Nov-16 Number of improvements being implemented in A&E although some not fully introduced due to staffing and space concerns, particularly at Conquest site. May-17 Trust allocated A&E capital funding from DH - £700k for Conquest and £985k for DGH. This will support streaming in the emergency departments. Funding bid also submitted for wider Urgent Care Programme eg development of ambulatory care. Jul-17 Project in place streaming redevelopment commencing to be in place by Oct 17 Sep-17 Building work commenced at DGH for ambulatory care. Nov-17 Ambulatory care at DGH expected to be complete by Christmas. Old fracture clinical at CQ being used as minor injury/minor illness area. Dedicated area for minor illness at both sites which will reduce overcrowding in majors.	end Dec 17	◄►	COO	SLF
2.1.3	C	Focus required on patient flow and delayed discharges across Trust sites to minimise impact on emergency departments and support compliance with constitutional standards.	Nov-16 Principles of Medical Model approved by Urgent Care Board and SAFER bundle pilot of 6 wards commenced in October with aim of improving patient flow by discharging patients earlier in the day to enable patients to be “pulled” from A&E, CDU and AMUs earlier in the day. Jan-17 Continued pressure on Urgent Care and Patient Pathway. Urgent Care Improvement Plan ion place and monitored weekly against the 9 improvement areas to ensure the anticipated impact is being realised. Streaming has led to an improvement in the number of breaches. New clinical lead for EDs appointed. Daily Opex call in place to discuss system wide issues. Mar-17 SRO reviewing project and re-aligning to focus on five priority areas. Streaming pathways written up for sign-off with specialties. ESHT Principles of Effective Emergency Care published and communicated to consultant and junior medical staff. SAFER bundle being rolled out across the Trust. May-17 Achievement of key constitutional targets and trajectories remains challenging however, performance is improving . A number of actions completed and being embedded, refer to performance report. Continued focus and programmes of work around A&E management, medical model and improved discharge. July-17 4 week improvement challenge started June with a concerted effort across the Trust to meet the 4 hour clinical standard. Achieved significant improvement in meeting the A&E standard but increased A&E attendance made it difficult to sustain. A&E Improvement Plan is in place and monitored weekly against 9 improvement areas to ensure the anticipated impact is being realised. Streaming in particularly has shown a marked improvement in the number of minors breaches. Sept-17 A&E Attendance increased by 6.9% year to date. A&E performance 87.7% July, and improved to 92.5% in August. Nov-17 Reduction in delayed transfers of care and continued improvement in ED performance Oct 92% Systemwide winter plan in place.	end Dec17	◄►	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**
2.1.6	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 -Mar 17 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. Strategy meeting planned and also meeting SPFT to discuss further support, need sufficiently skilled staff. Hospital Director CQ linking in with SPFT for mental health matters. Jul-17 Ward nurses having mental health training currently as part of away days. Special Observations Policy ratified and specials being requested ad hoc. Paediatric strategic work including mental health in reach plan Sep-17 - Meeting arranged to review issues on 25.09.17. Audit of children admitted to the paediatric ward with a mental health diagnosis commenced. Nov-17 Audit complete, will be presented at Nov WCSH audit meeting. SPFT continuing with training and support (particularly from the MH nurse daily) and will meet to review audit results in Nov/Dec	end Dec-17	◄►	COO	SLF Q&S
2.1.7	C	Effective controls are required to monitor and formally report on follow up appointments in order to ensure there is no clinical risk to patients suffering a delay.	Mar -17 Inability to formally extract data from Oasis PAS to report on patients follow up by time period. Local systems in place but require Trust wide system for monitoring and analysis. Liaising with supplier regarding options for reporting. May-17 Position resolved with community paediatrics due to data transition to Systm One. Ongoing discussion to find Trustwide solution. Jul-17 All doctors validating Follow Up waiting lists and telephone Follow Ups now taking place. Longest waiter 36 weeks. Sep-17 IT reviewing to develop a follow up waiting list that can be easily complied from existing systems and monitored at a specialty/consultant level for volumes and timeframe for appointments Nov-17 E system still under development but as a mitigation data re non appointed follow ups (within clinically defined timeframes) is sent to all service managers weekly for action.	end Dec-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. 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. Jan-17-Jul17 – Appraisal rate upward trajectory since Dec. Refresher training for newly appointed managers who undertake appraisals and Jul-17 Appraisal 81.73% and Mandatory Training 88.29% L&D continue to analysis and work with managers to achieve compliance. Sep-17 Continued improvement in both Appraisal 82.86% and Mandatory Training 89.56% all subjects reported to Board are now green (over 85%) and are nearing the 90% target. Risk that coming into the autumn/winter period levels may drop due to ability for staff to be released for training but we will continue to work with managers to maintain levels where possible. Nov-17 Oct data awaited - slight drop in both Appraisal and Compliance rates during Sept. Continued work with Divisions to focus on improvement. Highlighting drop in sessions, e-learning and workbooks for quick updates in many subjects.	end Sep-17	◄► Mar-16	HRD	POD SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.2.2	A	The Trust needs to develop and support its clinical leadership to empower them to lead quality improvement in order to realise the ambition of becoming an outstanding organisation by 2020.	Jul-16 Reviewing medical leadership roles to ensure they are appropriately resourced. Faculty of Medical Leadership Programme in place. CEO leading regular meetings with consultant body. Medical education team continue to work with junior doctors to improve engagement and enhanced support. New Medical Director appointment (subject to central approval) Revision and reappointment of all key medical role job descriptions: CU Lead; Speciality Lead; Chairs of Clinical Boards (urgent care, elective, cancer); Chairs and ToR of key Medical Clinical Governance sub committees. Sept-16 New Medical Director in post, progressing appointments of Chiefs and deputies. Nov-16 Consultant meeting 3rd Nov with CEO, MD, FD. Faculty of Medical Leadership and management training for newly appointed medical leaders 8th and 9th November. Appointments made for Divisions of Medicine and Surgery/Anaesthetics/Diagnostics, but no appointment as yet for W+C. Chairs of Urgent Care and Elective Care Boards have been made. Jan-17 Final FMLM training end of Jan. All Chiefs now appointed, including Women's and Children. Specialist leads advertised. Mar-17 Most speciality leads now appointed. Job planning training to follow. Other training possibilities arranged eg for “case investigation” May-17 Developing with Health Education England bespoke leadership development programme for ESHT to support organisational leaders in transformation, systems leadership and improvement. Initial scoping meetings taking place. Jul-17 Cohort 1 of Leading excellence programme identified and invited to attend first programme commencing in August Sep-17 The first Cohort for Leading service programme has been identified and will commence in October. The pilot for the new managers induction programme will take place in September. A stakeholder event is being held in September to discuss the new Leadership and talent management strategy Nov-17 Leading excellence course progressing, good feedback received. Propose move to green.	end Dec-17	▲	MD	POD

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.2.1	A	Assurance is required that the Trust will be able to develop a five year integrated business plan aligned to the Challenged Health Economy work.	Challenged Health Economy and Better Together Work on-going. Trust developing clinical strategy. STP for Sussex and East Surrey now incorporates placed based care (ESBT) as one of its key elements. Mar-17 Trust are continuing to work with all STP partners to further develop plans. Current work includes participation in the Acute Networks Steering group which is being facilitated by Carnall Farrar. Work is ongoing in developing the governance structures and framework for the ACO which is due to enter shadow form in April 2017 May-17 STP Programme Board is reviewing Carnall Farrar work to provide a broad strategic understanding of demand and capacity issues in our Acute Hospitals in the STP footprint and all partners are working closely together to consider how we can provide Acute services that will meet the future needs of our population sustainably. Jul-17 Our System wide placed based plans (ESBT) are the local delivery plan that aligns commissioners and providers in health and social care. We have undertaken significant work across the system to redesign care pathways and this is linked to our clinical strategy which is currently being consulted on. Work is ongoing with the wider STP work currently reviewing pathology provision along with other acute services. Sep-17 Working with commissioners on aligned financial and operational plan that will move the system to a balanced financial position. Will be agreed by Alliance executive and progress against plan will be monitored by this group. Work commencing on Acute strategy with support from the WSHT/BSUH Medical Director and our own Medical Director. Will align with Tertiary currently being developed by BSUH. Nov-17 work is ongoing with commissioners and NHSi to agree and align our long term financial position and operational plan. Planning for 18/19 is progressing with the divisional teams with regular updates provided to FISC	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	C	Effective controls are required to ensure the Trust achieves compliance with the four core 7 day service standards by 2020. There is a risk that the Trust may not achieve compliance with three of the four resulting in loss of reputation due to difficulties in funding, staff recruitment to manage increased rota requirements. Standards 5 (access to diagnostic tests), 6 (access to specialist consultant led interventions) and 8 (Patients with high-dependency care needs receive twice or one daily specialist consultant review depending on condition) are those at risk.	01/07/2017 7 Day Service Steering Group reporting into Clinical Effectiveness Group and Quality Improvement Steering Group. Project has support from Programme Management Office, with dedicated project lead assigned. Baseline audit being undertaken. Working closely with NHS England and NHS Improvement to gain best practice/lessons learnt from other Trusts Sept-17 Baseline template to be reviewed prior to distribution and gap analysis underway; Discussions with VitalPAC provider taking place. Strategy/Plan for submission to 7DS Steering Group. Project Initiation Document being drafted. Nov-17 Project initiation document being progressed will be considered by 7 day steering group.	end Apr-18	◄► **Jul-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	Ongoing requirement for assurance on the controls in place to deliver the financial plan for 2017/18, with an efficiency requirement of £28.7m, leading to a reduction in deficit for the Trust and exit from financial special measures.	July 2017 – the Trust has a detailed financial plan for 2017/18, initially approved by the Trust Board in January 2017 and which has been subject to an iterative development process.Trust has delivered on plan to Month 2, and early indicators suggest delivery at Month 3. From Month 4, the level of risk increases, and the level of both delivery support and scrutiny/challenge will continue to increase to ensure adverse variance or emerging risk is identified and escalated at the right pace. Key risks to the financial position are articulated in the Board report, and discussed in more detail at the Finance and Investment Committee. The Trust has appointed a new Head of Contracts, to ensure early escalation of contentious contract issues, and has bolstered the Financial Management Team to ensure appropriate support for budget-holders. A detailed activity and bed management plan has been agreed with the operational teams and clinical units, and the Performance and Information team are providing regular updates on performance against the plan to ensure early identification and action of performance below expectations. Sept-17 – at Month 4, the Trust was reporting fully delivery of plan, noting a number of significant risks in respect of the profiling of elective activity, the CIP plan and the recoverability of income from Clinical Commissioners in East Sussex. The initial financial results from Month 5 indicate that August trading was below plan, and intensive work is in train to ensure that the plan was calibrated correctly and that all actions are in train to address variance and to ensure a return to plan. A full review of the deliverability of the CIP programme is in train and reforecast of the Trust's financial position will ne reviewed for the Finance and Investment Committee meeting in September 2017. CCGs and Trust developing a shared forecast for the activity-based outturn for the system for the year. There remain significant risks to the system financial position, as well as individual organisational positions. The Trust has reached provisional agreement with the CCG in the 16/17 issues (noting that a new set of challenges were subsequently issued) and has reflected the appropriate component of the cost in the year to date financial position. Nov-17 – At Month 6, the Trust has moved off financial plan by £2.4m excluding STF (with a further £2.2m of lost STF) and is working with NHSI and Commissioners to develop a full year forecast. The movement is driven by non-delivery of elective work, and delays in delivery of the CIP programme. The Trust met with the FSM lead in October 2017, and has been asked to refresh the forecast, to secure additional support to validate the forecast, and to revisit potential recovery actions – with a brief to return this to NHSI and the Finance and Investment Committee in November 2017 . New Director of Financial Improvement appointed to the Trust and commenced work with the organisation on 6/11/17, with a brief to support the Trust Board and Executive in moving towards financial sustainability. Trust has reached provisional agreement with the East Sussex CCGs on a minimum income level, aimed at providing stability within the local health economy for financial planning purposes. However, this creates a significant financial challenge for the system, which manifests itself in the CCG financial position, and the Trust is working closely with system partners to support delivery of the £5.2m system financial recovery plan.	Commenced and on-going review and monitoring to end Mar-18	◄►	DF	F&I

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

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

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
4.2.1	A	The Trust has a five year plan, which makes a number of assumptions around external as well as internal funding. Assurance is required that the Trust has the necessary investment required for estate infrastructure, IT and medical equipment over and above that included in the Clinical Strategy FBC. Available capital resource is limited to that internally generated through depreciation which is not currently adequate for need. As a result there is a significant overplanning margin over the 5 year planning period and a risk that essential works may not be affordable.	May-17 – The Trust has set an initial capital plan for 2017/18, which reflects key organisational priorities and the funding available. Five year capital plan is being redeveloped and refreshed to reflect the challenges and opportunities facing the Trust. Jul-17 – the Trust has an approved capital plan for the year, following a detailed prioritisation process, and this is reviewed by the Capital Review Group on a monthly basis, with interim checkpoints to refresh the forecast. The demand for capital is greater than that available, and the Trust has a number of applications for capital in with NHSI for loan capital (primary care streaming, and ambulatory care). The Trust is also working with a number of potential strategic partners and with the Friends to establish alternative sources of capital funding to ensure that the clinical infrastructure is maintained. It will be important to review the capital programme – both the spend and the demand for capital – on a regular basis through the CRG and FIC to maintain sight of risks to clinical quality. Sept-17 – Full year forecast for capital plan remains under careful review, with a number of key priorities requiring in-year funding and being balanced against the more strategic investment required. Spend at Month 5 includes expenditure being incurred on the implementation of the ambulatory care units and GP streaming centres, with PDC received from DH for the latter. Significant investment in estates infrastructure required to address historical compartmentalisation issues in respect of the Eastbourne site. Overarching requirement over next three years will be in the region of £12m, with the Trust working to develop a business case with NHSI support. F&I monitors capital programme with quarterly deep dives. Nov-17 – Month 6 Trust has spent £6m of capital across all expenditure lines. Capital Review Group was forecasting a £3m overspend against capital to Month 6, but a full review of the capital plans and forecasts across the Trust has been undertaken during October and November 2017, resulting in a downward revision of the forecast – the Trust is now forecasting delivery of the capital plan within budget (subject to receipt of the loan from DH for the Ambulatory Care Units). Planning process for 2018/19 commenced, with key stakeholders asked to review capital priorities and requirements during Nov, to support development of a draft plan for Dec 17. Plan will be reviewed by the Senior Leaders Forum and F&I. Alongside this, the Trust is developing a detailed long-term financial model which will include a capital component over the modelled period with a target completion date of Jan 18.	On-going review and monitoring to end Mar-18	◄►	DF	F&I
4.3.1	C	Adequate controls are required to ensure that the Trust is compliant with Fire Safety Legislation.There are a number of defective buildings across the estate and systems which may lead to failure of statutory duty inspections. This includes inadequate Fire Compartmentation at EDGH	Sept -17 Ongoing programme behind schedule due to unable to gain decant ward and asbestos issues. Fire doors replaced and Stairs wells upgraded. EDGH Compartment project has been revisited in July to plan for upgrading compartmentation in Seaford and Hailsham Wards, which will require closing the Wards. Meeting held with ESFRS to discuss timescales for improvement Nov-17 Meeting with ESFRS 6 November. Trust to provide information in respect of balanced risk related to ward decants required to complete fire compartmentation works.	end Mar-18	Sep 17 ◄►	CEO	Audit Committee

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 Anti-virus and Anti-malware software Client and server patching NHS Digital CareCert notifications Information Governance Toolkit
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 SESCSG Sussex and East Surrey Cyber Security Group

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
4.4.1	C	Adequate controls are required to minimise the risks of a cyberattack to the Trust's IT systems. Global malware attacks can infect computers and server operating systems and if successful impact on the provision of services and business continuity.	Nov -17 Develop Information security programme of work Staff Training - Phishing Simulation software Formal information security certification for internally provided digital services	end Mar-18	NEW	DF	Audit Committee

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 Substantive workforce numbers increased from 5684 ftes to 5949 ftes (Apr-Nov). 80 offers made to overseas nurse. Introduction of a number of new roles to address recruitment issues. Discussions with Brighton University to establish work placements for Physicians Associates Aug-17 and appointable from Aug-18. Mar-17 6 Doctors assistants started, positive impact on workload of Junior Drs, consideration will be given to roll-out to other Trust specialties. GP Fellowship role advertised, anticipated start Sept-17. Quarterly CU workforce planning and recruitment meetings commenced to review action plans to address recruitment issues. Head hunters engaged to assist with Hard to fill positions. Overseas nurse recruitment continues with additional 76 Philippine nurses offered (start Nov-17). EU nurses c30 offers. Targeted UK nurse campaign commenced Feb-17. Joined NHS Employers Retention programme, undertaking a project internally on the retention of staff. Attending local carers fairs to promote the Trust. May-17 Recruitment hotspots identified. Regular vacancy review and action plans to address priority vacancies. R&R Policies examined as a method of addressing turnover and attraction issues. Continued focus on overseas recruitment for registered nursing; 76 Philippine nurses offered (start date /Nov/Dec 2017.15 Italian nurses recruited in March/April. Additional visits to EU/Italy proposed to address future requirements and turnover. AHP- Workforce planning to be carried out to identify and address future requirements ((MSK contract).Recruitment campaign to support. Trial of Refer a Friend and Golden Handshake for Theatre nurses, with subsequent roll out across Trust. Workforce planning process developed to identify skill mix and new roles. Jul-17 Recruitment Incentives developed to assist with attracting suitable candidates for difficult to recruit areas. Utilising agencies on preferred list of suppliers as Expressions of Interest. International Nurse recruitment continues. Regular monthly events planned and recruitment booklet being finalised. Continued development of new roles. Workforce reviews and planning sessions programed for autumn, linked to the business planning cycle. Sep-17 Medical and Dental Head-hunters engaged. Business case for single Agency working. Recruitment Incentives introduced. Other roles being developed e.g. GP in A& E. Recruitment booklet for attraction of overseas doctors.REG NRS & MIDWIFERY Monthly Skype interviews from Jul-Oct for overseas international nurses with MSI(recruitment agency)- July event 13 offers made. Target 35-40 nurses. Rolling nurse recruitment adverts and selection-targeted approach for specific areas. Nov-17 Discussions with external Recruitment Practices Outsourcing Agency to assist with recruiting 50 most difficult to recruit medical posts. This would assist with reducing current vacancy rates across key Trust areas. Ongoing International Nurse recruitment -16 candidates to join Trust between Dec 2017 and April 2018. UK student nurse recruitment event -21 candidates confirmed.. Workforce plans produced by Department. Workforce meeting with Nursing to agree future recruitment plans in greater detail. Continued social media activity across hard to recruit posts to drive candidate traffic to the Trust website. Targeted activity around ED vacancies.	end Dec-17	◄►	HRD	SLF

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

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

Key controls	Leading for Success Programme Leadership meetings Listening in Action Programme Clinically led structure of Clinical Units Feedback and implementation of action following Quality Walks. Organisation values and behaviours developed by staff and being embedded Staff Engagement Plan developed OD Strategy and Workstreams in place Management Essentials Programme
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.	Mar-17 - May 17 The most recent CQC inspection (October 2016) found that staff were largely positive and well engaged. Work will continue to improve staff engagement at all levels of the organisation. Quarterly Staff Family and Friends Test - significant year on year increase in two questions asked If a friend or relative needed treatment would you be happy with the standard of care provided by the organisation? increased from 61% Q4 2015 to 77% Q4 2016 Would you recommend your organisation as a place to work? Increased from 38% Q4 2015 to 66% Q4 2016 Jul-17 – Work continues following staff feedback in the National Staff survey – working on the three corporate priorities and each division has own action plan. Latest Staff FFT identified an increase in the number of staff who would recommend the trust for care and treatment to 80% but there has been a reduction in the number of staff who would recommend us as a place to work. Engaging with teams to find out more about this responses and what they feel will make a difference. Sep-17 Renewed focus on medical engagement . During Sept all consultants and SAS doctors will be asked their views on their experience of working here at the Trust via the national medical engagement survey. Divisions continue to look at different ways to improve staff engagement. Results from the most recent pulse surveys been published and shared with divisions . Overall the results are positive but we are investigating further how we are involving staff in decisions. Nov-17 Continued work on ensuring that staff feel valued and wellbeing is key priority. Unsung Hero's roadshows and celebration event in Oct . Range of health and wellbeing activities available to staff including: Health Checks for aged 40-70 , flu vaccination in workplace. Staff listening conversations to share views on what we could do better about stress in the workplace which will inform new Stress at Work policy, our physiotherapist in occupational Health is supporting staff with MSK injuries as well as trying to raise the profile of how to prevent MSK injuries. Three very successful Schwartz rounds at EDGH, Conquest and Bexhill hospitals	end Sep-17	◄►	HRD	POD SLF

Chief Executive's Report

Meeting information:			
Date of Meeting:	28th November 2017	Agenda Item:	9
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

Improvement Directors

Since the last Board meeting we have had a change in both our Quality and Financial Improvement Directors and would like to place on record our thanks to both Philippa Slinger and Ian Miller. We are now being supported on a part time basis by Alan Thorne for Quality Improvement and Mark Hackett, Financial Improvement.

Financial position

There is further detail on this below and in the papers. The Trust has seen very significant improvement in its quality and safety management and operational performance over the past 12 months. The financial position however is not yet improving in line with our ambition, and the Trust is off plan for the year. A detailed review of the underlying position is under way. The cost improvement programme is being revised. A firm assessment of the current position and year end forecast is being developed and will be brought to F&I Committee and to NHSE.

2. Quality and Safety

2.1 New Director of Nursing

Vikki Carruth started in the Trust on 2 October 2017

2.2 During October we had our fourth Never Event of the financial year which involved the ophthalmology team. Initial learning and actions already implemented. It has been identified that three out of the four Never Events involved the effective use of the surgical safety checklist in the theatre environment. Steps are being taken to address this issue

2.3 There has been an increased level of post-operative infections in orthopaedic patients over the past 12 months. The Trust is now an outlier on this issue. A detailed review has identified no specific or single cause. A number of steps are being taken to tighten all aspects of operating procedures in the theatres. A meeting of orthopaedic surgeons has been held to discuss all aspects of the matter.

2.4 Due to focussed work on prevention, the rate of post-operative DVT or Pulmonary Embolism has reduced by over 50% from a peak of 0.07% in June last year to 0.025% currently.

2.5 There has also been significant improvement in the screening for and management of sepsis. Over the past 15 months, the monthly mortality index for sepsis has reduce from 166 to 41; the rolling 12 month RAMI has reduced from 124 (against a peer comparator of 92) to 78 (against a peer comparator of 77).

2.6 A CQC mock inspection was conducted at EDGH and Conquest on 21 September. The feedback was generally very positive. Some areas for improvement were noted and are being addressed.

2.7 End of Life Care remains a core priority for our organisation and for our patients. The End of Life Care Steering Group has focussed on the CQC key recommendations and has made good progress on embedding changes. The key changes include:

- A system that ensures the ward staff inform the site team daily about end of life patients on their wards to ensure they are prioritised.
- A process of gaining family and carer feedback.
- A revised training and development programme has been developed. EoL training has been included in the mandatory training programme.
- ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) will replace DNACPR.

- The Supportive and Palliative Care Team cover (7 days a week) is being developed into a business case.
- The EoLC Steering Group will broaden its focus and will report into Clinical Outcomes Group and to the ESBT End of Life Clinical Reference Group. The Working Group has seven work streams which will take forward all new developments.

3. People, Leadership and Culture

3.1 Recruitment & Retention

Recruitment

- UK student nurse recruitment event in November, 21 candidates confirmed.
- International recruitment continuing in the Philippines and Indian sub-continent for Nursing, Medical and AHP staff groups
- Ongoing discussions with Medacs (RPO Agency) with regard to medical recruitment for 50 difficult to recruit posts over the next 2 years.

Temporary Workforce

- Continued progress on conversion of agency staff to bank and direct recruitment to bank.

Workforce Planning

- Seven workforce planning sessions were delivered during September and October as part of the business planning process, as well as bespoke divisional sessions
- Workforce plans and narrative to be completed by 3rd November.

3.2 Junior Doctors' Contract

- All Doctors in Training are now on the 2016 contract, and we are no longer required to report weekly to NHSi.
- Interviews for GOSWH at Conquest undertaken 2nd November. Dr Nadia Muhi-Iddin appointed (due to start January 2018)
- Exception reports for Education remained at 3 in both September and October. Exception reports for Hours show a decrease of 10 from 84 in September to 74 in October.
- Junior Doctors Forum held on 13th September. Key issue raised was allocations of Doctors in Training for escalation wards.

3.3 Staff engagement

- The Leading Service programme of leadership training commenced October 2017
- The first cohort of Leading for Excellence has also commenced
- Action Learning Sets are being undertaken for Ward Matrons
- Leadership / Career Development workshops are being undertaken with Band 6 Nurses
- Supporting a number of staff to do NHS Leadership Programmes.

4. Finance and Capital

4.1 The Trust's financial position is challenging. Good progress has been made on strengthening financial management across the Divisions, and improving the underlying run-rate. However, as at Month 6, the Trust is reporting a £2.4m adverse variance to its operational plan – driven by a fall in planned care work, and a series of cost pressures. Movement off plan means that the Trust is ineligible for the national STF funding stream, which adds a further £2.3m to the position. The Trust is reviewing in detail the forecast for the remainder of the financial year, with the Finance and Investment Committee overseeing a detailed analysis of the likely outturn position. The Trust is working closely with the NHS Improvement Financial Special Measures and Regional Teams to validate the forecast and identity appropriate recovery actions.

4.2 The Trust has reached provisional agreement with the Eastbourne/Hailsham and Hastings/Rother Clinical Commissioners around the overall income available for the year. This represents a considerable commitment by the Commissioners to supporting the Trust, and will significantly improve the cash flow as well as allowing the local health economy to focus on reducing the cost of provision. There is work to do to finalise the contractual arrangements, and the funding provided by the CCGs crystallises a significant financial challenge for the local health economy. The Trust and the CCGs, alongside East Sussex County Council, are working to develop a system financial recovery plan aimed at reducing the overall system deficit. The East Sussex Better Together partners are also working closely with regulators, NHS England and NHS Improvement, to develop a shared approach to the management of the system challenge.

4.3 The Trust recognises that the cash flow consequences of differences of opinion with Clinical Commissioners have been challenging, and coupled with adverse financial performance, this has created a number of challenges for the Trust in timely payment of suppliers. The agreement with the CCGs on the financial position will significantly improve the Trust's cash position, and improvements in both cash management and the scrutiny of high priority and local supplier payment profiles should lead to improvements in payment times. The Trust is grateful to both our supplier partners and our staff for their continued support and patience during this period.

4.4 The Trust's capital forecast is now within budget, reflecting the results of a full reforecast and review by the Director of Finance. The Trust is making, with support from NHS Improvement, significant investments in technology, infrastructure and improvements to the estate – including the implementation of primary care streaming on both sites, and the development of an AMU on the Eastbourne acute site.

5. Access and Delivery

5.1 We were pleased to receive a letter from the Secretary of State for Health in October for having the most improved quarterly performance in A&E in the country. As outlined in the performance report there is real commitment across the health and social care system to maintain and further improve this performance.

5.2 The 4 hour clinical standard continues to improve through October, with performance of over 90% being sustained, putting the Trust in the top third of the country.

5.3 Cancer two week wait continues to deliver, and the 62 day standard has improved. However this continues to be high priority, with an expectation nationally that the Trust will deliver 85%.

5.4 There has been a reduction in total bed days and length of stay, despite an increase in non-elective demand. However there remains a further opportunity to reduce the number of patients waiting for diagnostics, therapies, continuing health care and social care placements. We continue to work with system partners to improve processes over the next few weeks before the winter pressures manifest.

5.5 Primary care streaming has started at DGH, with the new facilities being completed in mid-November. We continue to recruit GPs and Advanced Nurse Practitioners to deliver a skill-mix offering 12 hours of primary care service 7 days a week.

5.6 The extended ambulatory and acute medical unit opens at DGH in early December. The full benefits will be impacted until recruitment is complete, this will benefit patient care, reducing demand on the emergency departments with increased direct streaming to the medical unit, with a greater emphasis on avoiding admissions where patients do not medically require it.

6. Strategy, Innovation and Planning

6.1 The ESHT Clinical strategy has now been presented and discussed at the ESBT clinical forum and comes here today for formal ratification from the Board. The key change has been to articulate that our Clinical Strategy is part of an emerging ESBT Strategy which will be developed over the coming months.

6.2 Our planning team is busy supporting the divisions to develop their business plans for 2018/19. There is a timetable for regular Executive and FISC review and plans will be presented to the Board in due course.

6.3 We held our first ESHT Improvement Forum at the beginning of the month and over 70 people attended from across the Trust. We had displays of our ESHT /ESBT recent and current improvement programmes; and we had guest speakers from Western Sussex Hospitals Trust who described some of their improvement processes and initiatives. We intend to run these as a regular event and the next one will be at The Conquest site.

7. Corporate Affairs

7.1 <u>Care Quality Commission</u>
A CQC system wide review took place during the week of the 13th November to evaluate how well people move through the health and social care system, and what improvements could be made. The review has been co-ordinated by ESCC and provided an opportunity for system partners to demonstrate how the local system works together to deliver safe, timely and high quality care for older people living in East Sussex. The CQC report is expected in January and a quality summit will take place.

We continue preparations for our own CQC inspection and anticipate this will take place early in 2018.

7.2 <u>Kipling Ward Children's Play Area</u>
On behalf of the Board, I would like to publicly thank the members of Darvell Bruderhof community whose team of young people have helped us to revamp the children's ward play area at the Conquest Hospital. This included painting a large and colourful mural on the wall. Photographs are available on the Trust website.

Integrated Performance Report - Month 6

Meeting information:			
Date of Meeting:	28th November 2017	Agenda Item:	10H
Meeting:	Trust Board	Reporting Officer:	Executive Directors

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)	☒

Have any risks been identified ☒ *(Please highlight these in the narrative below)* Risks identified are captured on the risk register	On the risk register?

Executive Summary:

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

The attached document provides an overview of performance for the period ended 30 September 2017. Key points to review and note:

Access

- Cancer : continued delivery of 2 week wait and 31 day cancer metrics. Continued improvement in 62 day performance now 81.6%
- A&E : Attendances continue to increase, up by 6.6% year to date. 4 hour standard 87.8% continued improvement will be evident in Oct data.
- Diagnostics: Failed to meet the 1% standard with a performance of 2.5%. Predominantly due to CT failures over the month and staffing in other key specialties. Additional radiology sessions have taken place to reduce the backlog and minimise further breaches.
- Delayed transfers of care: 4.3% for September and working to meet the national 3.5% target to support winter plans.

Quality

- Serious Incidents: 4 serious incidents were reported in September - 1 patient fall, 2 related to stroke and diabetes pathways and the final incident was a Never Event that involved the incorrect size prosthesis inserted as part of an orthopaedic procedure. Comprehensive RCA's are taking place.
- Falls: 11.3% year on year reduction in falls. Trust participating in National Falls Collaborative working with NHSI. Trialling new falls risk assessment tool and conducting deep dive of the last 20 serious and moderate harm falls to identify themes/trends.
- Complaints: 43 new complaints were received in September, equates to 1.9 complaints per 1,000 bed days. Since April 2017 , 7 cases have been referred to the Parliamentary and Health Service Ombudsman (PHSO); to date 1 case has been upheld and 2 partially upheld.

- Patient Experience: Inpatient FFT response improved year on year from 15.2% to 39.2% Trust currently 8th nationally on number of responses. 97% of inpatients who complete the FFT who recommend the Trust
- Mortality: Latest SHMI published for period April 2016 to March 2017 within expected range at 1.11. RAMI August 2016 to July 2017 (rolling 12 months) is 93 compared to 106 for the same period last year (August 2015 to July 2016). July 2016 to June 2017 was 94

Leadership and Culture

- Temporary staff expenditure: £3,491K in September; comprising £2,177K bank expenditure, £1,269K agency expenditure and £45K overtime. An increase of £332K compared to August. Analysis of expenditure is given on slide 26.
- Vacancies: 745.9 fte (a vacancy factor of 11.0%), this is 39.5 ftes higher than August but is due to an increase in budgeted establishment.
- Annual turnover: 0.4% higher at 11.6%, representing 654.7 fte leavers in the last year.
- Sickness: Monthly sickness rate 4.3%,annual sickness rate was also 4.3%, unchanged from last month. Urgent Care 6.4% and Estates 6.1% have the highest sickness absence level. A comprehensive action plan is in place to manage sickness absence.
- Mandatory training: Decreased slightly by 0.3% to 88.8% and appraisal compliance increased by 0.6% to 82.2%

Finance

- Financial Position: September reported a £1.2m adverse variance in month and a £2.4m adverse variance against plan YTD. STF funding of £2.2m for Q2 has not been achieved.
- CIP: Reclassified £10.9m CIP to regular budgetary management, leaving £17.8m of planned schemes.

Sustainability

- Clinical Strategy: Developed and separate item on the Board agenda
- Business Planning: process commenced and divisions being supported

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

Performance is reviewed by the relevant Board sub-committee. For example Quality is considered at Quality and Safety Committee, Workforce at People and Organisational Development etc.

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

The Board is asked to review the integrated performance report and consider the adequacy of controls and actions.

East Sussex Healthcare NHS
NHS Trust

Month 6 – September 2017

TRUST INTEGRATED PERFORMANCE REPORT

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East Sussex Healthcare NHS
NHS Trust

Contents

East Sussex Healthcare NHS Trust

September 2017

Key Successes

- The Trust continues to meet the 2 week wait and Cancer 31 day targets.
- Improvements have been seen in the 62 day performance

Key Issues

- A&E Attendances remain at highest levels in over a year, adding pressure to the 4 hour target.
- The higher than expected number of non-elective admissions is impacting on flow through the hospital
- Demand and staffing issues impacted the Diagnostics standard
- The number of patients waiting over 62 days for cancer treatment is higher than expected.

Key Risks

- Delivery of the financial targets and savings plans

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

Quality and Safety

QUALITY AND SAFETY

Indicators

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Sep-16	Sep-17	Var	2016/17	2017/18	Var		
Total patient safety incidents reported	M	1786	998	-44.1%	8228	6477	-21.3%	1192	
Total falls	M	152	122	-19.7%	905	803	-11.3%	145	
Falls assessment compliance	M	85.2%	92.8%	7.6%	91.1%	90.1%	-1.0%	89.4%	
Total grade 2 to 4 pressure ulcers	M	53	38	-28.3%	302	289	-4.3%	54	
Pressure ulcer assessment compliance	M	94.0%	96.2%	2.2%	89.9%	89.8%	0.0%	92.0%	
Number of MRSA Cases	0	0	0	0	0	1	1	0	
Number of Cdiff cases	4	3	0	-3	27	17	-10	3	
Number of MSSA cases	M	4	1	-3	9	4	-5	1	
All ward moves	M	2280	2254	-1.1%	13809	13259	-4.0%	2232	
Night ward moves	M	399	442	10.8%	2573	2424	-5.8%	402	

The total patient safety incidents reported per month has continued to decrease. The previous increase was party due to the changes in health records and now the system has been in place for a while the number of missing records has significantly reduced.

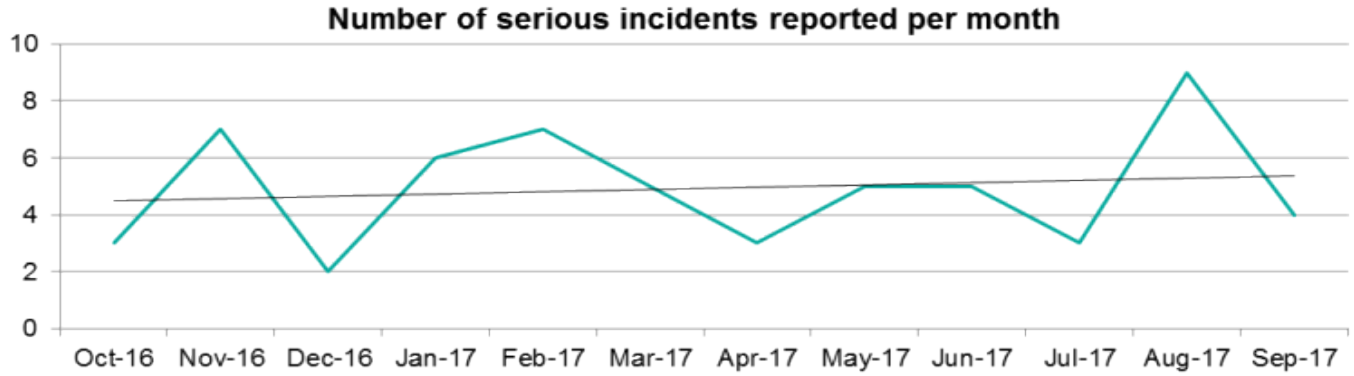
The percentage of no harm/near miss incidents is 84% of all patient safety incidents which is an indicator of a good reporting culture.

Patient falls remain at 5.5.per 1000 bed days for 2017/18 which is a reduction from last year (6.1). The DoN has signed the Trust up to the National Falls Collaborative working with NHSI.

Pressure Ulcers (all category 2 and above) are currently at 1.3 per 1000 bed days for the Acute and Community Hospitals April to Sept 2017. Since April 2017 there have been:

2 x category 4 Pu's, 7 x category 3 PU's in Acute and Community Hospital and 16 x category 3 in patients home and nursing home. Further work is in progress to provide information on avoidable or unavoidable cases where lapses in care may lead to avoidable harm. RCAs will ensure any lapses are discussed and lessons are learned, shared & embedded.

Serious Incidents (SIs) reported in September



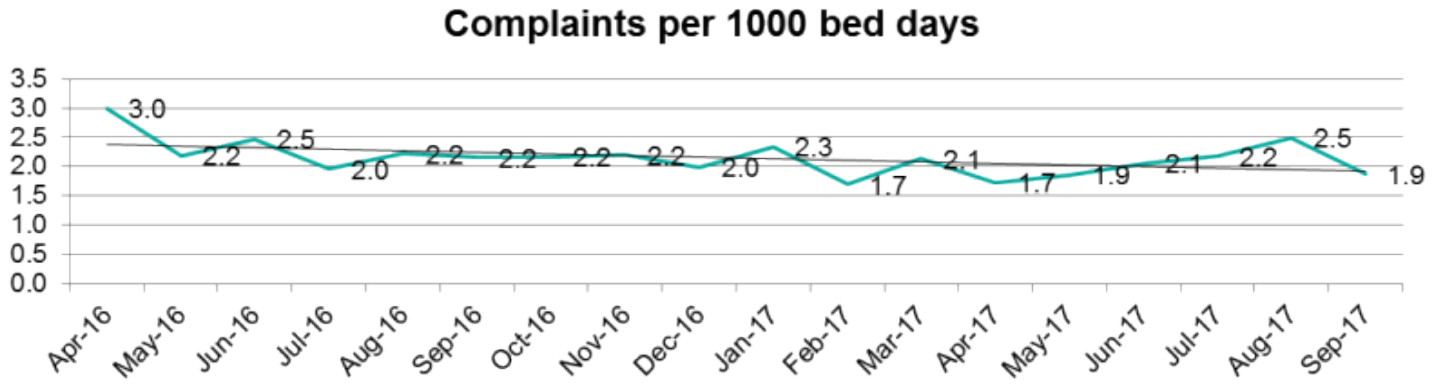
The most reported serious incident category continues to be clinical treatment and care pathways. This includes injuries and complications whilst in the operating theatre or misdiagnosis and delays to treatment. Patient falls is the second highest category and although there is a reduction in falls further work is underway to trial a new falls risk assessment tool and to conduct a deep dive of the last 20 serious and moderate harm falls to identify any trends or themes. This will report to the Patient safety & Quality Group.

During September 4 serious incidents were reported. These consisted of a patient fall, two were related to pathways for stroke and diabetes and the final incident was a Never Event that involved the incorrect size prosthesis inserted as part of an orthopaedic procedure. The investigations are underway for all these incidents and an external review has been commissioned by the Trust to provide assurance on our theatre services as an additional safety measure. All Never Evenst are now being overseen by the DoN and/or MD, and all SIs are now being overseen by the DoN.

There are currently no overdue SI reports and 25 open in the system which are either under investigation or with the CCG for scrutiny review. Duty of Candour compliance for all moderate and above harm incidents remains at 85% informed verbally, 87% followed up in writing and 78% findings shared with patient or family upon completed investigation.

East Sussex Healthcare NHS
NHS Trust

Complaints



43 new complaints were received in September and 2 open complaints were overdue (69 back in April 2017).

The highest number of complaints within the Divisions since Sept 2016 to Sept 2017 are DAS (229), Medicine (181), Urgent Care (117) and Women Children and Sexual Health (79).

The area with highest numbers of complaints in September was the Accident and Emergency departments (6) followed by general surgery (4). The main themes are staff attitude, missed diagnosis, care whilst in A&E and concerns with surgical procedures. The learning from complaints is recorded as an action where appropriate on the Datix system and tracked to ensure completion. Examples of actions are increased supervision for staff, placing alerts on a patients health record and sharing patients experience with the whole team.

4 complaints were re-opened by the Trust in September and to date since April 2017 one complaint was upheld by the Parliamentary and Health Service Ombudsman (PHSO) and 2 were partially upheld.

Since April 2017 there have been 7 cases referred to the PHSO. More detailed reports are discussed at the Patient Experience & Engagement Steering Group.

East Sussex Healthcare NHS
NHS Trust

Patient Experience

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Sep-16	Sep-17	Var	2016/17	2017/18	Var		
Inpatient FFT response rate	45.0%	14.0%	45.6%	31.6%	15.2%	39.2%	24.0%	33.3%	
Inpatient FFT score	96.0%	97.0%	96.8%	-0.2%	97.3%	96.9%	-0.4%	97.0%	
A&E FFT response rate	22.0%	7.0%	9.8%	2.8%	8.0%	9.8%	1.8%	8.6%	
A&E FFT score	88.0%	85.7%	90.1%	4.4%	87.8%	88.5%	0.7%	87.4%	
Outpatient FFT Score	M	94.6%	97.1%	2.4%	95.7%	95.5%	-0.2%	95.6%	
Maternity FFT response rate	45.0%	32.7%	32.5%	-0.2%	31.3%	36.2%	4.9%	35.4%	
Maternity FFT score	96.0%	94.8%	97.7%	2.9%	93.8%	97.8%	4.1%	96.9%	

The Governance Team commenced an improvement plan last October with an ambition for the inpatient FFT response rate to be at 50%. This was through engagement with departments and improving the feedback information provided to them from the data. Although the actual score is the most important measure the greater the response rate the greater the feedback. The trust is currently 8th nationally on number of responses. Our responses include the complete experience questionnaire and not just the FFT question.
A very small number of examples of positive and negative comments from the feedback are:

- *Care and thoughtfulness of all staff was terrific, thank you;*
- *Care, attention, compassion cannot fault anything or anybody, my stay was first class;*
- *Caring and cheerful atmosphere, friendly staff, complete confidence in treatment;*
- *Information and explanation good also;*
- *Cared for quickly and I was given an option for what treatment suited me;*
- *I feel that the doctors did not involve me in my care, give me any information or give me their names';*
- *More attention to medical needs on admittance, better communication needed between departments on arrival,*
- *A smile from staff would be nice*

Generally, the positive responses outweigh the negative and the DoN is looking at ways of trying to present the very large numbers of comments more widely in various reports. All responses are sent back monthly to the departments for sharing with their teams. The A&E response rate will be the next area to focus on to ensure greater feedback albeit the survey is voluntary and it is not unusual for A&E and some areas of Maternity to suffer from survey fatigue.
We currently have 4 stars for Eastbourne and 4.5 Stars for the Conquest on the NHS Choices website. The trust does also receive other social media feedback albeit small in numbers.

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Aug-16	Aug-17	Var	2016/17	2017/18	Var		
Crude Mortality Rate	M	1.4%	1.4%	0.1%	1.6%	1.5%	-0.1%	1.6%	

Indicator Description	Target	Previous Months										
		Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
HSMR (CHKS)	M	108	106	106	104	103	106	107	104	103	101	99
SHMI (NHS Digital)	M	1.1	1.1	1.09	1.09	1.09	1.09	1.09				

Commentary

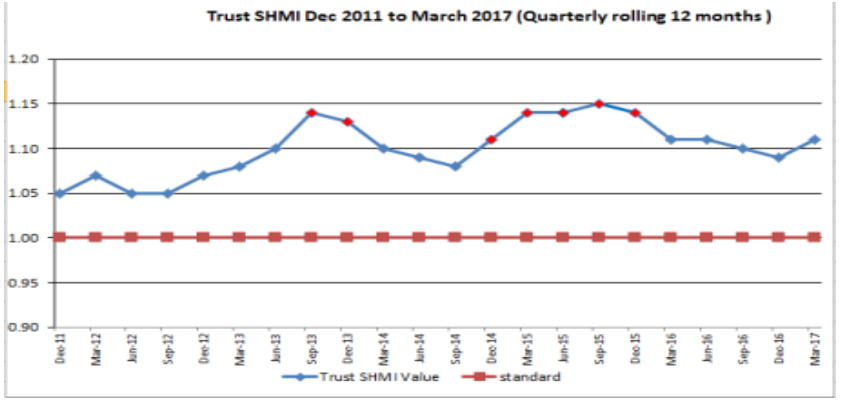
- Format of mortality review database has been changed to comply with the new “Learning from Deaths” project, and no major problems so far. Additional background on the new initiative and training on the database part of next mortality summit. We will report on Q4 avoidable deaths to the Board in Q2, and then have a rolling program of reports 3 months in arrears
- Annual RAMI has fallen significantly in spite of the rise in Dec 16 and Jan 17. Remains low in March and April.
- Sepsis mortality falling steadily towards peer

Mortality Metrics

East Sussex Healthcare NHS Trust

RAMI (Rolling 12 months)

SHMI (Rolling 12 months)



SHMI for the period April 2016 to March 2017 is the latest published and is 1.11. The Trust remains within the EXPECTED range.

RAMI August 2016 to July 2017 (rolling 12 months) is 93 compared to 106 for the same period last year (August 2015 to July 2016). July 2016 to June 2017 was 94

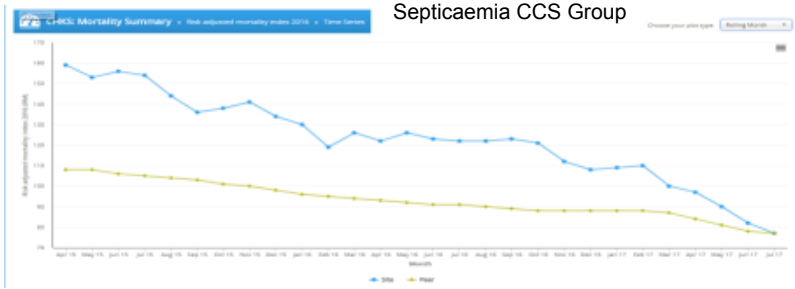
RAMI shows a July position of 85 against a peer value of 88. The June position was 70 against a peer value of 74.

Crude mortality shows August 2016 to July 2017 at 1.81% compared to August 2015 to July 2016 at 1.88% (a 3.7% reduction)

The percentage of deaths reviewed within 3 months was 63% in June 2017, compared to 61% in May 2017.

SHMI (NHS Digital) Top 5 diagnostic groups by Volume Apr 16 to Mar 17	Observed deaths	Expected deaths	SHMI
Pneumonia (except that caused by tuberculosis or std).	438	429.19	1.02
Septicaemia (except in labour), Shock.	179	153.44	1.17
Acute cerebrovascular disease.	160	135.15	1.18
Urinary tract infections.	120	104.72	1.15
Congestive heart failure; nonhypertensive.	109	98.57	1.11

Septicaemia CCS Group



Access & Delivery

ACCESS AND DELIVERY

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Sep-16	Sep-17	Var	2016/17	2017/18	Var		
Four hour standard	95.0%	80.5%	87.8%	7.3%	82.4%	86.3%	3.9%	82.5%	
12 Hour DTAs	0	0	0	0	1	0	-1	0	
Unplanned re-attendance to Emergency Department	5.0%	3.0%	2.7%	-0.3%	3.1%	2.9%	-0.2%	2.9%	
% Patients waiting less than 15 minutes for assessment in ED	M	90.6%	80.0%	-10.6%	91.7%	82.8%	-9.0%	85.1%	
% Patients waiting less than 60 minutes for treatment in ED	M	38.8%	40.7%	1.9%	39.2%	42.0%	2.8%	42.7%	
% Patients waiting less than 120 minutes for treatment in ED	M	69.0%	71.4%	2.4%	65.9%	71.1%	5.2%	71.3%	
% Patients that left without being seen in ED	M	1.2%	2.2%	1.0%	1.6%	1.7%	0.1%	1.5%	
% Patients admitted from ED (Conversion rate)	M	23.1%	28.5%	5.3%	24.3%	27.2%	2.9%	27.1%	
Number of ambulatory care admissions with zero length of stay	M	404	769	365	3347	4590	1243	638	
% of ambulatory care admissions with zero length of stay	M	31.5%	44.0%	12.5%	38.6%	45.2%	6.6%	41.4%	

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Sep-16	Sep-17	Var	2016/17	2017/18	Var		
Emergency Department attendances	M	9470	9859	4.1%	56852	60615	6.6%	9525	
Ambulance conveyances	M	3051	3123	2.4%	18187	19125	5.2%	3168	
Admissions via A&E	M	23.1%	28.5%	5.3%	24.3%	27.2%	2.9%	27.1%	

Commentary

Attendances continue to increase, up by 6.6% year to date. This increase is seen both in the number of self presenters and those being conveyed by Ambulance.

Flow through the department is improving as demonstrated by the improvements in treatment time and the ambulatory pathway

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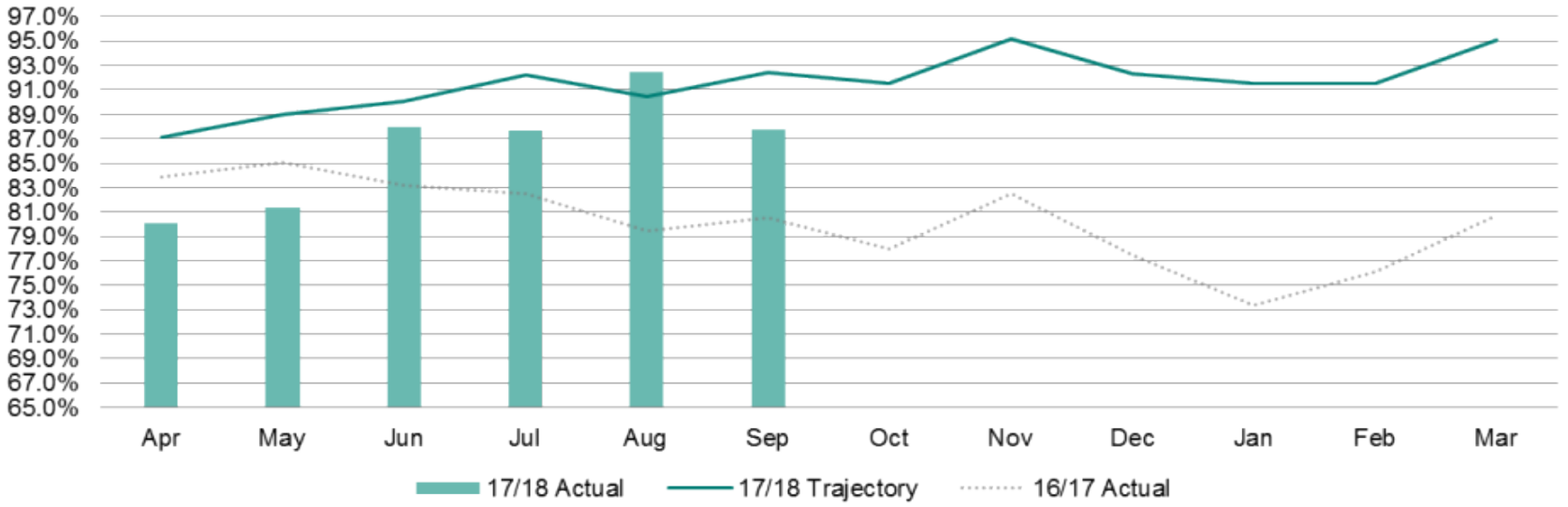
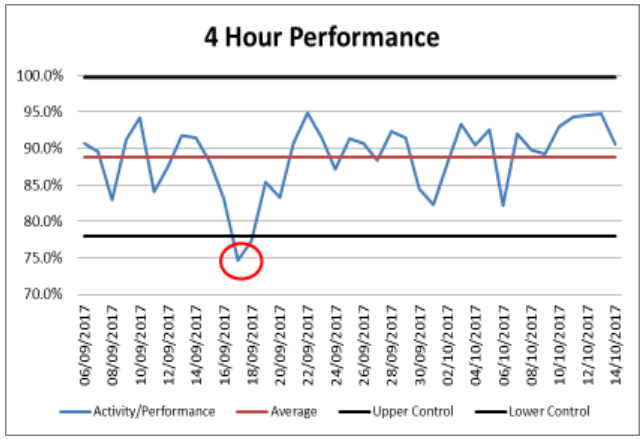
A&E Trajectory

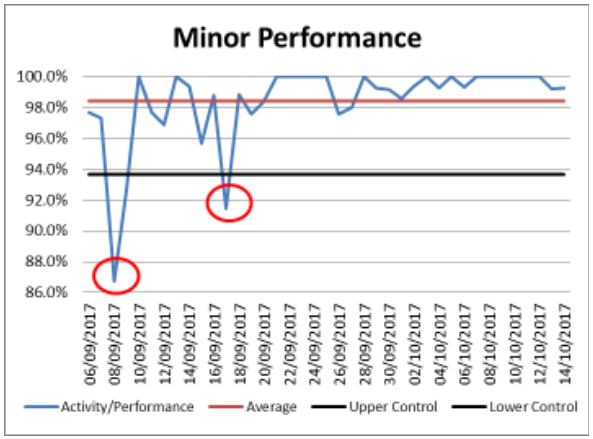
East Sussex Healthcare NHS
NHS Trust



A&E performance dropped marginally in September 87.8%, falling short of the trajectory target. The beginning of the month experienced a particularly challenging time. This was partly due to an increase in patients staying longer than 7 days. Attendances remain on the increase across both sites and were up 4.1% on September 2016, and 6.6% year on year.

The system has been working closely together to reduce the number of patients waiting for a transfer out of the hospital by increasing the capacity in the wider community


4 Hour Performance
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
06/09/2017
08/09/2017
10/09/2017
12/09/2017
14/09/2017
16/09/2017
18/09/2017
20/09/2017
22/09/2017
24/09/2017
26/09/2017
28/09/2017
30/09/2017
02/10/2017
04/10/2017
06/10/2017
08/10/2017
10/10/2017
12/10/2017
14/10/2017
Activity/Performance
Average
Upper Control
Lower Control


Minor Performance
100.0%
98.0%
96.0%
94.0%
92.0%
90.0%
88.0%
86.0%
06/09/2017
08/09/2017
10/09/2017
12/09/2017
14/09/2017
16/09/2017
18/09/2017
20/09/2017
22/09/2017
24/09/2017
26/09/2017
28/09/2017
30/09/2017
02/10/2017
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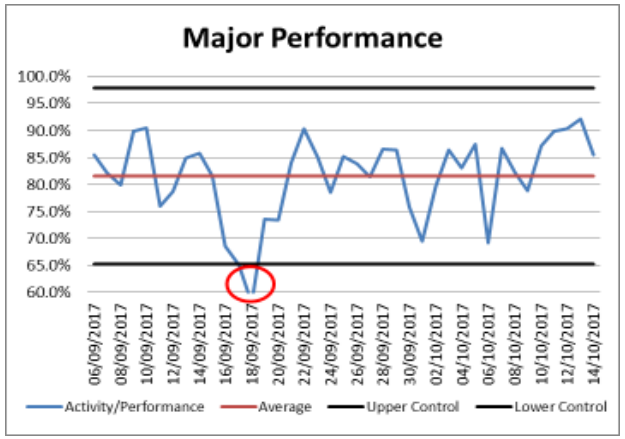
08/10/2017
10/10/2017
12/10/2017
14/10/2017
Activity/Performance
Average
Upper Control
Lower Control


Major Performance
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
06/09/2017
08/09/2017
10/09/2017
12/09/2017
14/09/2017
16/09/2017
18/09/2017
20/09/2017
22/09/2017
24/09/2017
26/09/2017
28/09/2017
30/09/2017
02/10/2017
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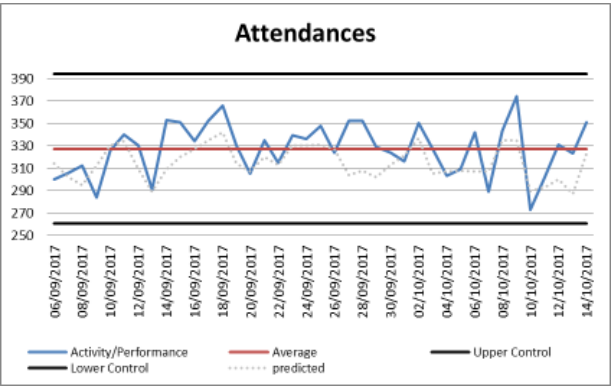
08/10/2017
10/10/2017
12/10/2017
14/10/2017
Activity/Performance
Average
Upper Control
Lower Control


Attendances
390
370
350
330
310
290
270
250
06/09/2017
08/09/2017
10/09/2017
12/09/2017
14/09/2017
16/09/2017
18/09/2017
20/09/2017
22/09/2017
24/09/2017
26/09/2017
28/09/2017
30/09/2017
02/10/2017
04/10/2017
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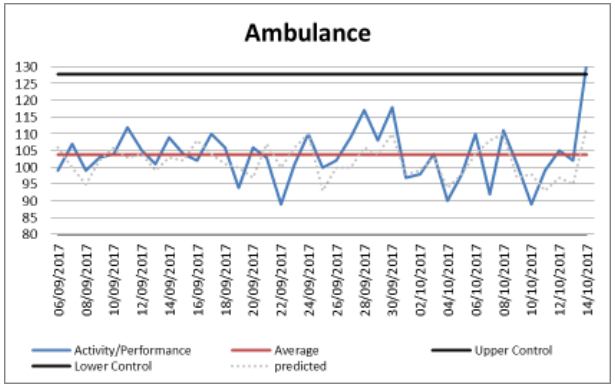
10/10/2017
12/10/2017
14/10/2017
Activity/Performance
Average
Upper Control
Lower Control
predicted


Ambulance
130
125
120
115
110
105
100
95
90
85
80
06/09/2017
08/09/2017
10/09/2017
12/09/2017
14/09/2017
16/09/2017
18/09/2017
20/09/2017
22/09/2017
24/09/2017
26/09/2017
28/09/2017
30/09/2017
02/10/2017
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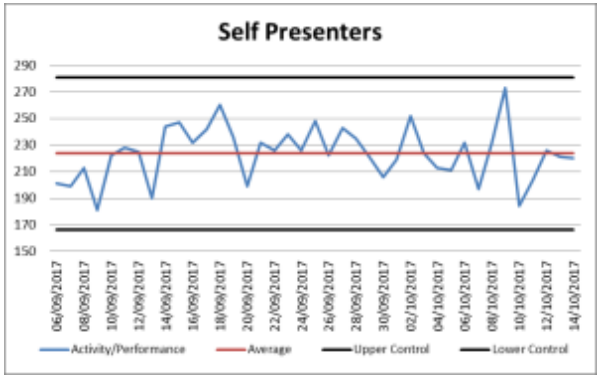
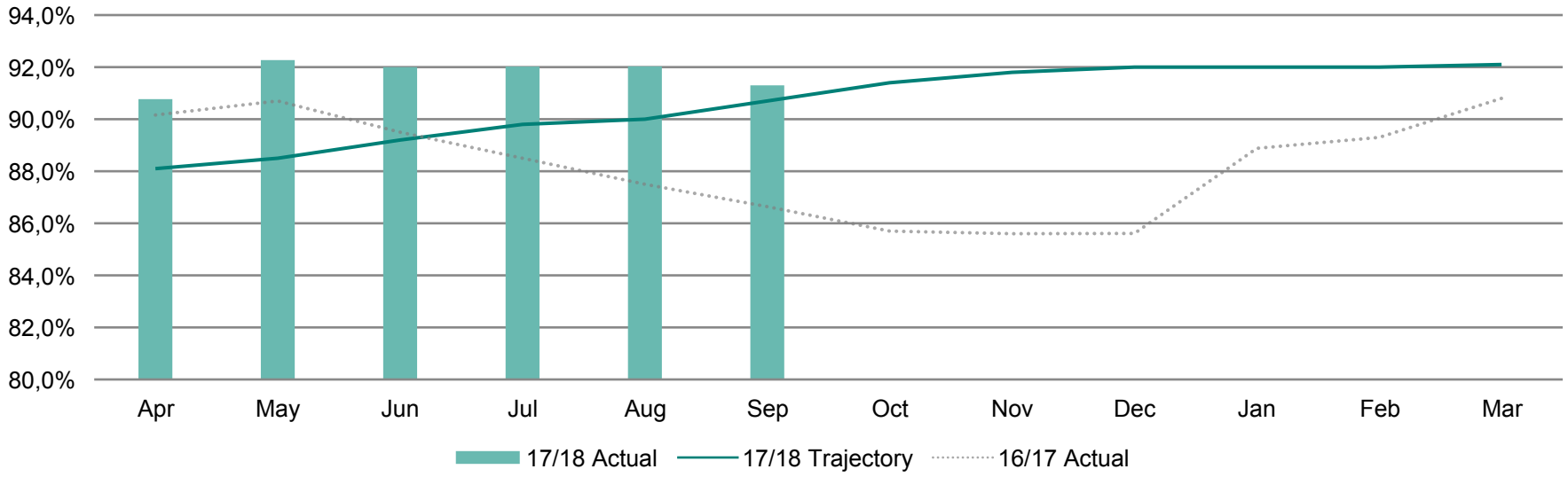
Activity/Performance
Average
Upper Control
Lower Control
predicted


Self Presenters
290
270
250
230
210
190
170
150
06/09/2017
08/09/2017
10/09/2017
12/09/2017
14/09/2017
16/09/2017
18/09/2017
20/09/2017
22/09/2017
24/09/2017
26/09/2017
28/09/2017
30/09/2017
02/10/2017
04/10/2017
06/10/2017
08/10/2017
10/10/2017
12/10/2017
14/10/2017
Activity/Performance
Average
Upper Control
Lower Control

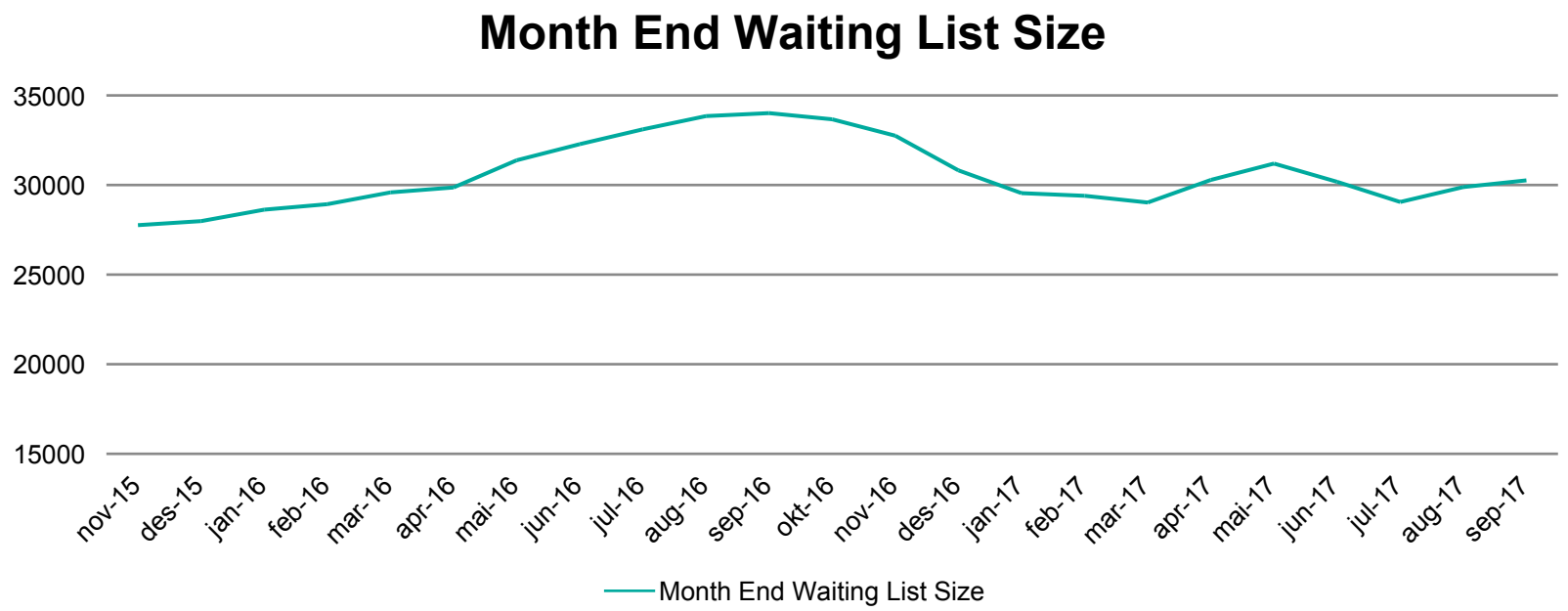
East Sussex Healthcare NHS Trust



Commentary

The Trust performance for the month was 91.3% which is marginally short of the RTT standard. The performance does however exceed the trajectory of 90.7%. The waiting list has reduced. An outsourcing plan is being discussed to supplement additional throughput in theatres and outpatient efficiencies to mitigate the impact of additional cost to the reduce the backlog.

RTT

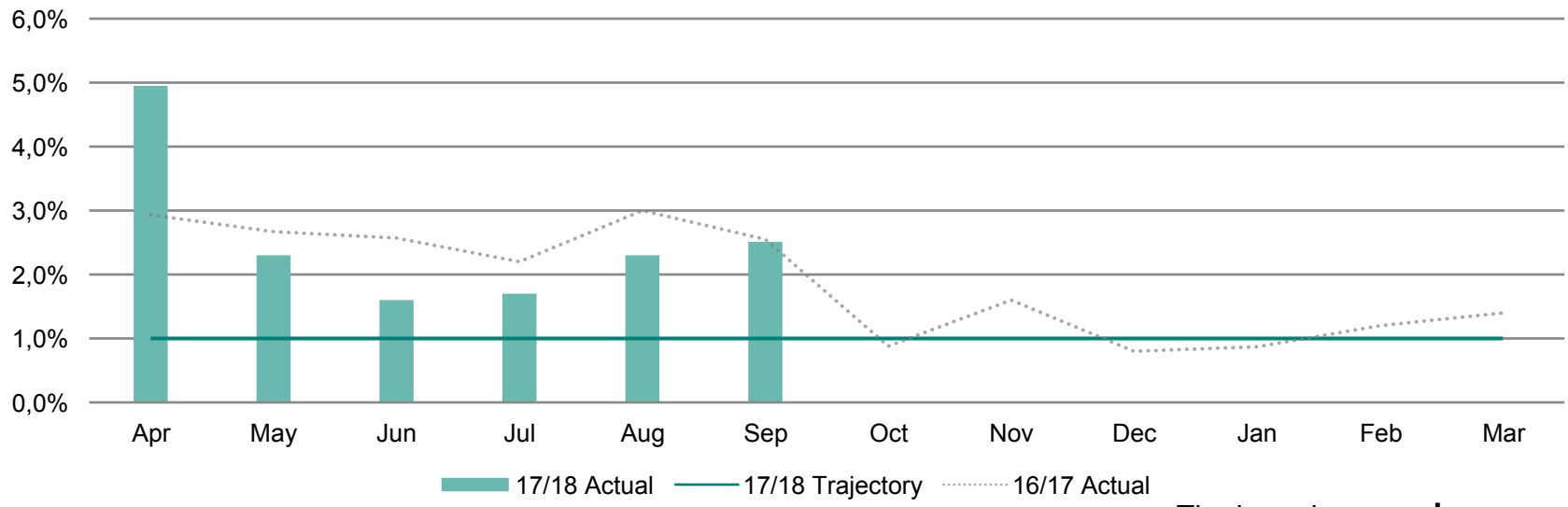


Commentary

The waiting list increased for the second month. This has been impacted by reduced levels of elective activity during the month.

Diagnostics

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Sep-16	Sep-17	Var	2016/17	2017/18	Var		
Diagnostic standard (% patients waiting more than 6 weeks)	1.0%	2.5%	2.5%	0.0%	2.7%	2.6%	-0.1%	1.8%	



Diagnostics failed to meet the 1% standard with a performance of 2.5%. This was predominantly due to CT failures over the month and staffing in other key specialties. Additional radiology sessions have taken place to reduce the backlog and minimise further breaches. However, there has been a sustained increase in demand

The breaches were:

Imaging	125
Physiological Measurement	7
Endoscopy	23

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Aug-16	Aug-17	Var	2016/17	2017/18	Var		
Cancer 2WW Standard	93.0%	97.3%	94.7%	-2.6%	96.6%	95.8%	-0.9%	96.9%	
Cancer 62 day urgent referral standard	85.0%	79.5%	81.6%	2.2%	74.8%	75.7%	0.9%	77.1%	
Cancer 2WW Standard (breast symptoms)	93.0%	95.8%	94.2%	-1.7%	96.3%	95.9%	-0.4%	96.8%	
Cancer 31 day standard	96.0%	99.1%	97.7%	-1.3%	98.7%	97.3%	-1.3%	98.1%	
Cancer 31 day subsequent drug treatment	98.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Cancer 31 day subsequent surgery	94.0%	100.0%	94.9%	-5.1%	98.4%	97.6%	-0.8%	97.8%	
Cancer 62 day screening standard	90.0%	88.9%	85.7%	-3.2%	83.1%	79.4%	-3.7%	86.4%	

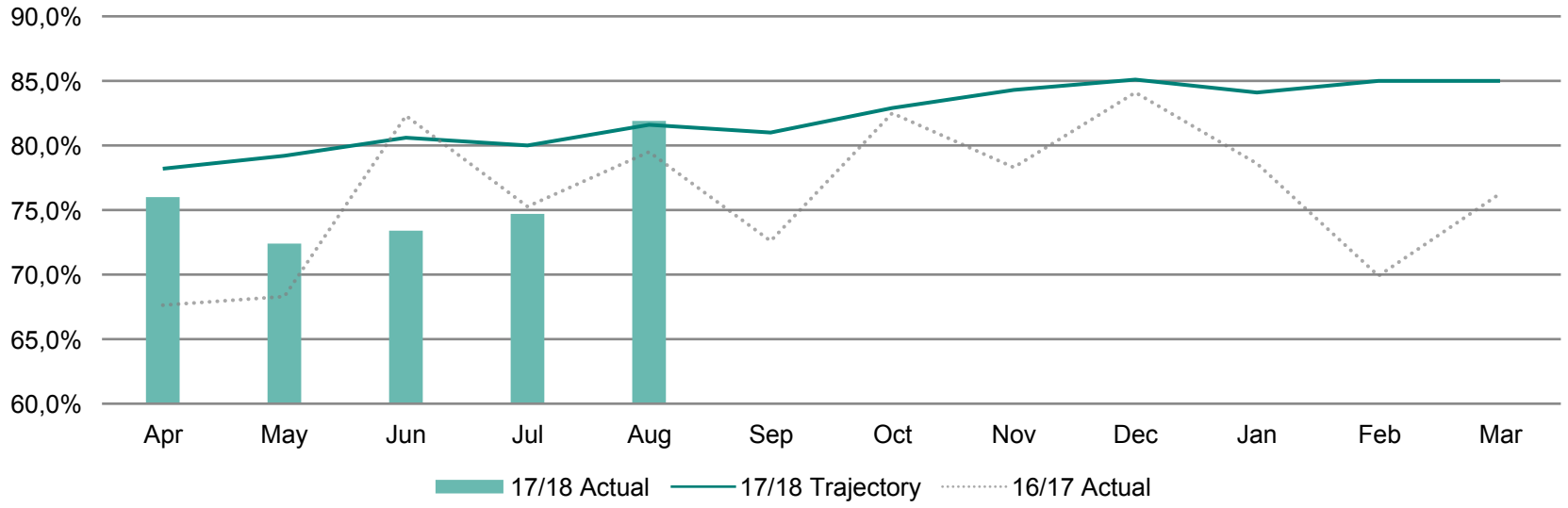
The trust continues to meet the 2 week wait target despite a continuing increase in referrals.

The trust is working hard to recover the 62 day standard however this remains a challenging target.. Daily telephone conferences are being held to ensure patients are seen within timescales.

A new reporting system is being developed to provide staff with a live view/dashboard. This development will use the same principles and platform as used a recent similar development for A&E. Performance in A&E has subsequently shown significant improvements and so it is anticipated that using these lessons learnt will deliver improvements to cancer performance.

East Sussex Healthcare NHS Trust

Cancer 62 Days



There has been a significant improvement in the performance against the 62 Day Standard.

Changes in practice within the trust have included daily telephone conferences to focus on patient pathways through the system and the introduction of daily performance updates emailed out to staff.

Key actions are being taken to implement further changes and to ensure the changes are embedded and sustainable.

August 2017 2WW Ref to First Treatment 62 Days													
Site	Seen/Treated			On Target			Breaches			Compliance			Target
	Conq.	EDGH	All	Conq.	EDGH	All	Conq.	EDGH	All	Conq.	EDGH	All	
Breast Cancer	9.0	6.0	15.0	9.0	3.0	12.0	0.0	3.0	3.0	100 %	50.0 %	80.0 %	85 %
Colorectal	8.5	5.5	14.0	6.5	4.5	11.0	2.0	1.0	3.0	76.5 %	81.8 %	78.6 %	85 %
Gynaecology	3.0	2.0	5.0	2.5	1.0	3.5	0.5	1.0	1.5	83.3 %	50.0 %	70.0 %	85 %
Haematology	0.0	7.0	7.0	0.0	5.0	5.0	0.0	2.0	2.0		71.4 %	71.4 %	85 %
Head & Neck	0.5	3.0	3.5	0.5	1.5	2.0	0.0	1.5	1.5	100 %	50.0 %	57.1 %	85 %
Lung	5.5	10.0	15.5	4.0	5.5	9.5	1.5	4.5	6.0	72.7 %	55.0 %	61.3 %	85 %
Other	1.0	1.0	2.0	1.0	1.0	2.0	0.0	0.0	0.0	100 %	100 %	100 %	85 %
Skin	11.0	21.0	32.0	11.0	21.0	32.0	0.0	0.0	0.0	100 %	100 %	100 %	85 %
Upper GI	2.0	6.0	8.0	2.0	3.0	5.0	0.0	3.0	3.0	100 %	50.0 %	62.5 %	85 %
Urology	4.0	27.5	31.5	4.0	23.0	27.0	0.0	4.5	4.5	100 %	83.6 %	85.7 %	85 %
Total	44.5	89.0	133.5	40.5	68.5	109.0	4.0	20.5	24.5	91.0 %	77.0 %	81.6 %	85 %

Breach reasons:

Capacity -	3
Complex Pathway -	7
Diagnostic Delay -	4
Administrative Delay -	1
Other* -	13

*This includes holidays and late transfers and delays at other trusts

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Sep-16	Sep-17	Var	2016/17	2017/18	Var		
Delayed transfer of care national standard	3.5%	9.7%	4.3%	-5.4%	7.2%	21.3%	14.1%	14.7%	
Cancellations									
Urgent operations cancelled for a second time	0	2	0	-2	2	1	-1	1	
Proportion of last minute cancellations not rebooked within 28 days	0.0%	3.8%			1.2%	0.0%	-1.2%	99.2%	
Outpatient appointment cancellations <6 weeks	M	30	37	23.3%	190	260	36.8%	44	
Outpatient appointment cancellations >6 weeks	M	1297	1293	-0.3%	7727	8331	7.8%	1314	

DTC deteriorated marginally in September. However, this does not correlate with the number of stranded patients as would be expected. As such, the Trust will be undertaking a review of the process for counting and coding DTCs. This review will involve adult social care and the operational executive across the system.

Locally, the Trust is working to meet the national 3.5% target to support the winter plans.

Leadership & Culture

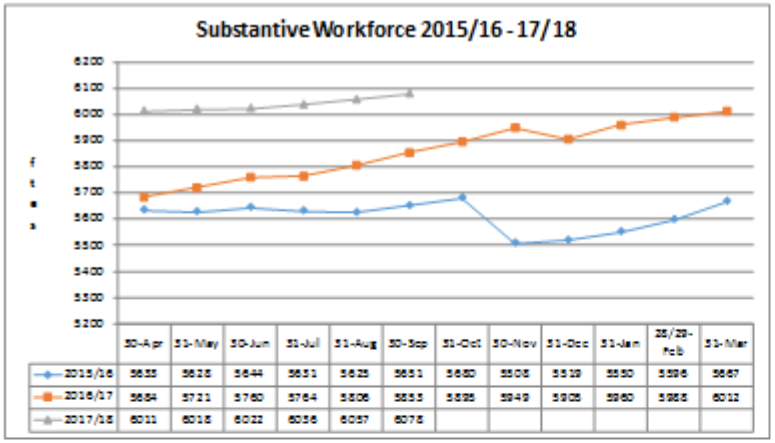
LEADERSHIP & CULTURE

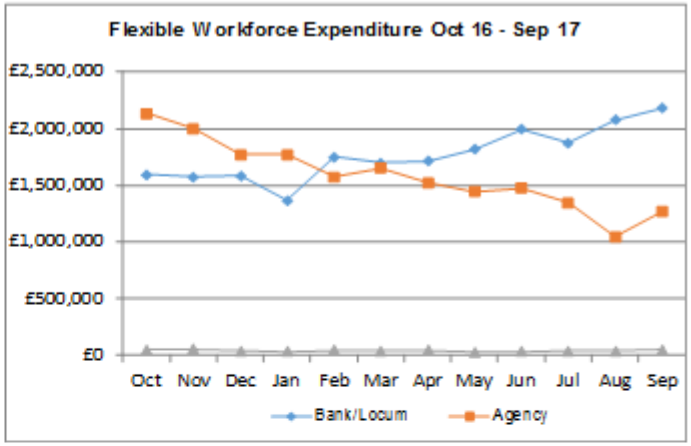
East Sussex Healthcare NHS
NHS Trust

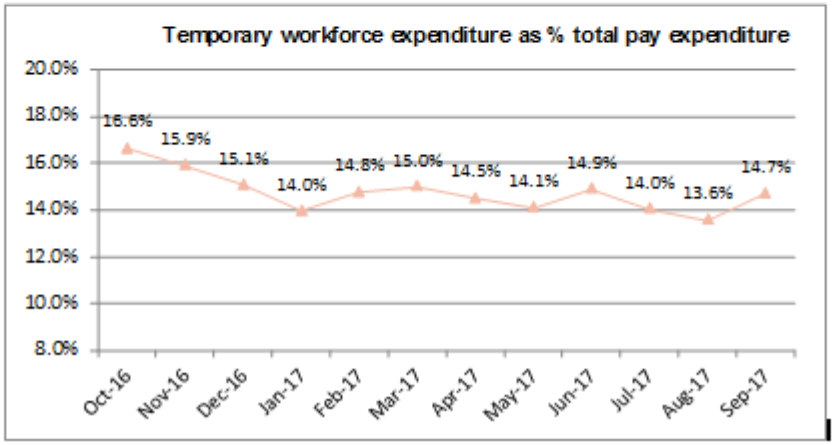
Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Sep-16	Sep-17	Var	2016/17	2017/18	Var		
Trust turnover rate	10.0%	9.7%	11.6%	1.9%	10.0%	11.2%	1.2%	10.5%	
Trust total sickness rate	3.3%	4.0%	4.3%	0.3%	4.0%	3.9%	-0.1%	4.2%	
Trust vacancy rate	10.0%	91.7%	89.0%	-2.7%	91.1%	88.7%	-2.4%	90.6%	
Temporary costs and overtime as a % of total paybill	10.0%	17.1%	14.6%	-2.4%	15.6%	14.3%	-1.4%	14.7%	
Proportion of staff with up to date annual appraisal	85.0%	83.2%	82.3%	-0.9%	87.1%	81.4%	-5.8%	80.4%	

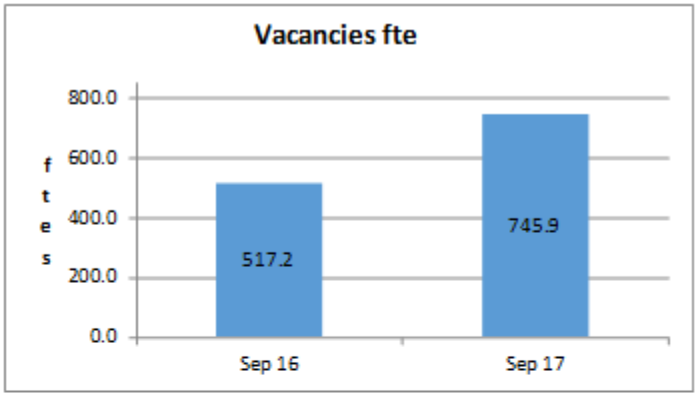
Commentary

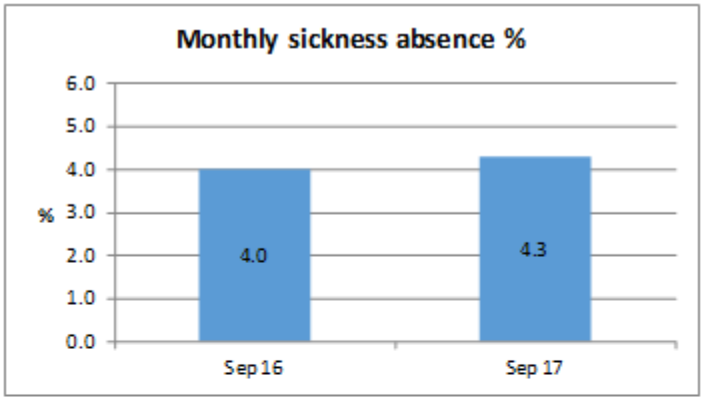
- Actual workforce usage of staff in September was 6695.4 full time equivalents (ftes), 197.6 ftes below the budgeted establishment.
- Temporary staff expenditure was £3,491K in September (14.7% of total pay expenditure). This comprised £2,177K bank expenditure, £1,269K agency expenditure and £45K overtime. This is an increase of £332K overall compared to August.
- There were 745.9 fte vacancies (a vacancy factor of 11.0%), this is 39.5 ftes higher than August but is due to an increase in budgeted establishment.
- Annual turnover was 0.4% higher at 11.6%, which represents 654.7 fte leavers in the last year.
- Monthly sickness was 4.3%, an increase of 0.1% from August. The annual sickness rate was also 4.3%, unchanged from last month.
- The overall mandatory training rate has decreased slightly by 0.3% to 88.8%. Compliance has dropped slightly in all subjects except for Information Governance and Safeguarding Children Level 3, where compliance increased. .
- Appraisal compliance increased by 0.6% to 82.2%

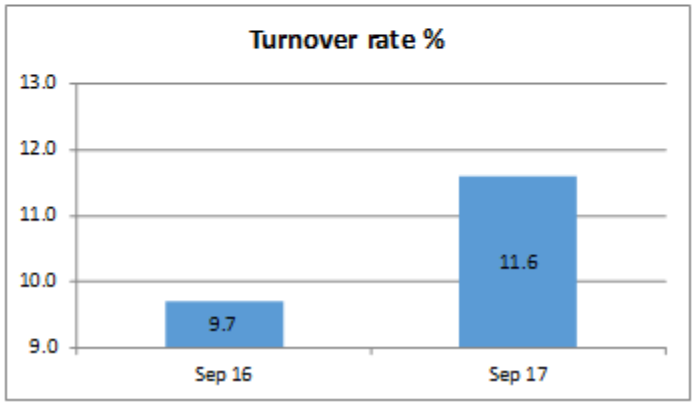

Substantive Workforce 2015/16 - 17/18
6200
6100
6000
5900
5800
5700
5600
5500
5400
5300
5200
30-Apr 31-May 30-Jun 31-Jul 31-Aug 30-Sep 31-Oct 30-Nov 31-Dec 31-Jan 28/29-Feb 31-Mar
2015/16 5633 5626 5644 5651 5625 5651 5680 5506 5519 5550 5596 5667
2016/17 5684 5721 5760 5764 5806 5853 5895 5949 5905 5960 5966 6012
2017/16 6011 6016 6022 6036 6057 6076

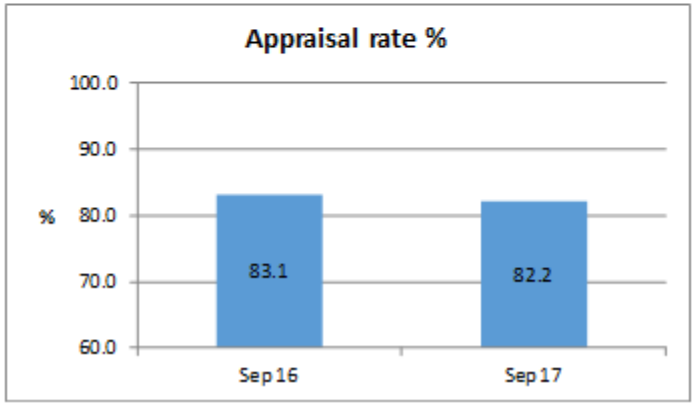

Flexible Workforce Expenditure Oct 16 - Sep 17
£2,500,000
£2,000,000
£1,500,000
£1,000,000
£500,000
£0
Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep
Bank/Locum
Agency


Temporary workforce expenditure as % total pay expenditure
20.0%
18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
16.6% 15.9% 15.1% 14.0% 14.8% 15.0% 14.5% 14.1% 14.9% 14.0% 13.6% 14.7%
Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17

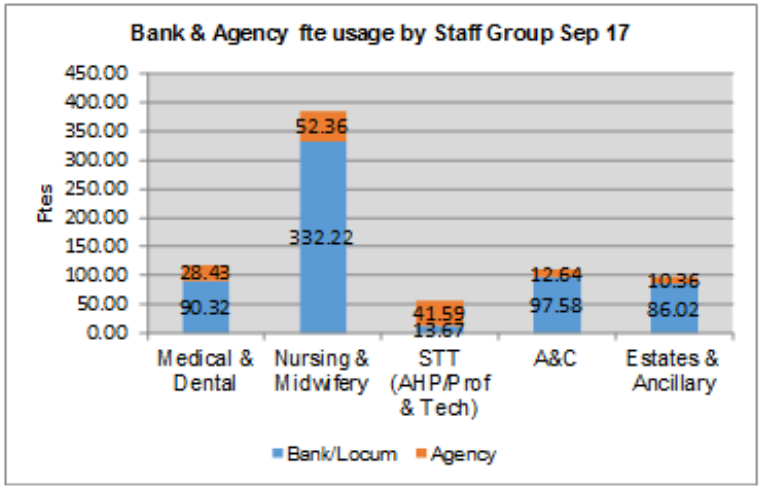

Vacancies fte
800.0
600.0
400.0
200.0
0.0
ftes
517.2
745.9
Sep 16
Sep 17

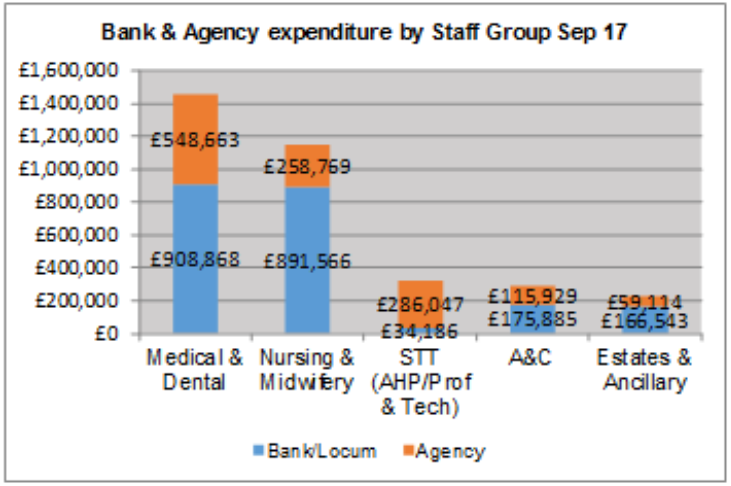

Monthly sickness absence %
6.0
5.0
4.0
3.0
2.0
1.0
0.0
%
4.0
4.3
Sep 16
Sep 17


Turnover rate %
13.0
12.0
11.0
10.0
9.0
9.7
11.6
Sep 16
Sep 17


Appraisal rate %
100.0
90.0
80.0
70.0
60.0
%
83.1
82.2
Sep 16
Sep 17

3. Recruitment

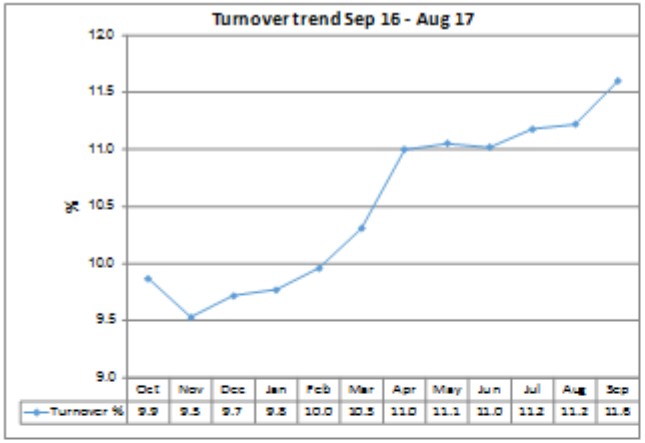




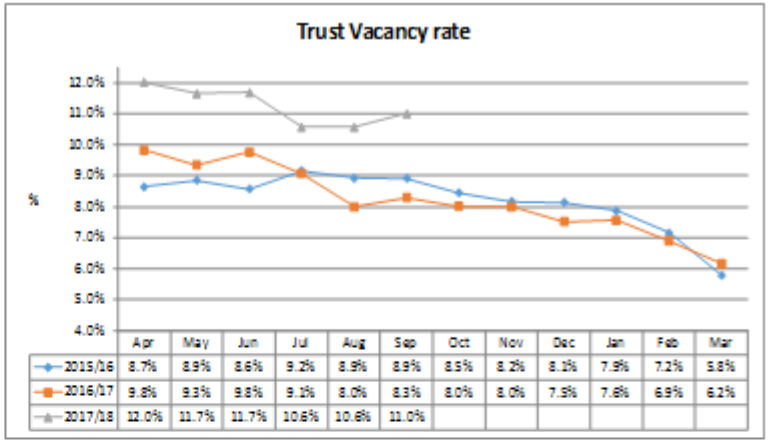
The budgeted establishment has increased this month by 68.5 ftes. This is mostly due to the reinstatement of the budget for the Escalation ward at EDGH and the addition of ambulance turnaround posts in Urgent Care at both Conquest and Eastbourne sites

Temporary workforce expenditure has increased this month by £332K overall. Bank expenditure has increased by £100K and agency expenditure by £226K, whilst overtime expenditure increased by £6K this month. Bank expenditure has increased, due to consultant sickness cover in Microbiology, activity increases in Ophthalmology and General Surgery, the late submission of medical locum invoices in areas such as Gastroenterology, Elderly Care and Anaesthetics and the transfer of medical staff from agency to bank in Elderly Care and Anaesthetics. There was also backfill for career grade vacancies in ENT and nursing vacancies in Conquest Critical Care.

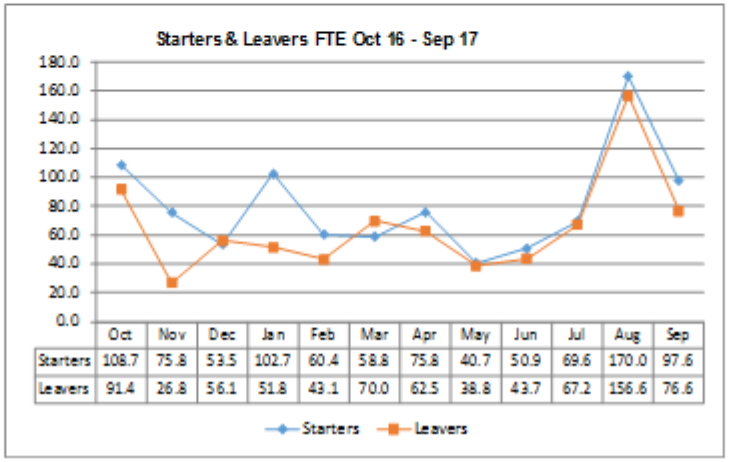
The increase in agency expenditure is partly due to cover for vacant posts in Rheumatology and Gastroenterology plus a backlog of endoscopy patients who were seen this month. Part of the comparative increase in agency expenditure between months, however, is due to the fact that agency expenditure was artificially lower in August, when shifts for the previous 3 months were reviewed and expenditure deducted for those unused during that time. Expenditure in September is more indicative of usage in that month



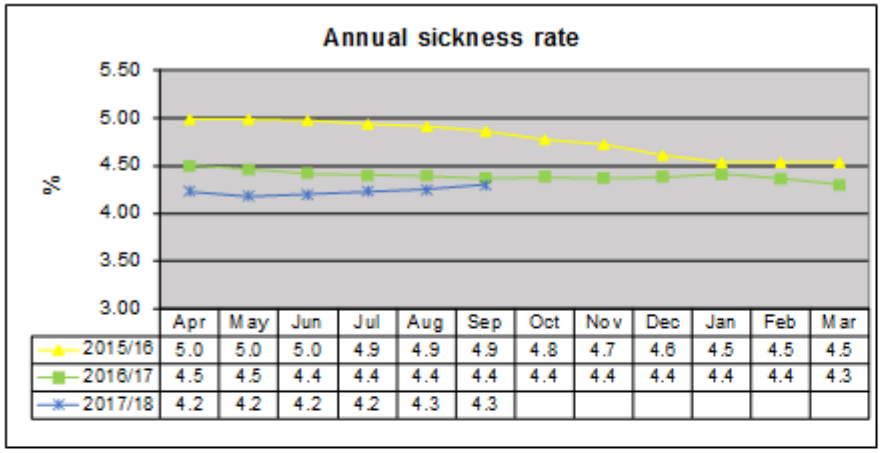
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Turnover %	9.9	9.5	9.7	9.8	10.0	10.3	11.0	11.1	11.0	11.2	11.2	11.6



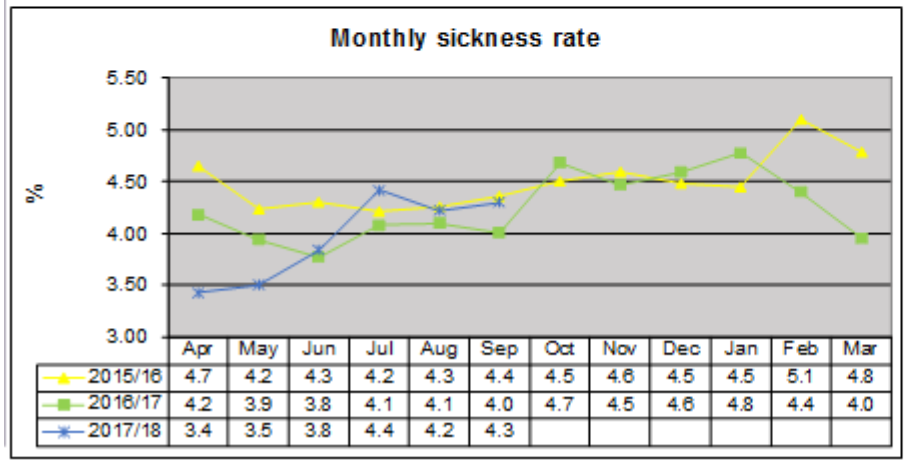
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	8.7%	8.9%	8.6%	9.2%	8.9%	8.9%	8.5%	8.2%	8.1%	7.9%	7.2%	5.8%
2016/17	9.8%	9.3%	9.8%	9.1%	8.0%	8.3%	8.0%	8.0%	7.5%	7.8%	6.9%	6.2%
2017/18	12.0%	11.7%	11.7%	10.6%	10.6%	11.0%						



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Starters	108.7	75.8	53.5	102.7	60.4	58.8	75.8	40.7	50.9	69.6	170.0	97.6
Leavers	91.4	26.8	56.1	51.8	43.1	70.0	62.5	38.8	43.7	67.2	156.6	76.6



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	5.0	5.0	5.0	4.9	4.9	4.9	4.8	4.7	4.6	4.5	4.5	4.5
2016/17	4.5	4.5	4.4	4.4	4.4	4.4	4.4	4.4	4.4	4.4	4.4	4.3
2017/18	4.2	4.2	4.2	4.2	4.3	4.3						



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	4.7	4.2	4.3	4.2	4.3	4.4	4.5	4.6	4.5	4.5	5.1	4.8
2016/17	4.2	3.9	3.8	4.1	4.1	4.0	4.7	4.5	4.6	4.8	4.4	4.0
2017/18	3.4	3.5	3.8	4.4	4.2	4.3						

Monthly sickness has increased by 0.1% to 4.3% in September, whilst the annual sickness rate remains unchanged also at 4.3%.

The Divisions with the highest monthly sickness are Urgent Care at 6.4% (though this is 0.8% lower than last month) and Estates & Facilities at 6.1% (up by 0.8%).

The Operational HR department continue to enforce the action plan to reduce absence management by:

- targeting actions and casework monitoring on areas with high absence and high backfill costs
- auditing policy compliance; particularly in regard to Return to Work Interviews. A targeted campaign will be set up on the importance of Return to Work Interviews.
- highlighting the benefits of using the management Liveflo tool to enable managers to consistently apply the Attendance Management Procedure and training managers where appropriate. There has been a positive response to using this tool which will continue to be promoted.
- working with Occupational Health to fast track cases where appropriate; this has enabled more timely application of the Attendance Management Procedure.
- reviewing employee relations cases and their impact on sickness rates
- analysing reasons for absence and working with Occupational Health to target interventions

7. Mandatory Training

Mandatory Training – Six Month Trend

Mandatory training course	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Induction %	95.8	95.1	95.5	95.0	95.0	94.3
Fire %	83.3	84.4	84.2	85.5	85.9	85.5
Moving & Handling %	88.7	89.2	89.7	90.2	90.2	89.7
Infection Control %	86.9	87.6	88.1	89.0	89.6	89.3
Info Gov %	83.7	84.3	84.4	85.8	85.3	85.7
Health & Safety %	87.6	88.1	88.8	89.6	88.8	88.1
Mental Capacity Act %	96.0	96.0	96.2	96.5	96.0	95.8
Depriv of Liberties %	98.1	98.0	97.8	98.0	97.6	97.5
Safeguard Vuln Adults	88.2	88.6	89.6	90.3	90.1	88.9
Safeguard Child Level 2	86.8	87.1	87.2	87.4	86.4	86.1

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	Deprivof Liberties training	Safeguard Vulnerable Adults	Safeguard Children Level 2	Safeguard Children Level 3	Appraisal compliance
Urgent Care	83.0%	87.1%	93.8%	84.8%	87.7%	92.4%	93.0%	88.1%	79.7%	84.6%	89.1%	93.8%
Medicine Division	87.8%	90.4%	92.6%	89.0%	86.3%	86.8%	93.8%	95.9%	87.8%	83.9%	n/a	83.0%
Out of Hospital Care Division	84.5%	87.3%	94.3%	89.9%	79.3%	84.4%	96.1%	99.2%	83.8%	82.1%	n/a	80.0%
Diagnostics Anaesthetics & Surgery	83.4%	87.9%	94.6%	86.1%	83.0%	87.3%	97.6%	97.5%	93.0%	89.2%	n/a	82.6%
Womens Childrens & Sexual Health Division	84.9%	89.5%	93.8%	89.2%	84.2%	86.3%	95.5%	95.9%	91.0%	87.5%	85.9%	81.8%
Estates & Facilites	84.2%	88.1%	98.4%	96.1%	93.2%	94.9%	n/a	n/a	n/a	n/a	n/a	89.5%
Corporate	89.1%	95.4%	94.4%	91.7%	92.4%	91.2%	97.8%	99.1%	90.4%	91.2%	91.7%	85.0%
TRUST	85.9%	89.7%	94.3%	89.3%	85.7%	88.1%	95.8%	97.5%	88.9%	86.1%	86.3%	82.2%

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

It's disappointing to note that the majority of topics have seen a slight dip in compliance this month although the Trust being in "Black" status and other service pressures have contributed to this as is borne out by the high level of non attenders (DNAs) across all courses in September (143 DNAs in total). A large number of staff also completed the safeguarding workbooks 3 years ago and these have now expired, though this is being addressed. Email reminders are going out to teams each month and the Safeguarding team are also distributing paper workbooks to the areas with the lowest compliance.

Appraisal compliance continues to increase, up by a further 0.6%.

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	90.3%	100.6%	93.6%	104.4%
CONQUEST HOSPITAL	83.9%	112.1%	84.1%	111.5%
EASTBOURNE DISTRICT GENERAL HOSPITAL	84.2%	113.1%	88.3%	130.5%

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.

Finance

FINANCE

Financial Summary – September 2017

Key metrics	Plan YTD	Actual YTD	Variance YTD
Agreed control total (exc STF) (£'m)	(22.4)	(24.8)	(2.4)
Agreed control total (inc STF) (£'m)	(18.9)	(23.5)	(4.6)
Re-scoped CIPs	4.3	3.4	(0.9)
Cash balance (£'m)	2.1	3.4	1.3

Better Payments practice code	Month Volume	Month Value	YTD Volume	YTD Value
Trade invoices	13.0%	24.3%	12.1%	25.0%
NHS invoices	53.2%	91.8%	34.3%	93.5%

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

Key Issue	Summary
Financial Summary	• The Trust is currently in the process of reforecasting year end position and working through remedial actions with the Executive Directors. There is a separate paper on re-forecasting and therefore this in not addressed in this paper, the Trust officially reported a forecast outturn in line with plan as required. • September reported a £1.2m adverse variance in month and the Trust is reporting a £2.4m adverse variance against plan YTD. Therefore £2.2m STF funding for Q2 has not been achieved. • Contract income in DAS remains the largest driver of the variance.
Efficiencies	• The Trust has re-scoped it's £28.7m CIP plan and reclassified £10.9m as being transferred to regular budgetary management, leaving £17.8m of planned schemes. • YTD the Trust is reporting £0.9m adverse variance on these schemes but future further slippage is anticipated – this is covered in the re-forecasting paper.
Balance Sheet	• Receivables and Payables remain high, cash remains under pressure.
Cash Flow	• Cashflow remains extremely challenging resulting in significant creditor pressure. • A separate paper of cash and working capital is included.
Capital Programme	• The overall capital programme has a significant level of over commitment as a result of demand for infrastructure and equipment requirements. The Capital Review Group (CRG) is closely monitoring capital spend and is forecasting delivery.

Variance Highlights – September 2017

Division	Variance against budget YTD (£'m)				
	Other Income	Contract Income	Pay	Non pay	Total
Medicine	0.0	(0.1)	(0.2)	(0.5)	(0.8)
Surgery	(0.5)	(4.6)	(0.4)	(0.6)	(6.0)
Emergency Care	0.0	0.9	(0.6)	(0.1)	0.3
Womens & Childrens	0.2	0.1	(0.2)	(0.0)	0.1
Out of Hospital	(0.3)	(0.8)	0.8	0.4	0.1
Operational sub total	**(0.5)**	**(4.5)**	**(0.6)**	**(0.8)**	**(6.4)**
Estates & Facilities	(0.3)	-	0.4	0.2	0.3
Central and Corporate	1.9	3.2	(0.7)	(1.1)	3.3
Capital Charges	-	-	-	0.3	0.3
Donated assets adj	-	-	-	0.1	0.1
Total trading deficit	**1.1**	**(1.3)**	**(0.9)**	**(1.3)**	**(2.4)**
TEDDs	-	0.4	-	(0.4)	-
STF	-	(2.2)	-	-	(2.2)
Total deficit	**1.1**	**(3.1)**	**(0.9)**	**(1.7)**	**(4.6)**

Operational highlights

- Overall the five operational divisions are below plan by £6.4m (£3.1m M5).
- Contract income is below plan both in the month and YTD, predominantly this is driven by elective activity.
- The Trust continues to see higher levels of non elective activity than planned and a reduction in electives both inpatient and day cases.
- The impact of new tariff HRGv4+ has been reflected in plans.
- ESBT investment (and pay costs) remain below plan leading to variances in the OOH CU.
- Agency, Medical and Prof & Tech combined with WLI payments drive overspends in pay.
- Non pay overspends are predominantly in drugs, clinical supplies and services.

Adverse variances less than £50k

Corporate highlights

- Estates and Facilities have reported a benefit in month following a review of property services costs.
- Central and corporate includes some CSR and workforce savings targets that haven't yet been allocated to divisions along with central reserves and capital charges, this also reflects the impact of HRG4+ plan changes in divisions.
- TEDDs (Tariff Excluded Drugs and Devices) are pass through income and costs and therefore the variances net out.

More detailed variances and commentary can be found on pages five and six.

Income & Expenditure – September 2017

I&E Summary (£'m)	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
NHS Patient Income	26.9	26.3	(0.6)	158.1	156.8	(1.3)
Tariff-Excluded Drugs & Devices	2.8	3.2	0.4	16.8	17.1	0.4
Private Patient / ICR	0.3	0.3	(0.0)	1.9	1.6	(0.3)
Other Non Clinical Income	3.1	3.7	0.6	17.6	19.1	1.5
Total Income	**33.2**	**33.5**	**0.3**	**194.4**	**194.6**	**0.2**
Pay - Substantive	(21.7)	(20.4)	1.4	(135.0)	(120.4)	14.5
Pay - Bank	(1.0)	(2.2)	(1.2)	(3.4)	(11.7)	(8.3)
Pay - Agency	(0.2)	(1.3)	(1.1)	(0.9)	(8.1)	(7.2)
Total Pay	**(22.9)**	**(23.8)**	**(0.9)**	**(139.2)**	**(140.2)**	**(0.9)**
Drugs	(3.4)	(3.7)	(0.3)	(20.1)	(21.4)	(1.3)
Supplies and services - Clinical	(3.9)	(2.8)	1.1	(17.2)	(17.1)	0.1
Supplies and services - General	(0.4)	(0.4)	(0.0)	(2.1)	(2.1)	(0.1)
Purchase of healthcare (non NHS bodies)	(0.3)	(0.4)	(0.1)	(1.9)	(2.5)	(0.5)
Consultancy costs	0.1	0.1	(0.0)	(0.1)	(0.3)	(0.1)
Clinical Negligence	(1.2)	(1.2)	-	(7.3)	(7.3)	(0.0)
Premises	(1.2)	(1.1)	0.1	(6.8)	(6.6)	0.2
Depreciation	(1.1)	(1.1)	(0.0)	(6.4)	(6.4)	0.0
Other	(1.0)	(2.7)	(1.7)	(11.5)	(11.8)	(0.3)
Total Non Pay	**(12.3)**	**(13.2)**	**(1.0)**	**(73.4)**	**(75.4)**	**(2.0)**
Total Operating Costs	**(35.2)**	**(37.1)**	**(1.9)**	**(212.6)**	**(215.6)**	**(3.0)**
Surplus/-Deficit from Operations	**(2.0)**	**(3.5)**	**(1.6)**	**(18.3)**	**(21.0)**	**(2.7)**
Financing Costs: Interest, PDC, Etc	(0.7)	(0.6)	0.1	(4.1)	(3.8)	0.3
Total Non Operating Costs	**(0.7)**	**(0.6)**	**0.1**	**(4.1)**	**(3.8)**	**0.3**
Total Costs	**(35.9)**	**(37.7)**	**(1.8)**	**(216.7)**	**(219.4)**	**(2.7)**
Net Surplus/-Deficit	**(2.7)**	**(4.1)**	**(1.5)**	**(22.4)**	**(24.8)**	**(2.4)**
Donated Asset/Impairment Adjustment	-	(0.0)	(0.0)	-	0.1	0.1
Operational Surplus/-Deficit	**(2.7)**	**(4.2)**	**(1.5)**	**(22.4)**	**(24.8)**	**(2.4)**
Sustainability & Transformation Fund	0.7	(1.3)	(2.0)	3.5	1.3	(2.2)
Net Surplus/-Deficit	**(2.0)**	**(5.5)**	**(3.5)**	**(18.9)**	**(23.5)**	**(4.6)**

Highlights

- Total income is slightly ahead of plan, under delivery against contract income is off set by higher than anticipated levels of other income.
- Overspends (£0.9m) in pay predominately driven by medical and Prof & Tech agency costs and non delivery of in month CIPs – more detail is shown on page 7.
- ESBT investment (and pay costs) remain below plan leading to variances in the OOH CU.
- YTD non pay overspends are predominantly in drugs and Medica (radiology reporting) costs.
- Reporting away from plan drives no STF delivery in Q2.

Divisional Performance (1) – September 2017

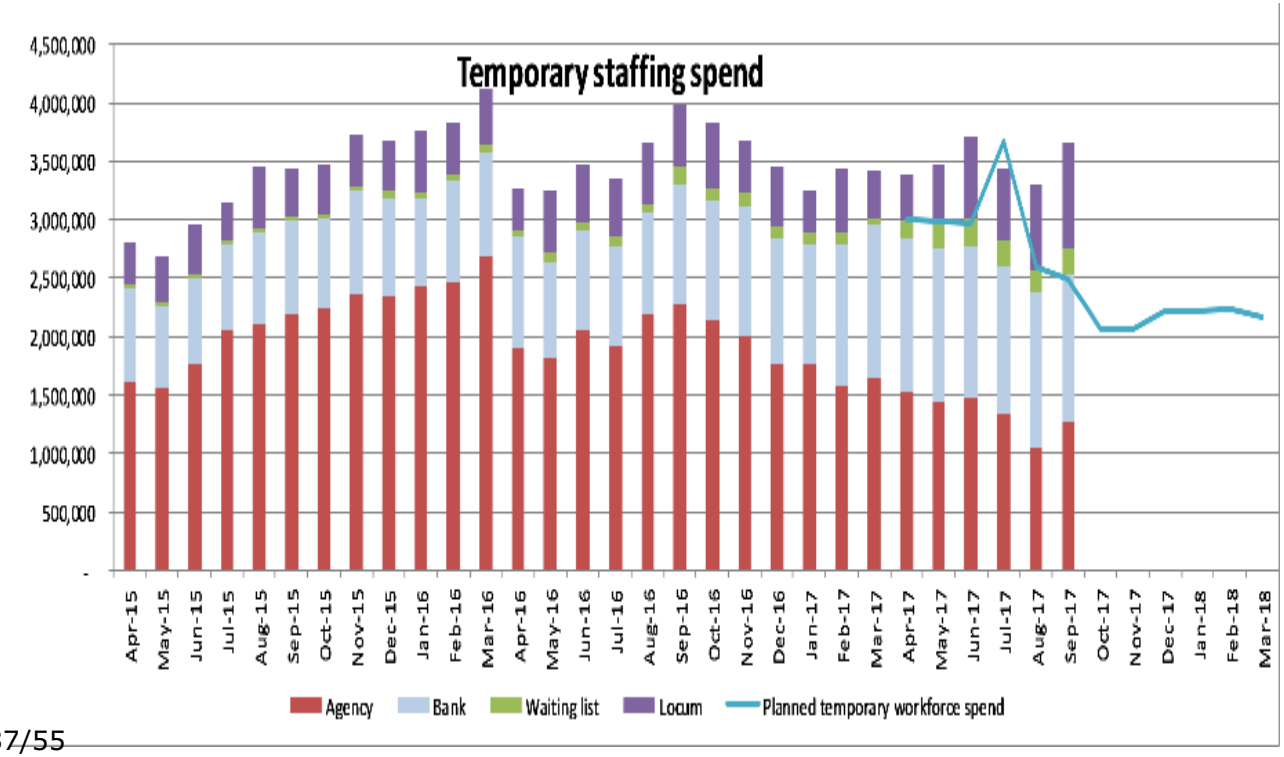
Divisional Summary (£'m)	In Month			YTD			Notes
	Plan	Actual	Variance	Plan	Actual	Variance	
Urgent Care:							Contract income for September was fractionally below plan (£0.2m) although the YTD variance position £0.9m is still favourable. Medical pay increased in the month. The spend on temporary staff continues to exceed the budgeted vacancies, YTD variance £0.6m (£0.4m medical £0.1m nursing). Slight increase in clinical supplies and services drives the non pay variance.
Contract Income	2.2	2.0	(0.3)	10.7	11.6	0.9	
Other Income	0.0	0.0	0.0	0.0	0.0	0.0	
Pay	(1.0)	(1.2)	(0.2)	(5.5)	(6.1)	(0.6)	
Non Pay	(0.1)	(0.1)	(0.0)	(0.3)	(0.4)	(0.1)	
Total	**1.2**	**0.8**	**(0.5)**	**4.8**	**5.1**	**0.3**	
Medicine:							Contract income is below plan in the month but largely on plan YTD Temporary medical staff & WLI costs drive the pay overspends. One off corrections and adjustments allowed delivery of the non pay plan this month.
Contract Income	9.0	7.6	(1.4)	44.5	44.4	(0.1)	
Other Income	0.3	0.3	0.0	1.9	1.9	0.0	
Pay	(5.3)	(5.0)	0.3	(29.2)	(29.4)	(0.2)	
Non Pay	(0.7)	(0.7)	0.0	(4.3)	(4.9)	(0.5)	
Total	**3.3**	**2.3**	**(1.1)**	**12.8**	**12.0**	**(0.8)**	
DAS:							YTD contract income adverse variance mainly due to T & O and reduced delivery of CIP schemes. YTD non-pay overspend mainly due to radiology cost pressures. Full year adverse variance mainly due to contract income. Forecast reduced delivery of CIP schemes are a key driver in contract income and non-pay, where radiology cost pressures also continue. Pay overspend mainly related to WLIs (£1.4m).
Contract Income	9.6	8.6	(1.0)	55.2	50.6	(4.6)	
Other Income	0.5	0.4	(0.1)	2.8	2.3	(0.5)	
Pay	(7.3)	(7.3)	0.0	(43.8)	(44.1)	(0.4)	
Non Pay	(2.7)	(2.8)	(0.1)	(15.6)	(16.2)	(0.6)	
Total	**0.1**	**(1.1)**	**(1.2)**	**(1.4)**	**(7.5)**	**(6.0)**	
WAC							YTD Contract income above plan, YTD HRG+4 variation to CI budget YTD pay; underspends in nursing don't quite offset the Medical agency overspends mainly in paediatrics and unbudgeted WLI payments. Non pay remains on plan.
Contract Income	4.7	3.8	(0.9)	23.1	23.2	0.1	
Other Income	0.0	0.0	0.0	0.2	0.3	0.2	
Pay	(2.5)	(2.5)	0.0	(15.0)	(15.1)	(0.2)	
Non Pay	(0.3)	(0.3)	(0.0)	(1.7)	(1.7)	(0.0)	
Total	**1.9**	**1.1**	**(0.9)**	**6.6**	**6.6**	**0.1**	

Divisional Performance (2) – September 2017

Divisional Summary (£'m)	In Month			YTD			Notes
	Plan	Actual	Variance	Plan	Actual	Variance	
Out of Hospital:							PMU income 8% below plan YTD. Recruitment delays in ESBT drive the variance in both contract income and pay YTD. Drugs overspend reduced by £0.2m in the month, due to an increase in TEDDs charging, leaving a £0.2m overspend YTD. iMSK non-pay underspent by £0.3m in the month, however this is offset by income.
Contract Income	3.6	3.3	(0.3)	19.9	19.1	(0.8)	
Other Income	0.5	0.4	(0.0)	2.8	2.5	(0.3)	
Pay	(3.0)	(2.9)	0.1	(18.0)	(17.2)	0.8	
Non Pay	(1.5)	(1.0)	0.6	(7.4)	(7.0)	0.4	
Total	**(0.4)**	**(0.1)**	**0.3**	**(2.7)**	**(2.6)**	**0.1**	
Estates & Facilities:							NHSPS Property year to date adjustment reflected in September and estates pay vacancies contribute to an underspend in month & YTD position. Income underachieving in Laundry, Car Parking & Accommodation.
Contract Income	0.0	0.0	0.0	0.0	0.0	0.0	
Other Income	1.6	1.5	(0.1)	4.4	4.1	(0.3)	
Pay	(1.5)	(1.4)	0.1	(8.6)	(8.3)	0.4	
Non Pay	(2.2)	(1.8)	0.4	(8.2)	(8.0)	0.2	
Total	**(2.1)**	**(1.8)**	**0.3**	**(12.4)**	**(12.1)**	**0.3**	
Corporate Services:							Pay vacancies across Corporate offset by agency usage & financial improvement costs. Hosted budgets target has been adjusted down in M6 but offset by backdated HMRC tax & Technical savings
Contract Income	0.0	0.0	0.0	0.0	0.0	0.0	
Other Income	1.3	1.3	0.0	7.6	7.8	0.2	
Pay	(3.5)	(3.6)	(0.2)	(19.9)	(19.9)	(0.1)	
Non Pay	(3.1)	(2.4)	0.6	(14.1)	(14.4)	(0.3)	
Total	**(5.2)**	**(4.7)**	**0.5**	**(26.4)**	**(26.6)**	**(0.2)**	
Other:							Non delivery of Q2 STF along with the Q1 A&E element drive the forecast contract income variance. TEDDs £0.4m above plan YTD for both income and non pay. Non pay plan (other) includes central reserves and capital charges.
Contract Income (TEDDs)	2.8	3.2	0.4	16.8	17.1	0.4	
Contract Income (Other)	(1.6)	(0.3)	1.3	8.2	9.2	1.0	
Other Income	(0.6)	0.0	0.7	(0.0)	1.7	1.7	
Pay	1.1	0.0	(1.1)	0.6	(0.0)	(0.7)	
Non Pay TEDDs)	(2.8)	(3.2)	(0.4)	(16.8)	(17.1)	(0.4)	
Non Pay (Other)	0.3	(1.5)	(1.9)	(9.1)	(9.4)	(0.3)	
Total	**(0.9)**	**(1.8)**	**(1.0)**	**(0.2)**	**1.5**	**1.7**	

Workforce Pay Costs – September 2017

Staff Category £'m	FTE Plan	FTE Actual	In Month			YTD		
			Plan	Actual	Variance	Plan	Actual	Variance
Nursing	3,152	3,048	10.3	9.4	(0.9)	58.4	56.7	(1.7)
Medical	651	664	5.4	5.9	0.5	32.3	34.0	1.7
Administrative & Clerical	1,266	1,242	2.9	2.9	0.0	17.4	17.0	(0.4)
Prof & Tech	524	526	1.7	1.8	0.1	9.9	10.7	0.8
Professions Allied to Medicine	514	432	1.6	1.5	(0.2)	10.3	8.7	(1.6)
Ancillary	720	673	1.5	1.4	(0.1)	8.7	8.4	(0.2)
Senior Manager (Other)	123	102	0.7	0.7	(0.1)	4.4	3.8	(0.6)
Executive	8	9	0.3	0.4	0.1	0.8	0.8	0.0
Other Employees	(4)	-	(0.7)	0.0	0.7	(0.1)	0.1	0.1
vacancy factor	(61)	-	(0.8)	0.0	0.8	(2.9)	0.0	2.9
Grand Total	**6,893**	**6,695**	**22.9**	**23.8**	**0.9**	**139.2**	**140.2**	**0.9**



Highlights

- YTD ward based nursing spend is over plan by £1.2m, this is offset by underspends predominately in ESBT (reduces income) £0.9m, health visiting £0.3m and corporate, some of these are also included in the vacancy factor line.
- YTD Medical overspends in WaCH, DAS & Medicine due to agency £3.7m, locum £2.5m & WLI £0.7m off set by £5.2m substantive underspends.
- Prof & Tech overspends in surgery agency.
- A&C underspends are predominately in DAS & OOH.
- Prof & Tech overspends in OOH £0.4m and DAS £0.4m
- PAMS YTD under spends in OOH £1.2m (offset by vacancy factor) due to vacancies in ESBT & DAS £0.3m
- Senior manager's YTD variance driven by corporate underspends £0.4m and OOH underspends of £0.1m
- Vacancy factor represents planned underspends in OOH £1.3m, WACH £0.2m and unallocated workforce CIPs £0.9m.

Cost Improvement Plan – September 2017

Workstream	£000's Original Plan	Tfr'd to regular Budgetary Mgmt	Re-scoped Plan	Allocate Risk Adj	Revised Plan
Clinical Services Review	6,323	443	5,880	(1,557)	4,323
Data Quality and Clinical Networks	3,838	3,838	0		0
Elective Pathways	6,070	636	5,434	(2,377)	3,057
Grip & Control	6,535	5,035	1,500		1,500
Commercial Income	1,837	732	1,105	(155)	950
Procurement	4,600	0	4,600		4,600
Patient Flow	686	191	495		495
Workforce	5,819	0	5,819	(2,901)	2,918
Central Risk Adjustment	(6,991)	0	(6,991)	6,991	0
Total	**28,717**	**10,874**	**17,842**	**0**	**17,843**

Workstream	YTD Plan £000	Actual £000	Variance £000
Clinical Services Review	0	529	529
Data Quality and Clinical Networks	0	0	0
Elective Pathways	1,311	1,109	(202)
Grip & Control	500	550	50
Commercial Income	417	221	(196)
Procurement	790	868	78
Patient Flow	165	0	(165)
Workforce	1,107	140	(967)
Total	4,290	3,417	(873)

Headlines

•The Trust has undertaken a re-scoping exercise of the £28.7m CIP, this has resulted in £10.9m of projects being captured as part of regular budgetary management. In addition to this the Central Risk Adjustment has been allocated out to workstreams so that it is no longer held centrally. The table to the left shows the breakdown of this.

•The Trust is behind the revised CIP plan by £0.9m YTD.

•The largest variance is on Workforce, we are struggling to capture all of the financial benefits arising from the actions being taken by the workstream.

•Elective Pathways variance is largely due to the activity fluctuations experienced in April, August and September.

•Commercial Income is behind plan, largely on Private Patients and Overseas visitor income.

•Patient Flow – LOS is improving, closure of beds in addition to the extra capacity beds is challenging.

•CSR is delivering ahead of plan, which commences in October.

•The forecast against the revised plan is captured in the reforecasting paper.

Activity & Contract Income – September 2017

Income (£'m)	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Inpatients - Electives	4.8	4.5	(0.3)	28.5	25.6	(3.0)
Inpatients - Emergency	7.2	8.0	0.8	43.9	46.6	2.7
Excess Bed Days	0.5	0.4	(0.1)	3.2	2.6	(0.7)
Outpatients	3.8	3.4	(0.4)	22.6	20.7	(1.9)
Other Acute based Activity	2.6	2.6	(0.1)	15.9	16.0	0.1
Direct Access	0.8	0.8	(0.0)	4.9	4.9	0.0
Block Contract	4.6	4.0	(0.6)	27.1	23.8	(3.4)
Fines & Penalties	0.0	0.0	0.0	0.0	0.0	0.0
Other	2.6	0.8	(1.8)	11.9	14.7	2.8
CQUIN	0.5	0.5	(0.0)	3.3	3.1	(0.2)
Subtotal	27.6	25.1	(2.5)	161.5	158.1	(3.4)
Exclusions	2.8	3.1	0.3	16.8	17.1	0.3
TOTAL	**30.4**	**28.2**	**(2.2)**	**178.3**	**175.2**	**(3.1)**

Activity	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Inpatients - Electives	4,473	4,160	-313	26,543	23,719	-2,824
Inpatients - Emergency	3,458	3,595	137	21,093	22,173	1,080
Excess Bed Days	2,208	1,832	-376	13,469	10,846	-2,623
Outpatients	31,056	30,369	-687	184,264	182,132	-2,132
Other Acute based Activity	11,887	11,546	-341	72,300	73,655	1,355
Direct Access	294,027	293,811	-216	1,744,562	1,790,091	45,529
Other	9,216	8,757	-459	55,101	56,678	1,577

Income Headlines

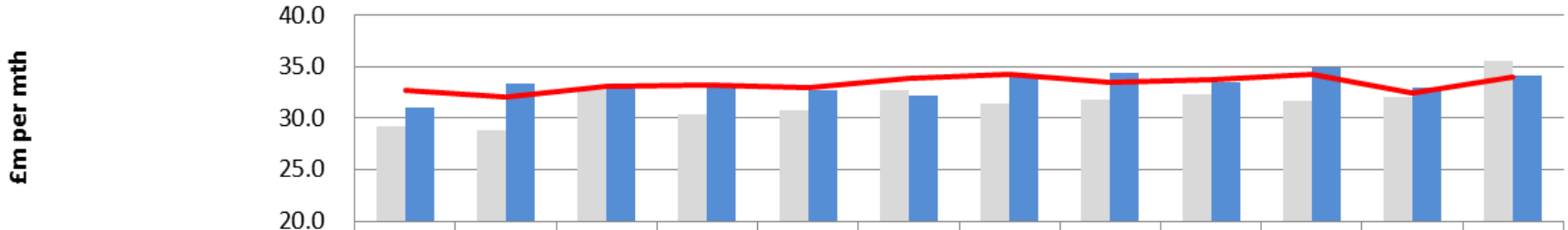
- Total contract income in the month is £2.2m adrift from plan although this includes a £2.0m adverse in month variance relating to STF (included in the 'other' line).
- YTD activity related income is £2.7m below plan, the trust continues to see a shift from elective income to non-elective, the reasons for this aren't fully clear but it appear to be part of a wider national effect. This together with ESBT £1.1m below plan account for most of the differences.
- Non delivery of STF is offset by unplanned income relating to iMSK, although there is a cost implication.
- Tariff excluded drugs and devices are £0.3m ahead of plan.
- The trust continues to see a shift from elective income to non-elective, the reasons for this aren't fully clear but it appear to be part of a wider national effect.
- The impact of moving to HRG4+ is reflected in divisional plans.

Activity Headlines

- Day case activity in September was 8% below plan and 11% below plan YTD. Elective activity is was 1.7% in month and is 7.2% below YTD plan.
- Non elective inpatient activity continues above plan 9% in month and 4.9% YTD.
- Outpatients when taken as a whole are 2.3% below in month plan which drives a 1% adverse variance YTD.

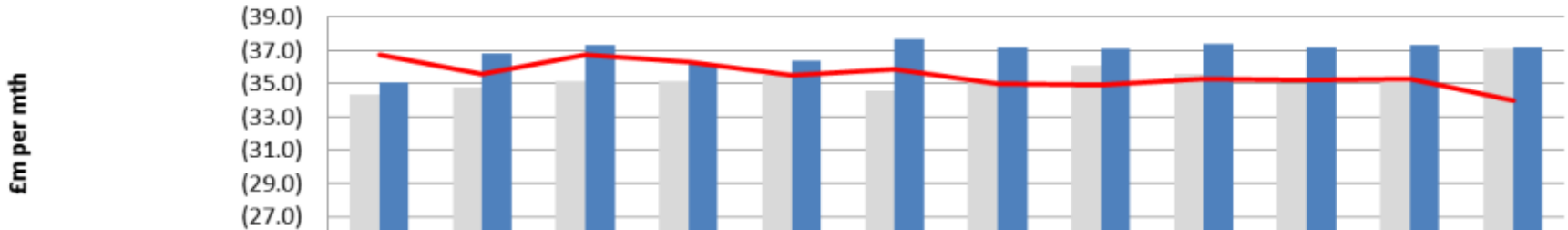
Trends – September 2017

Income run rate



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income 16/17	29.2	28.8	32.7	30.4	30.8	32.7	31.4	31.8	32.3	31.6	32.0	35.5
Run rate 2017/18 income	31.0	33.3	33.4	33.3	32.7	32.2	34.3	34.4	33.5	34.9	33.0	34.1
Budget 2017/18 income	32.7	32.0	33.1	33.2	33.0	33.9	34.2	33.5	33.7	34.2	32.4	34.1

Pay and non pay run rate



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
2016/17 run rate	(34.3)	(34.8)	(35.1)	(35.1)	(35.5)	(34.5)	(35.1)	(36.1)	(35.5)	(35.0)	(35.1)	(37.1)
Run rate 201718 spend	(35.1)	(36.8)	(37.3)	(36.2)	(36.4)	(37.7)	(37.2)	(37.1)	(37.4)	(37.2)	(37.3)	(37.2)
Budget 2017/18	(36.7)	(35.6)	(36.7)	(36.3)	(35.5)	(35.9)	(35.0)	(34.9)	(35.3)	(35.2)	(35.3)	(34.0)

Cash Flow – September 2017

13 month rolling cash flow statement (£'m)	Sep'17	Oct'17	Nov'17	Dec'17	Jan'18	Feb'18	Mar'18	Apr'18	May'18	Jun'18	Jul'18	Aug'18	Sep'18
	Actual	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
Cash flows from operations	(4.9)	(0.4)	(0.8)	(1.0)	0.1	1.2	2.2	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)
Depreciation and amortisation	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.2	1.2	1.2	1.2	1.2	1.2
Capital donations	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)
Trade and other receivables	1.1	4.5	3.2	2.6	2.6	2.0	0.9	0.3	0.3	0.3	0.3	0.3	0.3
Inventories	0.3	-	-	-	(0.1)	(0.3)	(1.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Trade and other payables	2.0	(5.2)	(3.8)	(2.1)	(2.4)	(3.7)	(6.7)	(0.2)	(0.4)	(0.5)	(0.2)	(0.2)	1.5
Provisions	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash from operations	**(0.5)**	**(0.0)**	**(0.3)**	**0.6**	**1.3**	**0.2**	**(3.5)**	**0.5**	**0.3**	**0.2**	**0.5**	**0.5**	**2.2**
Interest received	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Intangible assets	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Property, plant and equip.	(0.5)	(2.2)	(1.8)	(1.0)	(2.4)	(1.1)	(2.1)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)
Cash from investing activities	**(0.6)**	**(2.2)**	**(1.8)**	**(1.0)**	**(2.4)**	**(1.2)**	**(2.1)**	**(1.3)**	**(1.3)**	**(1.3)**	**(1.3)**	**(1.3)**	**(1.3)**
Loans - received	5.7	1.2	1.5	1.2	1.1	1.9	8.0	1.4	1.4	1.4	1.4	1.4	1.4
Loans - repaid	(0.2)	-	-	-	-	-	(0.2)	-	-	-	-	-	-
Other capital receipts	-	-	-	-	0.2	-	-	-	-	-	-	-	-
Interest paid	(0.8)	(0.2)	(0.2)	(0.3)	(0.5)	(0.7)	(0.9)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)
PDC dividend paid	(2.1)	-	-	-	-	-	(1.7)	-	-	-	-	-	(2.0)
Cash from financing activities	2.7	1.2	1.8	0.9	0.9	1.2	5.2	1.0	1.0	1.0	1.0	1.0	(1.0)
Increase/(decrease) in cash	1.6	(1.0)	(0.3)	0.5	(0.2)	0.3	(0.5)	0.1	(0.1)	(0.2)	0.1	0.1	(0.2)
Opening cash	1.8	3.4	2.4	2.1	2.5	2.3	2.6	2.1	2.2	2.2	2.0	2.2	2.3
Closing cash	**3.4**	**2.4**	**2.1**	**2.5**	**2.3**	**2.6**	**2.1**	**2.2**	**2.2**	**2.0**	**2.2**	**2.3**	**2.1**

Headlines

- The cash position of the Trust remains challenging and maintaining liquidity and supply of goods and services requires regular management intervention.
- The draw-down of RWCF is confirmed at the lower rate of 3.5%
- The Trust continues to work closely with NHSi to review options for drawing cash to meet current aged creditor balances.

Balance Sheet – September 2017

Headlines

- The forecast increase in non-current borrowings is in respect of the interim revolving working capital support facility (RWCF)
- Both payable and receivable balances remain high.
- Increase in PDC of £1.7m relates to additional funding in respect of A&E/GP Streaming capital scheme.
- Payable balances remain high due to lack of cash.

BALANCE SHEET £000s	Actual 31/03/2017	YTD Actual	Forecast 31/03/2018
Non Current Assets			
Property plant and equipment	237,135	236,095	238,634
Intangible Assets	1,860	1,897	1,980
Trade and other Receivables	1,308	1,149	1,308
	240,303	**239,140**	**241,922**
Current Assets			
Inventories	6,195	6,307	6,195
Trade receivables	29,734	24,576	26,002
Other receivables	11,072	24,352	9,617
Other current assets	0	0	0
Cash and cash equivalents	2,100	3,396	2,100
	49,101	**58,631**	**43,914**
Current Liabilities			
Trade payables	(23,586)	(42,204)	(16,470)
Other payables	(29,448)	(19,628)	(20,961)
DH Capital investment Loan	(427)	(427)	(427)
Other Financial Liabilities	0	0	0
Provisions	(502)	(341)	(502)
	(53,963)	**(62,600)**	**(38,360)**
Non Current Liabilities			
DH Capital Investment Loan	(3,126)	(2,913)	(3,126)
Borrowings - Revenue Support Facility	(89,662)	(112,276)	(126,757)
Other Financial Liabilities	0	0	0
Provisions	(2,488)	(2,464)	(2,488)
	(95,276)	**(117,653)**	**(132,371)**
Total Assets Employed	**140,165**	**117,519**	**115,105**
Financed by			
Public Dividend Capital (PDC)	153,562	154,481	155,247
Revaluation Reserve	104,708	104,707	104,708
Income & Expenditure Reserve	(118,105)	(141,669)	(144,850)
Total Tax Payers Equity	**140,165**	**117,519**	**115,105**

Capital Programme – September 2017

Headlines

• The Trust has an internally generated Capital Resource Limit (CRL) from depreciation of £11.7m.

•Recently agreed funding via PDC for GP streaming works has increased the CRL.

•The Trust can also increase its CRL by receiving donations and these are planned to total £1.0m over the year.

•During the planning stage there was a £1.8m over commitment , this was agreed in the knowledge that capital schemes often suffer from slippage.

•Currently the plan is £4.6m over committed – with additional external funding of £1.5m anticipated to mitigate new projects. The CRG is working to ensure the CRL is delivered at the end of the year.

•A review of the entire capital programme is underway with the joint aims of eliminating the over commitment and creating headroom for fire safety works on the Eastbourne site.

Capital Investment Programme (£'m)	Plan	Actual							Forecast
	2017/18	Apr	May	Jun	Jul	Aug	Sept	YTD	2017/18
Capital Resource Limit (CRL)	11.7	11.7	11.7	11.7	11.7	11.7	11.7	11.7	11.7
CRL increase									1.7
Updated CRL (exc donated assets)	**11.7**								**13.4**
Donated asset funding	1.0	0.1	0.1	0.0	0.1	0.1	0.1	0.2	1.0
Total capital funding	**12.7**	**11.8**	**11.8**	**11.7**	**11.8**	**11.8**	**11.8**	**11.9**	**14.4**
Schemes									
Brought Forward	0.0	0.1	0.2	0.0	0.0	0.1	0.1	0.3	0.4
Estates - Brought Forward	4.3	0.1	0.1	0.2	0.1	0.9	0.1	1.4	4.8
Estates - Backlog Maintenance	1.9	0.0	0.0	0.0	0.0	0.2	0.0	0.2	1.8
Estates - Central	0.0	0.0	0.0	0.0	0.0	0.1	0.4	0.1	3.5
Estates - Clinical	0.4	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.4
Estates - Statutory	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.5
IT - Brought Forward	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	2.0
IT - Core	2.2	0.0	0.1	0.0	0.0	0.0	0.0	0.2	0.4
IT - EDM	0.4	0.2	0.0	0.0	0.0	0.0	0.0	0.2	0.2
IT - Other	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Medical Equipment	2.0	0.2	0.0	0.0	0.0	0.3	0.1	0.6	2.0
Minor Capital	1.2	0.2	0.1	0.1	0.1	0.2	0.1	0.8	1.2
Unplanned Urgents	0.5	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.5
Donated Assets Purchased	1.0	0.1	0.1	0.0	0.1	0.1	0.1	0.3	1.0
Overplanning margin	-1.8								
Anticipated slippage									-4.6
Net Capital Charged against CRL	**12.7**	**0.9**	**0.6**	**0.5**	**0.6**	**1.9**	**1.0**	**4.4**	**14.4**

Receivables & Payables Performance – September 2017

Headlines

- The target achievement of BPPC is 95%, the Trust remains significantly below this target.
- Payables continue to increase in age.
- The Trust is working towards establishing a "cash Committee" as recommended by NHSi – once developed, this committee will support the decisions around prioritisation and payment of suppliers whilst the current liquidity issues remain.

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	7,794	4,754	1,753	1,694
31 - 60 Days	2,899	2,099	513	1,362
61 -90 Days	1,822	682	115	565
91 - 120 Days	576	648	67	1,272
> 120 Days	6,775	6,756	2,262	1,477
Total	19,866	14,939	4,710	6,370

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	5,197	6,193	6,188	6,799
31 - 60 Days	7,120	8,560	10,094	9,861
61 -90 Days	5,326	5,043	7,883	6,737
91 - 120 Days	3,539	3,509	5,402	4,792
> 120 Days	6,063	5,183	12,637	11,353
Total	27,245	28,488	42,204	39,542

Financial Risks & Mitigating Actions – September 2017

Risks	Mitigations
The Trust has a £28.7m savings requirement, re-scoped to £17.9m. YTD there is £0.9m slippage against the re-scoped plan	A full re-forecast has been undertaken and mitigations are being discussed with Executive directors.
The Trust has seen a significant and continued fall in it's elective activity, currently this is offset but increases in non-elective.	Theatre productivity work is in train to maximise in-house through-put.
The costs of escalation and other attributable items may not be contained within the £3.1m funding envelope, including the costs of Winter.	Funding for the system winter plan is being sought, discussions with commissioners are on-going.
Outsourcing, WLI & ad-hoc clinics do not deliver the required improvement in RTT and 2 WW/ 62 day cancer targets	The Trust is developing a plan to deliver it's RTT target at the lowest possible safe cost, and has been successful in securing NHSE funding to support additional clinics for 62 day cancer.
Activity in some specialties is below plan and need further validation to identify where these trends may continue	Weekly activity tracking in place to monitor activity performance and a review of demand and capacity will be undertaken to ensure all specialties are matching resource requirements to demand
Agency premium costs are currently mitigated by vacancies elsewhere.	The Trust has revamped it's vacancy control process and has a detailed workforce efficiency workstream and plan.
A £4.2m provision in planning for contract challenges has been made, including the outcome of the prior year disputed balances - there is a risk that total contract challenges will exceed this.	Discussions with CCGs are in train about securing a 'minimum income deal'.

Sustainability and Strategy

SUSTAINABILITY

Strategy

Strategy, Innovation and Planning

- The ESHT Clinical strategy has now been presented and discussed at the ESBT clinical forum and it will be presented to the November Board for formal ratification. The key change has been to articulate that our Clinical Strategy is part of an emerging ESBT Strategy which will be developed over the coming months.
- Our planning team is busy supporting the divisions to develop their business plans for 18/19 . There is a timetable for regular Executive and FISC review and plans will be presented to the Board in due course.
- We held our first ESHT Improvement Forum at the beginning of the month and over 70 people attended from across the Trust. We had displays of our ESHT /ESBT recent and current improvement programmes; and we had guest speakers from Western Sussex Hospitals Trust who described some of their improvement processes and initiatives. We intend to run these as a regular event and the next one will be at The Conquest site.

Activity

ACTIVITY

Activity Headlines

Daycase

The gap against plan has widened further to 12.6% under plan year to date

The largest area of variance both weekly and year to date is within Gastroenterology which equates to a third of the gap. This is a known issue with the profiling of the plan. Other key areas of underperformance are: Clinical Oncology, Cardiology, General Surgery and T&O which account for the majority of the remaining gap.

Inpatients

Variance against plan has decreased by 0.3% and is now under by 7.0%.

This is driven by trauma and orthopaedics and Urology predominantly

Against internal activity year on year (M5 Elective activity is down by 198 cases, daycases is up in medicine by 398 which covers the drop in surgical daycases (-66))

Outpatients

First Outpatient

- Under performance decreased slightly to 9.2% , year to date
- Ophthalmology has largest underperformance against plan .
- Orthopaedics, cardiology, T&O and ENT are also showing large underperformances.

Follow-up

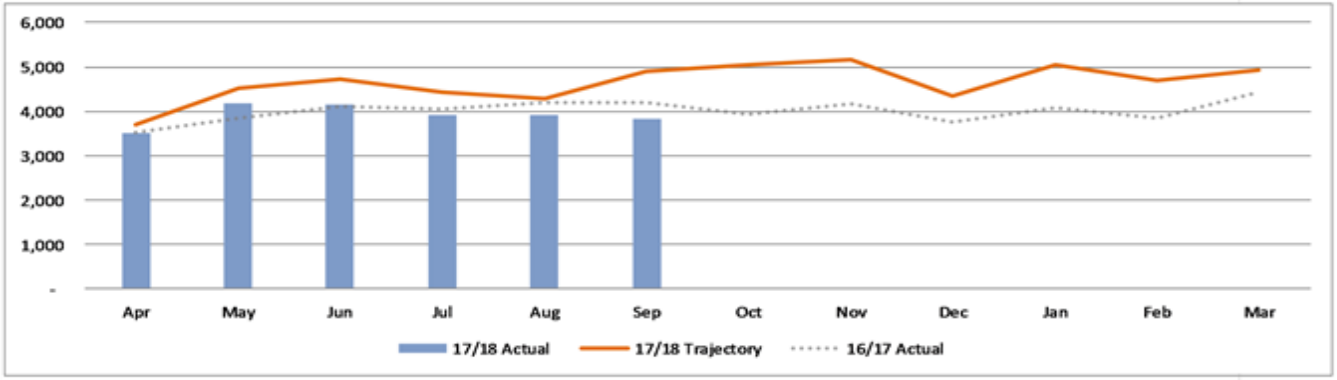
- Running marginally up against Plan year to date (1.2%).
- Year to date under performance in General Surgery and T&O masked by over performance in Thoracic Medicine, Gastroenterology and Ophthalmology .

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Sep-16	Sep-17	Var	2016/17	2017/18	Var		
Emergency Department attendances	M	9470	9859	4.1%	56853	60615	6.6%	9525	
Ambulance conveyances	M	3051	3123	2.4%	18187	19125	5.2%	3168	
Admissions via A&E	M	23.1%	28.5%	5.3%	24.3%	27.2%	2.9%	27.1%	
Primary Referrals	M	9206	7948	-13.7%	55081	50840	-7.7%	8713	
Consultant to Consultant referrals	M	1499	1727	15.2%	9448	10072	6.6%	1589	
2WW Referrals	M	1764	1574	-10.8%	10056	10099	0.4%	1649	
Elective spells	M	670	632	-5.7%	3983	3699	-7.1%	643	
Day Cases	M	4210	3821	-9.2%	23925	23544	-1.6%	3979	
Elective Beddays	M	2048	1473	-28.1%	11796	10033	-14.9%	1773	
Total Non-Elective Spells	M	3663	4034	10.1%	22943	24279	5.8%	3921	
Number of Emergency spells	M	3001	3451	15.0%	19076	20611	8.0%	3315	
Number of Maternity spells (ante and post partem)	M	344	304	-11.6%	2069	1962	-5.2%	326	
Number of other non-elective spells (Births/Transfers from other hospitals)	M	318	279	-12.3%	1798	1706	-5.1%	280	
Non-Elective beddays	M	22658	21203	-6.4%	135535	129786	-4.2%	22413	

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Sep-16	Sep-17	Var	2016/17	2017/18	Var		
Elective Average Length of Stay	M	3.1	2.3	-0.7	3.0	2.7	-0.2	2.8	
Non-Elective Average Length of Stay	M	6.1	5.1	-1.0	5.8	5.4	-0.4	5.8	
Inpatient Average Length of Stay at intermediate care units	M	27.9	26.4	-1.6	30.8	29.5	-1.3	30.8	
First outpatient attendances	M	10990	9291	-1699	68205	64003	-6.2%	10553	
Follow-up outpatient attendances	M	23933	23627	-306	154354	157942	2.3%	24140	
First outpatient DNA rate	M	9.3%	9.0%	-0.2%	8.9%	8.6%	-0.4%	8.8%	
New to follow up ratio	M	856.3	895.9	39.5	154354	157942	3588	796	
% Temporary files created as a proportion of all attendances									
Community nursing referrals	M	4098	3998	-100	23687	24467	780	4190	
Community nursing total contacts	M	32850	33676	826	206690	210826	4136	34954	
Community Nursing face-to-face contacts	M	18737	19045	308	116157	119785	3628	19787	
Community nursing ALOS	M	22.2	4.7	-18	23.8	11.8	-11.9	15	
Waiting Times									
% SALT patients waiting less than 13 weeks	M	100.0%	#DIV/0!	#DIV/0!	100.0%	100.0%	0.0%	100.0%	
Total SALT patients waiting	M	182	0	-182	1041	690	-351	126	
% Podiatry patients waiting less than 13 weeks	M	100.0%	#DIV/0!	#DIV/0!	100.0%	100.0%	0.0%	100.0%	
Total podiatry patients waiting	M	942	0	-942	5315	1342	-3973	303	
% Dietetics patients waiting less than 13 weeks	M	100.0%	#DIV/0!	#DIV/0!	100.0%	97.6%	-2.4%	98.6%	
Total dietetics patients waiting	M	54	0	-54	411	372	-39	58	
% MSK patients waiting less than 13 weeks	M	100.0%	98.0%	-2.0%	100.0%	93.4%	-6.6%	96.0%	
Total MSK patients waiting	M	105	0	-105	4267	6082	1815	1290	

2017/18 Activity

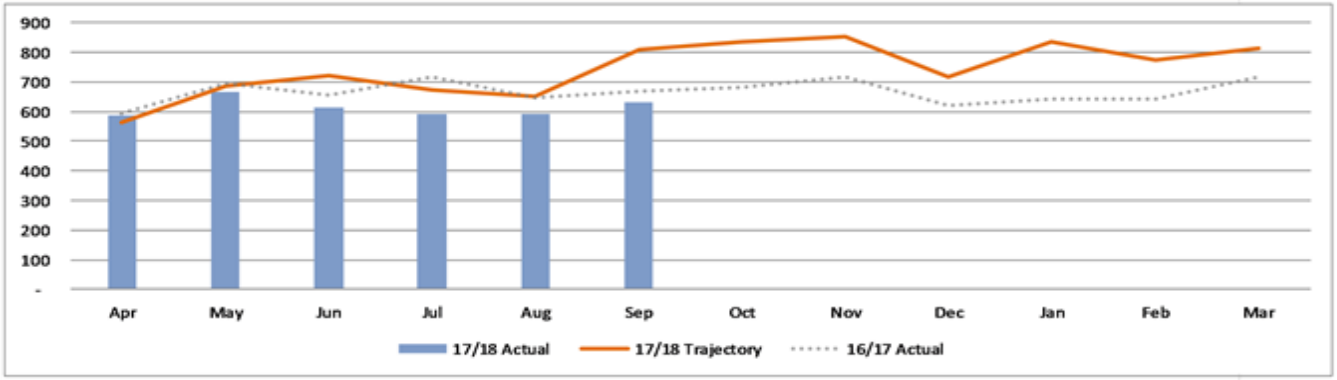
Daycase



YTD	
Plan	21,655
Actual	19,725
Var	-8.9%
16/17	65,465

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18 Trajectory	3,706	4,508	4,726	4,422	4,293	4,893	5,035	5,153	4,331	5,053	4,687	4,915
17/18 Actual	3,510	4,192	4,160	3,931	3,932	3,821						
Var	-5.3%	-7.0%	-12.0%	-11.1%	-8.4%	-21.9%						
16/17 Actual	3,521	3,840	4,119	4,036	4,199	4,210	3,934	4,165	3,755	4,087	3,831	4,437

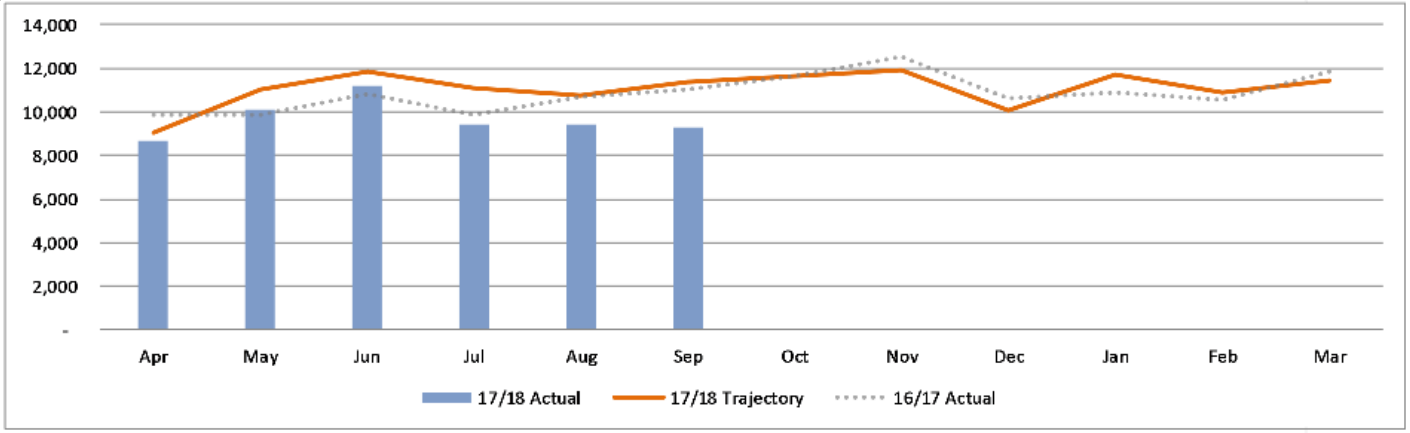
Elective IP



YTD	
Plan	3,298
Actual	3,052
Var	-7.5%
16/17	3,313

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18 Trajectory	564	686	722	673	653	809	834	851	718	835	776	813
17/18 Actual	586	665	614	593	594	632						
Var	3.9%	-3.1%	-15.0%	-11.9%	-9.0%	-21.9%						
16/17 Actual	596	697	656	715	649	670	682	717	619	642	644	715

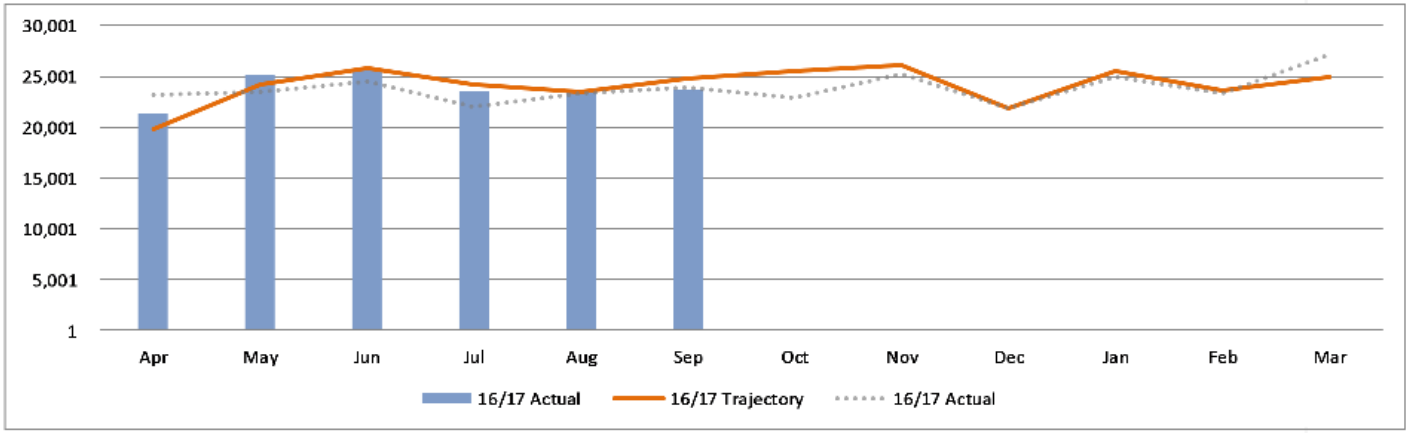
First Outpatient



YTD	
Plan	53,683
Actual	48,740
Var	-9.2%
16/17	51,142

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18 Trajectory	9,044	10,999	11,830	11,064	10,746	11,339	11,665	11,933	10,034	11,722	10,849	11,395
17/18 Actual	8,653	10,072	11,194	9,410	9,411	9,291						
Var	-4.3%	-8.4%	-5.4%	-14.9%	-12.4%	-18.1%						
16/17 Actual	9,853	9,876	10,838	9,868	10,707	10,990	11,652	12,489	10,642	10,906	10,567	11,845

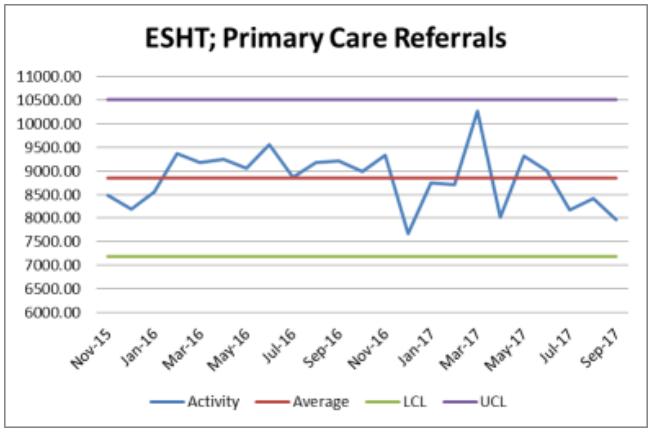
Follow-up Outpatient

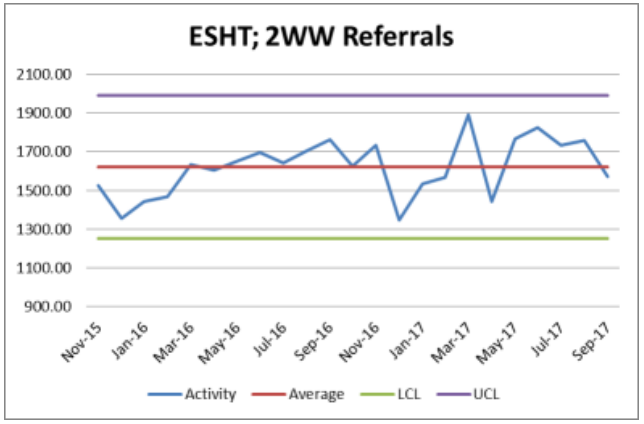


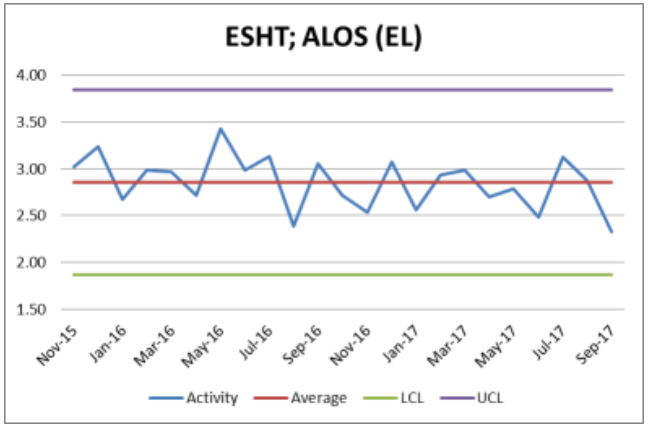
YTD	
Plan	117,418
Actual	119,316
Var	1.6%
16/17	116,507

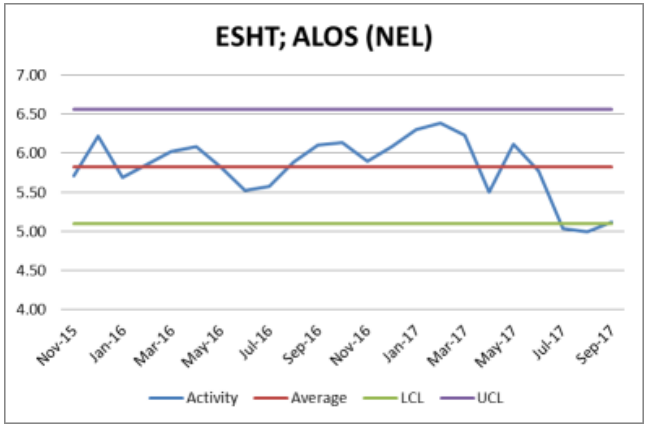
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17 Trajectory	19,855	24,156	25,808	24,156	23,443	24,743	25,456	26,045	21,905	25,572	23,681	24,864
16/17 Actual	21,336	25,097	25,802	23,540	23,541	23,627						
Var	7.5%	3.9%	0.0%	-2.6%	0.4%	-4.5%						
16/17 Actual	23,216	23,403	24,446	22,053	23,389	23,933	22,845	25,168	21,860	24,898	23,354	27,110

East Sussex Healthcare NHS
NHS Trust









Primary care referrals remain at lower than average levels following a sharp increase earlier in the year. This is off set against overall referrals and changes in referral criteria which gives a flatter overall trend.

The referrals for two week waits dropped after a period of stabilised levels. The Trust is expecting further increases with the impact of various national campaigns.

Non-elective ALoS remains at or below the lower control limit in September. This would indicate a higher than expected number of patients discharged with low lengths of stay.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Mortality Report – Learning from Deaths (1 April 2016 to 30 June 2017)

Meeting information:			
Date of Meeting:	28th November 2017	Agenda Item:	11
Meeting:	Trust Board	Reporting Officer:	David Walker

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

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

Other stakeholders please state: ……

Have any risks been identified ☒ *(Please highlight these in the narrative below)*	On the risk register? No

Executive Summary:

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

The requirements set out in the Care Quality Commission Learning from Deaths review have been incorporated into Trust policy. This has included updating the mortality database to reflect the new review process.

This report details the deaths recorded and reviewed from April 2016 – June 2017.

The importance of reviewing deaths within the 3 month timescale is critical to ensure that reporting is accurate and provides a useful overview on the number of deaths that were actually or potentially avoidable. This is the only risk remaining with the learning from deaths process changes.

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

The Learning from Deaths Board Report has been reviewed and approved at the Patient Safety Group, 21st November 2017.

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

The Board are requested to note the report. Learning from death reports are required on a quarterly basis.

EAST SUSSEX HEALTHCARE TRUST: Learning from Deaths Dashboard April/June 2017-18

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

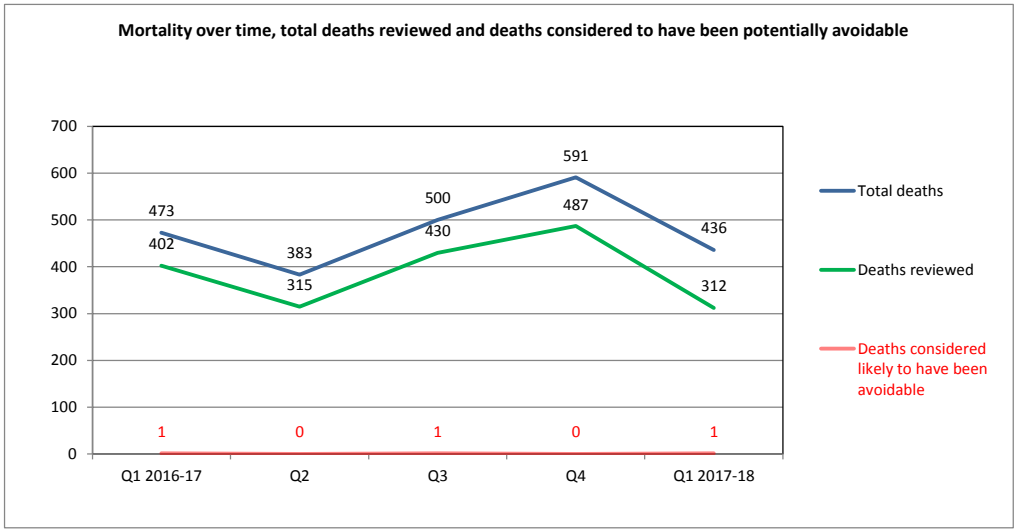
Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review methodology

Total number of deaths, deaths reviewed and deaths deemed avoidable (does not include patients with identified learning disabilities)

Time Series:	Start date	2016-17	Q1

End date	2017-18	Q1

Total number of deaths in scope		Total deaths reviewed		Total number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
127	162	84	122	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
436	591	312	487	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
436	1947	312	1634	1	2



Total deaths reviewed by RCP methodology score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	*1	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	*1	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-

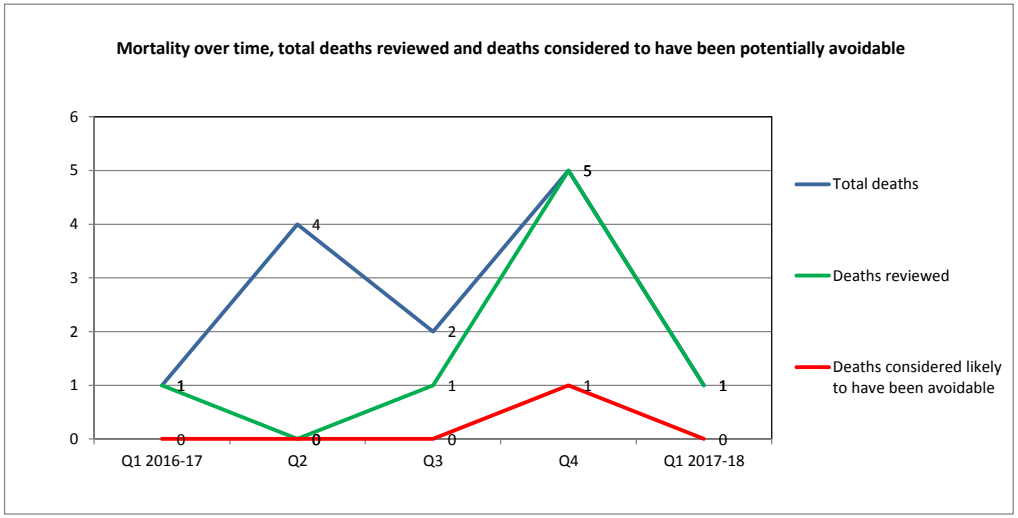
Data shown above is as at 06/10/2017 and does not include patients with identified learning disabilities.
*There was one severity 5 Serious Incident during Quarter 1 (Severity 5 would indicate the cause of death was significantly contributed to by a lapse in care or service delivery). This death has a draft review on the Mortality database at present, awaiting final decision and sign-off. The RCA has been submitted to the CCG for this Serious Incident.
Of the complaints received in Quarter 1 relating to patient deaths, one was upheld. Complaint description: *Issues raised by wife regarding awareness of staff for patient lack of hearing, appropriate assessments for ward placements, assistance with food and drink, phlebotomist, Nursing care and delays in ward transfers, HCL/THCL, Pain relief, dignity/ side rooms, lack of diagnosis *CONSENT**
The Mortality database has now been updated to include any family/carer concerns expressed to the Trust Bereavement team. Future reports (from Quarter 2 2017/18) will therefore include the number of concerns raised and a summary of actions taken as a result.
As at 06/10/2017 there were 124 April 2017 - June 2017 deaths still outstanding for review on the Mortality database.

Summary of total number of learning disability deaths and total number reviewed

Total number of deaths, deaths reviewed and deaths deemed avoidable for patients with identified learning disabilities

Time Series:	Start date	2016-17	Q1	End date	2017-18	Q1

Total number of deaths in scope		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	1	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	5	1	5	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1	12	1	7	0	1



In March 2016 the Mortality database was updated, allowing the Learning disability team to enter review comments for Learning disability deaths.
Data above shows the Learning disability deaths which have been reviewed by the Trust Learning disability team, prior to the national requirement of reviewing deaths using the new national LeDeR methodology.
The LeDeR (learning disability mortality review) programme will be implemented by the end of 2017 when Learning disability deaths will be reviewed against the new criteria.

Financial Special Measures Update

Meeting information:			
Date of Meeting: 28th November 2017		Agenda Item:	12
Meeting: Trust Board		Reporting Officer:	Jonathan Reid

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

Has this paper considered: (Please tick)

Key stakeholders:		Compliance with:	
Patients	☐	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐

Other stakeholders please state: .....

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

Executive Summary:

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

This report provides the Board with a summary of progress on the implementation of the CIP programme and the Trust's work within the Financial Special Measures programme. The report highlights delayed delivery of the full range of cost improvements in year, and notes the ongoing work to progress a full reforecast for the Trust's 2017/18 financial position. The reforecast is to be considered by the Trust Finance and Investment Committee on 29th November and the Trust is in detailed discussion with NHSI on the forecast and next steps. The Trust have been working with KPMG who have identified a significant improvement in the underlying run-rate and have reviewed the risks to the delivery of the full financial plan in 2017/18 identified by the Trust.

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

None – Finance and Investment Committee will review the full reforecast on 29th November.

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.

East Sussex Healthcare NHS
NHS Trust

EAST SUSSEX HEALTHCARE NHS TRUST

Financial Special Measures
Board Update November 2017

Jonathan Reid, Director of Finance
20/11/17

Executive Summary

- The Trust is adverse to plan at Month 6 by £4.7m excluding STF and is reporting a clear risk to delivery of the full year financial plan, driven by a reduction in elective activity against plan and challenges in the full delivery of the CIP programme.

- Working with support from KPMG, the Trust has developed a detailed reforecast for discussion at the Finance and Investment Committee, with the Trust Board and with NHS Improvement. The Trust can demonstrate that there is a clear reduction in the underlying deficit, but is identifying an in-year challenge in the delivery of the control total. The full reforecast is being reviewed by the Finance and Investment Committee on 29th November 2017, before full review by the Trust Board.

- Taking account of the financial position, the Trust has made some immediate changes to programme management and governance, including strengthening Executive oversight and accountability for key programmes. Through NHS Improvement, a new Financial Improvement Director has been appointed to the Trust and has developed an initial programme for strengthening financial governance, focusing on strengthening programme delivery arrangements and the support to delivery by Division teams and Clinical Units.

- The new FID will work with the Trust to establish opportunities to mitigate risk and improve the 2017/18 forecast, whilst simultaneously developing a challenging but achievable 2018/19 plan.

- The Trust is also seeking to agree an income figure with the local CCGs for 2017/18. This will improve cash flow, and reduce risk to forecast outturn – it will create capacity within the Trust to focus on cost reduction rather than challenges. The most significant risk to the Trust forecast is a deterioration in income, but the Trust recognises that it works within East Sussex Better Together, and is working to support an overall improvement in the system financial position.

- The Trust met with the NHS Improvement Financial Special Measures team in November and continues to work closely with NHSI colleagues on supporting a continued improvement in the underlying run-rate for the Trust.

Trust Financial Performance – Month 7 YTD

East Sussex Healthcare NHS Trust

The Month 7 position is consistent with the Month 6 forecast. The table below show the overall YTD Trust position - elective activity is underperforming and this is being mitigated by the impact of HRG4+.

	Year to Date		
£m	Plan	Actual	Variance
Income	227.6	228.2	0.6
Pay	(161.6)	(164.1)	(2.5)
Non-Pay	(90.1)	(92.9)	(2.8)
Total	**(24.1)**	**(28.8)**	(4.7)

NHS contract income is £0.3m behind plan YTD, A&E income and PbR exclusions are both ahead of plan, Elective income is behind plan. Other income is ahead of plan (£0.9m) predominately due to increased income relating to NHS property services recharges.

Pay costs are behind plan, due to non-delivery of CIP of £1.5m (£1.2m of this is workforce), the remainder is due to continued use of temporary staffing and WLI to cover RTT and Cancer Targets, this is partially offset by the underspend on community services due to delayed recruitment.

Non-Pay is behind plan, due to CIP non-delivery (£0.5m), increased drugs costs (£0.6m), unplanned diagnostics (£0.3m), financial improvement costs (£0.2m) commercial units (£0.3m), property services (£0.9m) (offset with income) and additional STP costs (£0.2m).

	YTD		
Workstream	Plan £000	Actual £000	Variance £000
Clinical Services Review	794	937	143
Data Quality and Clinical Networks	2,438	2,670	232
Elective Pathways	2,395	2,029	(366)
Grip & Control	3,085	2,562	(523)
Commercial Income	778	665	(113)
Procurement	1,182	1,045	(136)
Patient Flow	368	148	(220)
Workforce	1,406	167	(1,239)
Total	12,446	10,223	(2,222)

The variance on the YTD CIP is £2.2m, the main drivers of this are workforce non-delivery (56% of the total), grip and control and elective pathways – closely linked to activity falls in the year to date.

CIP Forecast 2017/18

East Sussex Healthcare NHS
NHS Trust

The Trust has undertaken a robust review of the CIP programme - there is a £6.1m shortfall against the full £28.7m CIP plan. The Trust Executive Team have requested a weekly review of the CIP programme, with Clinical and Divisional leads in attendance to ensure delivery. The first of these has taken place.

	Full Year		
	Plan	Forecast	Variance
Workstream	£000	£000	£000
Clinical Services Review	4,766	2,960	(1,806)
Data Quality and Clinical Networks	3,838	4,725	887
Elective Pathways	3,693	4,486	793
Grip & Control	6,535	5,228	(1,307)
Commercial Income	1,682	1,538	(144)
Procurement	4,600	2,733	(1,867)
Patient Flow	686	191	(495)
Workforce	2,918	669	(2,249)
Total	28,717	22,529	(6,188)

	Forecast		
Workstream (£000's)	Delivery	Active	Total
Clinical Services Review	1,559	1,401	2,960
Data Quality and Clinical Networks	4,725	0	4,725
Elective Pathways	1,524	2,962	4,486
Grip & Control	4,128	1,100	5,228
Commercial Income	1,366	172	1,538
Procurement	0	2,733	2,733
Patient Flow	191	0	191
Workforce	293	376	669
Total	13,785	8,744	22,529
M7 YTD Delivery	7,804	2,419	10,223

The £22.5m forecast has been broken down into what is in delivery £13.8m and active projects of £8.7m.

Of the active projects £2.4m has been delivered YTD, but there are further actions required to deliver the full £8.7m.

Four Eyes Insight are supporting the Elective Pathways workstream and all workstreams are supported through the FISC meetings.

Next Steps

There are some key next steps for the Trust within the FSM regime to support a strengthened financial position in year. These are being progressed within the Executive Team, and include:

- a refresh of the existing 'grip and control measures', focusing on pay and non-pay spend
- Implementation of refreshed financial governance arrangements, including strengthened PMO
- review of all opportunities to mitigate risk and improve the 2017/18 position with new FID
- Increased support to the Clinical Units to develop greater ownership of the CIP plans
- finalisation of the 17/18 income agreement with the CCG and NHSE/I and continued work with the regional teams to support an improvement in the local health economy position for 2017/18
- continued development of a robust financial plan for 2018/19, aimed at securing an improvement in the underlying run-rate
- Supporting the delivery of a robust system financial plan for 2018/19, which takes into account the cost base of the Trust, plans to reduce the cost base and current activity and demand levels

The FSM programme has delivered a significant improvement in the financial performance of the Trust, and continued work within the programme will be maintained in 2018.

Capital Programme – Mid Year Update 2017/18

Meeting information:	
Date of Meeting: 28th November 2017	Agenda Item: 13
Meeting: Trust Board	Reporting Officer: Jonathan Reid

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

Has this paper considered: (Please tick)

Key stakeholders:		Compliance with:	
Patients	☐	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐

Other stakeholders please state: ……

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

Executive Summary:

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

This report presents an update on the capital programme for 2017/18. The programme was set at the start of the financial year, based on funding through depreciation and an additional public dividend allocation received from NHS Improvement for primary care streaming. The capital programme is oversubscribed, reflecting the need to maintain and improve existing infrastructure, and is supported in delivery by the Capital Review Group. Following a detailed review, the forecast for the year has reduced, but further work is required to ensure that the forecast can be delivered within the overall funding envelope. At the mid-year stage, the Trust is confident that this forecast will be achieved, as it has in previous years. The Trust is continuing to work with NHS Improvement to secure a capital loan in respect of the ambulatory care unit investment.

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

None – Finance and Investment Committee will review the full capital report on 29th November.

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.

Introduction

1. The Trust has a limited capital programme, which is determined by the depreciation levels (£11.7m), plus capital donations, and additional funding through public dividend capital allocations (£1.7m received in year in respect of GP streaming). The Trust is working closely with NHSI colleagues to secure a loan of £1.5m from the Department of Health for the ambulatory care development work. The formal capital resource limit for the Trust is £13.4m, but it is anticipated to move to £14.9m, following agreement of the capital loan with the DH of £1.5m for the Ambulatory Care units. NHSI are aware that the Trust has committed the expenditure in advance of the drawdown of the loan, but the finance team are working with budget-holders bring the forecast down to a level below the formal capital limited, to provide against the risk that the loan is not approved.

2. The plan was developed by CRG on 20th April 2017 and approved by the Finance and Investment in May 2017. It sits within a broader five year capital and investment programme, which will be fully refreshed as part of the financial planning process for 2018/19. Delivery of the plan is monitored through the Capital Review Group which meets monthly, and reports to the Board and the Financial and Investment Committee.

3. At Month 5, the Trust was forecasting a significant increase in capital spend to the year end, and accordingly a pressure on the capital budgets. A full review of all capital budgets with the Finance Director and the budget-holders has now been undertaken and as a result no forecast overspend has been identified.

Expenditure at Month 6

4. At the end of Q2 the cumulative capital expenditure amounted to £5.0m, this excludes £0.4m related to donated assets and is shown below. Key areas of expenditure relate to the estates and facilities refurbishment programme and the work in train to deliver the primary care streaming and ambulatory care developments.

ESHT	CRG Lead	2017/18 PLAN £'000	ACTUAL EXPENDITURE INCURRED 2017/18 ACTUAL M1 - Apr £'000	2017/18 ACTUAL M2 - May £'000	2017/18 ACTUAL M3 - Jun £'000	2017/18 ACTUAL M4 - Jul £'001	2017/18 ACTUAL M5 - Aug £'001	2017/18 ACTUAL M6 - Sep £'001	2017/18 ACTUAL YTD £'000
Brought Forward	All	10	100	180	(15)	(10)	73	93	421
Estates - Brought Forward	Chris Hodgson	4,300	100	96	239	53	913	90	1,491
Estates - Backlog Maintenance	Chris Hodgson	1,924	12	24	5	43	165	47	296
Estates - Central	Chris Hodgson	1,685	0	0	0	0	90	351	441
Estates - Clinical	Chris Hodgson	366	(1)	3	16	(2)	72	17	107
Estates - Statutory	Chris Hodgson	380	19	27	19	9	16	13	104
IT - Core	Andy Bissenden	2,024	5	9	9	118	(45)	37	132
IT - EDM	Andy Bissenden	437	5	63	14	47	22	9	160
IT - Other	Andy Bissenden	192	192	0	0	0	(32)	0	160
IT - T4S (formerly GS1)	Andy Bissenden	196	6	11	8	8	9	15	58
Medical Equipment	Chris Hodgson	2,000	216	0	24	20	317	66	643
Minor Capital	Steve Hoaen	1,200	165	125	125	125	225	125	890
Unplanned Urgents	All	500	0	0	0	89	0	0	89
TOTAL		**15,214**	**819**	**538**	**445**	**501**	**1,826**	**865**	**4,993**

Full Year Forecast for Capital Expenditure

5. At the end of Q2, and following the full review of all budgets with estates, IT and other key staff, the revised forecast is shown below:

ESHT	CRG Lead	2017/18 PLAN £'000	EXPENDITURE 2017/18 ACTUAL YTD £'000	FORECAST 2017/18 FORECAST OUTTURN £'000	2017/18 Variance to PLAN £'000
Brought Forward	All	10	421	421	411
Estates - Brought Forward	Chris Hodgson	4,300	1,491	4,109	(191)
Estates - Backlog Maintenance	Chris Hodgson	1,924	296	1,409	(515)
Estates - Central	Chris Hodgson	1,685	441	2,127	442
Estates - Clinical	Chris Hodgson	366	107	540	174
Estates - Statutory	Chris Hodgson	380	104	327	(53)
IT - Core	Andy Bissenden	2,024	132	984	(1,040)
IT - EDM	Andy Bissenden	437	160	341	(96)
IT - Other	Andy Bissenden	192	160	160	(32)
IT - T4S (formerly GS1)	Andy Bissenden	196	58	139	(57)
Medical Equipment	Chris Hodgson	2,000	643	1,705	(295)
Minor Capital	Steve Hoaen	1,200	890	1,515	315
Unplanned Urgents	All	500	89	499	(1)
TOTAL		**15,214**	**4,993**	**14,277**	**(937)**

6. The forecast has improved, and is now more aligned with delivery plans held by estates – with a number of duplicates and double-counts removed. Further work is required to reduce this below £13.4m, and then to secure space within the programme to fund a number of emerging additional pressures (in particularly, in respect of the Cardiac Cath Labs where the Trust is likely to require £1m of additional investment to address immediate operational and safety requirements). In effect, the Trust will need to secure a further £1.8m reduction in the forecast (which will not be required if the capital loan of £1.5m is approved) and this will require continued monthly meetings with budget-holders. The forecasts for estates and IM&T expenditure have a degree of volatility, and careful management will ensure delivery of the programme.

7. The NHSI regional team are supporting the Trust to secure the £1.5m loan through a number of routes, with the Trust recognising that capital is constrained at a national level. The new facilities are essential for supporting improved patient flow and experience and ensuring continued improvement against the performance standards.

8. The Trust is in extensive discussions with both NHS Improvement and East Sussex Fire Authority around the review of compartmentalisation and any associated capital requirements. The Trust has commissioned the development of a business case to support any required investment, which is not reflected in the capital programme – other than a small investment in immediate works on a number of wards within the Trust.

Next Steps

9. The Trust is managing a constrained capital budget, and is working closely with colleagues across the organisation to ensure delivery of key infrastructure developments within the available resource. The revised forecast is closer to – but not yet within – the available resource, and the Capital Review Group will continue to monitor and work closely with the budget-holders to support delivery within the budget with the support of the Director of Finance.

Jonathan Reid

Director of Finance

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust

Clinical Strategy

2017 - 2022

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Contents

Specific actions for what we need to do to achieve this are outlined in the specialty level plans on a page (separate document)

1: Executive summary

This is East Sussex Healthcare NHS Trust's (ESHT) clinical strategy for 2017 - 2022. This Clinical Strategy describes the high level objectives for our clinical services and outlines the key priorities for development in 17/18. We will revisit, review and refresh our priorities each year in order to achieve our objectives and we will use this strategy as a roadmap to achieve our vision to be the lead provider of hospital and community healthcare services in East Sussex and our ambition of 'Outstanding' by 2020.

The Trust's overarching strategy 'ESHT 2020' describes how as an organisation we will combine community and hospital services to provide safe, compassionate and high quality care to improve the health and wellbeing of the people of East Sussex. The Clinical Strategy 2017-2022 is part of a wider emerging East Sussex Better Together (ESBT) strategy which will align Primary, Secondary, Community and Specialist services in a way that will drive the transformations necessary to meet future health needs of our populations. It will focus our system on development of new models of care and integrated pathways in order to deliver high quality services within the system budget.

The Clinical Strategy has been developed at a time that affords us with both challenges and opportunities. Our ambition to provide equitable, comprehensive, high quality healthcare has not changed, but the opportunity available to us through new technologies, innovations and models of care will be key in our ability to deliver our ambitions, in the context of long term chronic illnesses, multi-morbidity and a rapidly ageing population, increased demand for services and limited financial resources.

The NHS Five Year Forward View articulated a consensus about why and how the NHS should change. It described three improvement opportunities: a health gap, a quality gap, and a financial sustainability gap. It proposed a series of measures to bring about the 'triple integration' of primary and specialist hospital care, of physical and mental health services, and of health and social care.

This strategy demonstrates how ESHT, alongside our system partners, seeks to close these gaps and deliver excellent care to our patients. We want to make sure that safe, high quality care is the most important feature of all the services we provide at ESHT. It must underpin everything that we do and we need to show how we are ensuring the delivery of safe, high quality care in our strategy.

Our strategy reflects how we will make best use of the resources that are available to us. We cannot come up with a plan for delivering our vision that relies on resources we cannot access or costs more than we have been allocated. Being clinically and financially sustainable is a key part of the strategy and that is why we have to be innovative, efficient and effective in how we delivery services, so that we can achieve the balance of safe high quality services that are affordable, sustainable and demonstrate best value. We want to provide:

- Services that are evidence based, accessible, safe and effective,
- Care that delivers improvements in health outcomes and reduces inequalities
- Patient centred pathways that optimise resources and are integrated across providers

2: What will ESHT look like in 2022

- In 2022 the health and care landscape will be significantly changed, both nationally and locally. In East Sussex we will be part of an Accountable Care Organisation, providing integrated health and social care services for our population. We must recognise that within this context we will be providing acute and community services, albeit within a new operating structure that will enable us as a system to provide outstanding, integrated services within our system financial envelope.

- We are committed to providing a range of services that will be delivered through our two District General Hospitals in Eastbourne and Hastings for the population of East Sussex.

- We will continue to provide a range of services in the community and we will seek to integrate these with local primary care, East Sussex County Council (ESCC) and third sector provision where appropriate – through our emerging Alliance arrangements.

- We will continue to provide urgent and emergency care on both our acute sites with further consolidation of some specialties on single sites, to ensure that we are able to provide safe and sustainable services. We recognise the importance of local access for patients and public and where we can provide services locally, in a safe and sustainable way.

- Through our new medical model, we will ensure that we facilitate senior clinical decision making at the 'front door' to avoid unnecessary admissions and delivery of the right care at the right time in the right place

- In order to meet the needs of our population we need to ensure that we make the best use of the resources available to us as a health and social care system. Alliance partners will continue to develop integrated locality teams which will provide joined up response and care to maintain and improve the health of people close to home. We will focus on primary prevention and investing in health and well-being. Working as a system, patients will only be admitted to an acute hospital when they require services that can only be provided there, and they will be discharged in a timely way.

- Along with revisions to care pathways, we will provide seven day services and our length of stay in all specialties will meet upper decile national/ peer benchmarks. This will allow us to operate within our existing bed stock and avoid opening escalation areas. We will ensure that we have the right capacity to meet demand and we will review the opportunity to reduce our bed stock in line with increased delivery of services in the community.

- Day Surgery will be the norm unless an overnight/ longer stay is clinically indicated.

- We will be able to demonstrate strong performance across a range of access and quality indicators including cancer, A&E, and access to diagnostics. This will be facilitated by in investment in redesigning the layout of our A&E departments and in diagnostic services. We will work closely with our tertiary providers to deliver cancer pathways that meet regulatory requirements.

- There will be system wide integrated clinical leadership.

- The experience of patients will be improved through investment in our services and our staff. Patients the public and staff will be engaged in developing our services across the system.

- Continuous improvement will be embedded in our organisation and all staff will have been supported to attend training on improvement methodology.

- ESHT will attract, recruit and retain high calibre staff who recognise the opportunity to work in a high performing organisation which has patients at the heart of all we do and which supports staff to develop the services our population needs.

- Our digital strategy will support our clinical ambitions by ensuring that patient records are digital and interoperable, this will increase the opportunity to deliver integrated care pathways in a range of specialties.

- We will have integrated care pathways that will focus on the needs of the patient. Assessment and care will be delivered in the community and close to home where this has been demonstrated to be an effective use of our system resource.

Specific actions for what we need to do to achieve this are outlined in the specialty level plans on a page (separate document)

3: Introduction

'*Shaping our Future'* written in 2012 was the five year Clinical Strategy for the organisation which outlined a number of key initiatives and workstreams in eight primary access points. The majority of these initiatives were undertaken through service redesign but three services required major reconfiguration and warranted public consultation.

This was undertaken in 2012/13 and the outcome was the single siting of emergency orthopaedics and emergency surgery at the Conquest Hospital and stroke services at EDGH. Since then, and again after public consultation, obstetric care and inpatient paediatrics were also single sited at Hastings with a midwife-led unit at EDGH.

We have seen significant improvements in outcomes for these services since reconfiguration and we now need to consider the next steps we need to take to ensure that we continue to deliver improvements in the services we provide, which will enable us to achieve our vision.

4: Our Strategic Objectives

- **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 closely 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 timely fashion and expediting their return to health.
- **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.

5: Our Values

Our values were developed with the involvement of many people from across the organisation:

6: Our principles

We have been developing our Clinical Strategy with clinicians and stakeholders across primary and secondary care. Nineteen acute specialties have developed strategic plans and a further nine integrated pathways have been developed where there was an opportunity for primary and secondary care interface to be improved or streamlined. These clinical strategies underpin the delivery of our overarching strategic objectives and are based on the following assumptions or principles:

- We aim to provide comprehensive healthcare across the whole of East Sussex
- We will continue to provide a range of services in the community and we will seek to integrate these with local primary care, ESCC and third sector provision where appropriate
- We are committed to providing a range and level of acute services that will be delivered through our two District General Hospitals in Eastbourne and Hastings for the population of East Sussex.
- Urgent and emergency care will continue to be provided in both Eastbourne and Hastings
- We will continue to provide a midwifery-led birth unit at EDGH and consultant-led obstetric care at Conquest Hospital
- We will focus on how we use our resources in the most efficient and effective way. We will have a specific focus on reducing length of stay, increasing the opportunity for day surgery and meeting our regulatory requirements in terms of waiting times standards for our patients.
- We will play a full role in the development and implementation of the East Sussex placed based care plan (ESBT) and the emerging Accountable Care System plans. We will support the focus on primary prevention and investing in health and well-being.
- We will continue to participate fully in the delivery of the Sustainability and Transformation Partnership (STP) for Sussex and East Surrey
- Each of our divisions will be supported to deliver clinical strategies and business plans that align across the organisation and the wider system
- Our clinical and care strategies will encompass end-to-end patient care pathways, focusing on maintaining health, preventing deterioration, and providing rapid acute response when required
- Clinical leaders will have the opportunity to refresh and recommit to our clinical strategies annually

7: How we developed our strategy

All the approaches were underpinned by the Monitor/NHS Improvement strategic development framework described in the table below.

ESHT Phase	Stage	Summary / Actions
Phase 1	1 Frame	Establishing the scope by identifying the important strategic choices and decisions, e.g. delivery quality integrated care affordably
	2 Diagnose	System wide work to collate information on quality and performance alongside commissioning intentions and national drives: analysis of quality, operational, finance and workforce information and data
	3 Forecast	Creating a clear view of what our future may look like, taking into consideration current performance, external drivers and whole health economy challenges. Define our goals and ambition – 'what does an excellent integrated service look like'
	4 Generate options	Explore how we can either improve existing services or develop and deliver new ones, or stop doing some. Co-design with stakeholders to agree delivery models
Phase 2	5 Prioritise	Agree which developments are the most important Build into a coherent 5 year strategic plan to deliver excellent care which is financially viable resulting in a sustainable clinical service
Phase 3	6 Deliver	Develop an overarching implementation plan Use service improvement methodologies and project / programme planning Monitor delivery and performance through IPRs
	7 Evolve	Monitor the impact of the strategy, recommit, refresh or recreate when needed. Monitoring delivery to ensure strategy is effective using benefits realisation. Evaluate the implementation or mitigate if delivery does not achieve targets

The strategy has been developed using a combined top down (ESHT 2020) and bottom up approach with the staff engaged in providing the service and with the patients who use the service. Some are more detailed than others. All have developed a strategic ambition that describes what an excellent service will look like in five years' time and outlined at a high level the steps that need to be taken to achieve the aim. As well as the changes planned through the strategy, there will always be the need for services to evolve over time as evidence changes and new best practice models are developed. Clinical teams will be

expected to review their strategies, refresh their operational plans and recommit to delivery each year so we can to continue to meet the needs of our population.

Prior to meeting to develop the strategy, we provided the teams with finance, quality and business intelligence information. The finance team provided detailed information to each clinical specialty on cost, length of stay and quality measures, this has enabled them to focus on areas where they were not optimising resources.

We worked collaboratively with our Clinical Commissioning Groups (CCGs) and primary care and used a range of methodologies to develop these strategies. For ten workstreams we took a whole system approach to developing and redesigned end to end pathways, involving all the services that a patient engages with in that pathway. A further twenty specialties were developed with ESHT practitioners and wherever possible, the CCG and primary care.

8: Radiology, Intermediate Care and Rehabilitation services

The strategies for Radiology, Cancer, Intermediate Care and Rehabilitation services were developed within the services.

Approximately 100 stakeholders were engaged in developing the Radiology strategy via 1:1 interview or focus group. The results were collated and fed back at two strategy development events held in December 2016. Participants (staff from the service along with colleagues from different parts of the Trust and the CCG) at these events helped shape the priorities and identify streams of work to take the strategy forward.

The Intermediate Care and Rehabilitation strategies were developed with patients and partners in ESBT throughout the 150 week programme. A number of joint workshops were held and patients and carers were involved from the outset.

9: ESBT whole system reviews

ESBT has given us a great opportunity to redesign pathways from end to end, and we took this approach for the following ten clinical areas.

- Maternity & Obstetrics
- Acute Paediatrics
- Community Paediatrics
- Respiratory
- Trauma & Orthopaedics
- Cardiology
- Dementia interface with ESHT
- Mental Health interface with Acute Medicine
- Diabetes and Endocrinology
- Ophthalmology

The workstreams were invited to imagine they had a clean sheet of paper and could redesign the services as they should be. The introduction of the ESBT Alliance provides us with a chance to design the system as it should be and not to be restricted by current organisational structures and funding arrangements. It will allow us to build services around the patient.

Phase 1: NHS Elect Improvement Methodologies Training

ESHT secured Improvement methodologies training from NHS Elect and all those involved in the ten clinical areas were invited to attend one of the three training sessions. Over a hundred people attended including patients, staff from ESHT, primary care, Sussex Partnership Trust, public health and the third sector. The NHS Elect training equipped us to define a strategic aim, diagnose and identify the areas where we could make improvements and provided us with a range of approaches to implement the improvements.

Phase 2: Mapping 'as is' and identifying gaps, issues and areas needing more in-depth work

In March 2017, workshop sessions were held for each workstream to allow representatives from all partner organisations to map the whole system pathway from end-to-end. We used the ESBT 6+2 approach to identify the services that are currently available from prevention of illness through to end of life care. We mapped a patients' journey from healthy living, to self-management of a long-term condition, to safe discharge from hospital, transfer for tertiary care and or end of life care. While we did this we highlighted the challenges, gaps and areas that needed to be explored in more detail to improve the pathway.

There were valuable challenges in these sessions when, for example, a GP described making a referral using fax and the service explained that they no longer use fax and when a service described how quickly a service was provided, and a patient replied they had waited

considerably longer. Having all elements of a patient's pathway together gave us a unique opportunity to experience the complexities of the pathway and to work to streamline them.

Phase 3: Bridging the gap from current 'silo' services to an integrated approach

In the second workshops we agreed the strategic ambition and outlined a high level plan of work needed to get from our current state to that ambition.

'Strategy on a Page' summaries have been developed for each workstream. These describe the strategic ambition, and outline some of the key challenges or issues that the strategy seeks to overcome together with a high level roadmap for years 1 – 4/5.

The implementation of the strategy will be supported by an ESBT Project Manager for each workstream. Each workstream has a detailed project plan with milestone tracker, benefits realisation, stakeholder list of people who will support the changes and an issues and risks log.

10: ESHT specialities strategic approach

For the twenty other specialties, ESHT took a lean approach to developing a strategy on a page.

- Audiology
- Breast Service
- Cancer /oncology
- Community Dental
- Dermatology
- ENT
- General Surgery
- Gynaecology
- Haematology
- Max Fax
- Musculoskeletal (MSK)
- Neurology
- Orthodontics
- Palliative medicine and end of life care
- Rheumatology
- Sexual Health
- Sleep studies
- Stroke
- Vascular

Developing the strategy on a page

The specialities that did not undertake end-to-end pathway redesign worked together with CCG and GP representatives to identify what an outstanding integrated service would look like in five years' time. The same level of finance, quality and business intelligence information was provided .Clinical teams were facilitated to describe their strategic ambition and to identify where they could improve quality, and reduce waste such as ensuring consultants see only the patients that must be seen by a consultant, and where they could standardise service provision across sites.

The strategy on a page documents describe the strategic ambition and the high level roadmap. Some are more developed than others and work will be ongoing to develop these plans. These can be found in a separate document 'ESHT clinical strategy plans on a page'.

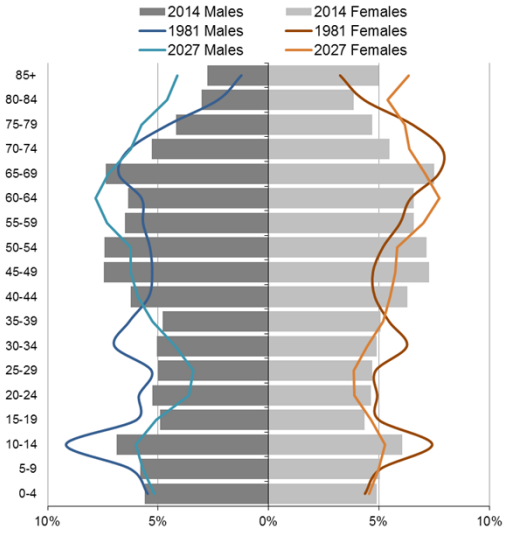
Strategies yet to be developed

An ESHT approach was taken to developing the strategy for Urology, Dermatology and End of Life care. The specialities quickly found that that to develop the type of changes they envisage, they needed to take an ESBT end-to-end whole system pathway redesign approach as their future model of care will be provided by ESHT in conjunction with other providers. These specialties will be redesigning their pathways end-to-end during 2017/18.

11: Demographic profile in East Sussex

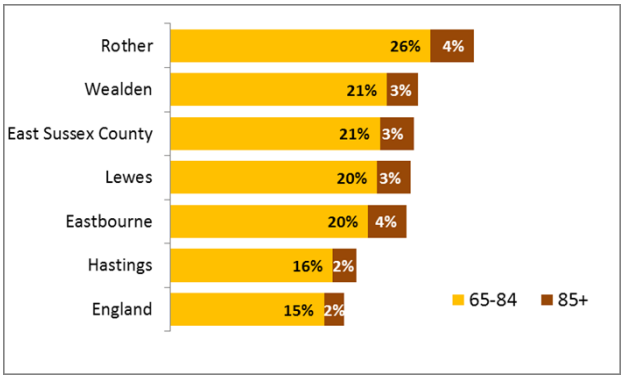
There is a rapidly changing demographic picture in East Sussex. Between 2014 and 2027, the population is predicted to grow by 6% with the over 65 group growing by 27%. Figure 1 illustrates the disproportionate growth in over 65s between 1981 and 2027. More than three out of four lower super output areas (LSOAs) in East Sussex have a greater percentage of persons aged 65 years and over compared to the England figure. Figure 2 shows the proportion of each borough and district who are over 65 and over 85 years. The approximate population of East Sussex is 540,000.

Figure 1: Population structure in East Sussex, 1981, 2014 and 2027 projections



Source: Mid-2014 resident population estimates, ONS June 2015

Figure 2: Population aged 65 years and over, districts and boroughs in East Sussex

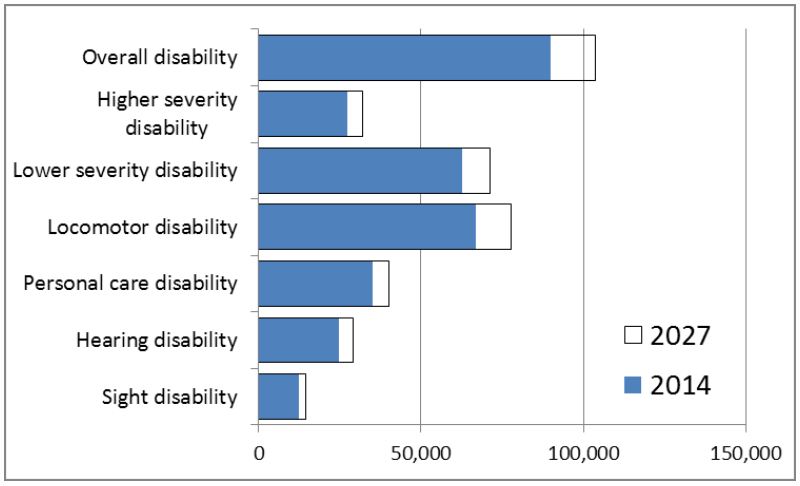


Source: ONS population estimates 1981 & 2014, ESCC projections for 2027

Life expectancy has increased and is higher than the national average, however, disability free life expectancy has not increased in line with this, and there are significant health and social inequalities across the county. The numbers of over 65s with dementia, diabetes and longstanding health conditions caused by stroke in our population is expected to increase. Between 2014 and 2027 there is projected to be a 15% increase in people with a disability (figure 3) with an 18% increase in people with a higher severity disability. There are also

inequalities in years of life lost for causes considered amenable to healthcare: Hastings & Rother CCG has rates 1.5 times higher than High Weald Lewes Havens CCG.

Figure 3 - Projected number of people with disability by disability type, 2014-2027.



Source: ESCC projections, July 2013

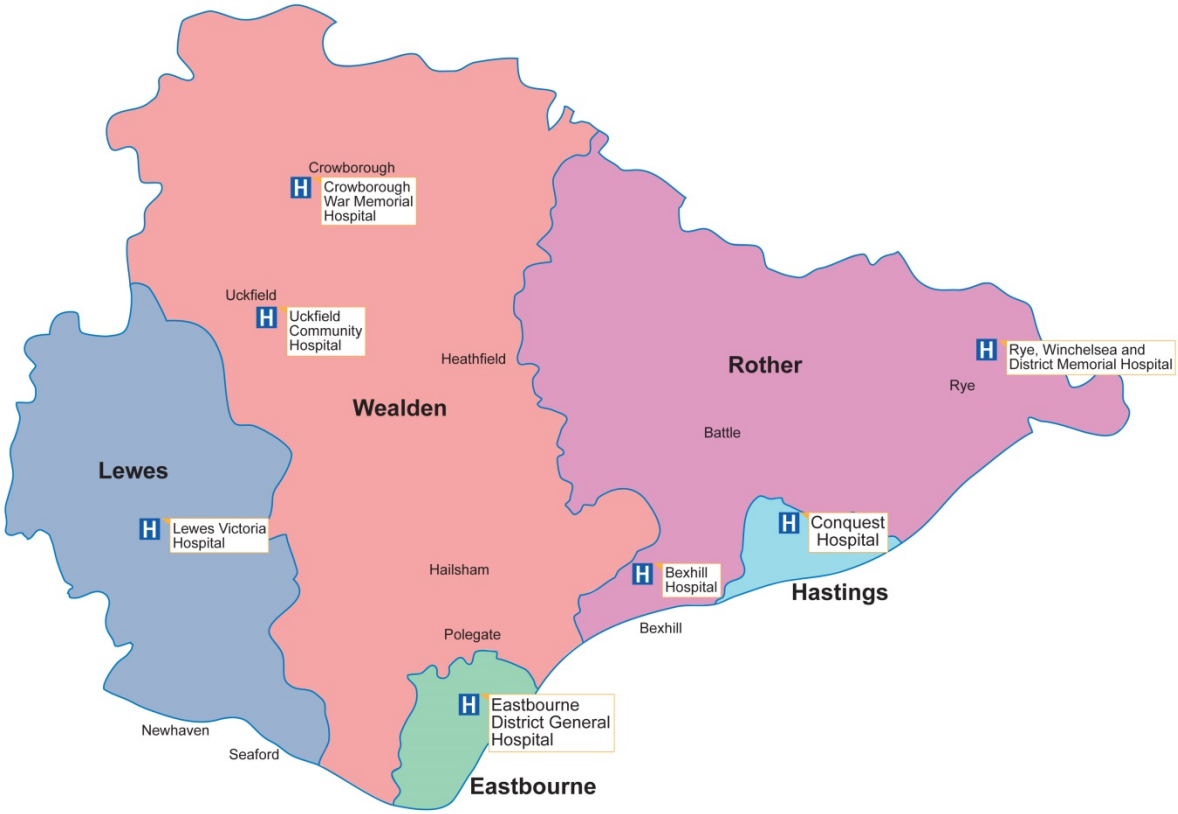
In 2012-14 the gap in life expectancy between the most and least deprived wards in East Sussex was 13.6 years. Circulatory diseases and cancer are the main contributors to the life expectancy gap between the most and the least deprived areas and to people dying prematurely.

12: Workforce and Estates

ESHT is an integrated community and acute provider, formed in 2011 from the merger of East Sussex Community Health Services and East Sussex Hospitals NHS Trust. We provide a wide range of community, intermediate care and rehabilitation and general acute services to the population of East Sussex and surrounding areas.

As an integrated acute and community Trust, staff come from a number of disciplines including nursing and midwifery, medical, scientific, technical, dental, allied health professionals, estates and ancillary, and administration and clerical staff. In April 2017 we had 6891 staff making 6012 whole time equivalent.

The Trust operates from two acute hospital sites - Eastbourne District General Hospital (EDGH) and Conquest Hospital (CQ) in Hastings and approximately 80 sites ranging in scale from shared community based premises to community hospitals; we provide services from Crowborough, Uckfield Bexhill Hospitals and Rye, Winchelsea and District Memorial Hospital.



13: Trust divisional structure

The Trust has five clinical divisions; Emergency Care, Women Children's and Sexual Health, Medicine, Diagnostics, Anaesthetics and Surgery, and Out of Hospitals. The specialties within the divisions are shown below.

Specialties				
Emergency Care	**Medicine**	**Diagnostics, Anaesthetics & Surgery**	**Women, Children's & Sexual Health**	**Out of Hospitals**
• Emergency Department	• AAU • Ambulatory Care • Cancer • Cardiology • Dermatology • Diabetes/ Endocrinology • Endoscopy Units • End of Life Care • Escalation areas • Frailty • Gastroenterology • Haematology • MAU / Baird • Neurology • Oncology • Outpatients • Palliative Care • Respiratory • Rheumatology • Stroke	• Acute Pain Team • Admission Lounge • Adult Audiology Services • Anaesthetics • Breast Services • Community Dental • Critical Care Outreach • Critical Care Units (ITU/HDU) • Day Surgery • Decontamination/HSDU • ENT / Max Fax • General Surgery • Interventional Radiology • IV Team • Medical Photography • MSK • Ophthalmology • Orthopaedic Outpatients • Pain • Pathology • Pre-operative Assessment • Pre-assessment Services • Private Patient Unit • Radiology • Resuscitation Services • Theatres	• Community Paediatrics • Gynaecology • Health Visiting • Midwifery • Paediatric Audiology • Paediatric short stay • Paediatrics Inpatients • Paediatrics Outpatients • Special Care Baby Unit • Sexual Health • Women's Health	• Acute Stroke Therapy • Community Stroke • Acute Therapies • Pharmacy • Dietetics • Podiatry • Speech and Language Therapy • Physiotherapy • Occupational Therapy • Orthotics • Bowel & Bladder Services • Community Hospitals • Integrated Locality Teams – • Community Nursing • Joint Community Rehab • HWLH JCR • Crisis Response • HSCC

Specialties				
Emergency Care	**Medicine**	**Diagnostics, Anaesthetics & Surgery**	**Women, Children's & Sexual Health**	**Out of Hospitals**
		• Trauma & Orthopaedics • Urology • Vascular Services		(Nursing) • Integrated Night Service • Frailty Practitioners • Intermediate Care Units • Falls Services

14: Current strategic context

We have had unprecedented change and challenge within national and local health services over the past three years. Nationally and locally we can expect minimal growth in terms of investment but an increased demand for our services. There is a shift from acute care towards primary prevention and community based models of care. This has led to a new focus on the integration agenda with the National Vanguards programme pioneering new models of care and with our local East Sussex Better Together Alliance model operating in shadow form from April 2017.

East Sussex Better Together

We are a partner, with Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG and East Sussex County Council – with Sussex Partnership NHS Trust as associate partner – in the ESBT Alliance. ESBT is a transformation programme to fully integrate health and social care in order to deliver high quality and sustainable services to the local population that we serve.

In July 2016, the recommendation to formalise closer integration between health and social care was taken to the ESBT Alliance governing bodies for approval. These plans were approved. This means we will now strengthen our Alliance arrangement in the short and medium term, with the supporting legal framework and single leadership to create the conditions to move towards a single health and care body for East Sussex in the future.

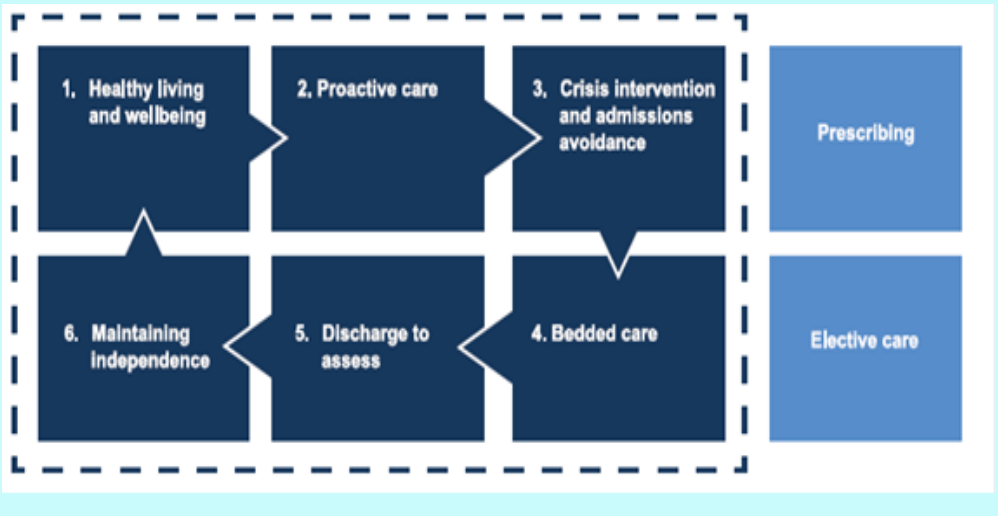
Our plans aim to integrate our whole system: primary prevention, primary and community care, social care, mental health, acute and specialist care so that we can demonstrably make the best use of the c£850m that is spent each year to meet the health and care needs of the people of East Sussex.

This will help to reduce variation and improve outcomes for local people, improving their health and wellbeing while making the experience of using health and care services better and more inclusive.

Our shared vision is to ensure that people receive proactive, joined up care, supporting them to live as independently as possible and achieve the best possible outcomes.

To achieve this we have developed a framework known as the 6 + 2 box model of care. The six boxes describe the services and support required throughout the whole cycle of a patient's care. Two further boxes – prescribing and elective care – are additional areas where we want to improve the quality and affordability of services.

East Sussex Better Together 6+2 box



Putting the 6+2 box model into action

- **Healthy living and wellbeing**

This is about preventing ill health, promoting independence and improving awareness of and access to services and activities that support healthy lifestyles.

- **Proactive care**

This will be focussed on patients with long-term conditions and illnesses. The aim is to support health and independence for as long as possible, by providing integrated health and social care services that will help people avoid having to go to hospital.

- **Crisis intervention and admissions avoidance**

We want to ensure the right services are in the right place at the right time to help people regain their independence and well-being quickly following a period of illness.

- **Maintaining independence**

This will support users of health and social care services, and their carers, to live independent lives.

- **Discharge to assess**

We want to ensure patients in hospitals and care homes are discharged as quickly as possible to an appropriate place, with a package of care to support their recovery.

- **Bedded care**

We want to make sure that people who require in-hospital care receive the best possible services.

- **Prescribing**

Research shows 50% of people do not take their medicines as prescribed. Across East Sussex, £90 million is spent on medicines prescribed by local GPs. This means up to £45 million of this might not be making the difference it should to the health of local people. We are bringing together clinicians and pharmacists from across the spectrum to develop ways of working with local patients to ensure they receive effective medicines as and when they need them.

- **Elective care**

This relates to care that is planned in advanced opposed to emergency treatment. We want to streamline this for patients and clinicians, ensuring local people have choice and are able to make informed decisions about their care.

Sussex and East Surrey Sustainability and Transformation Partnership (STP)

The creation of a Sustainability and Transformation Partnership (STP) for Sussex and East Surrey will provide us with the opportunity to work across wider clinical networks to solve some of the 'wicked issues' such as workforce, IT and clinical specialism, within networks. These programmes will support health and social care being delivered in new and innovative ways with genuine integration at the very heart of service delivery.

We have been fully engaged with the development of the Sussex and East Surrey Sustainability and Transformation Partnership and have been actively contributing to the various work-streams including digital, workforce, finance and acute hospitals. The STP is clearly aligned to our local ESBT plans for place based care and we will continue to contribute to the work streams.

15: Engagement

We have engaged with key stakeholders in developing our strategic plan including a broad range of clinicians both in the Trust and in Primary Care. We have worked closely with our commissioners and with colleagues in East Sussex County Council. We have used the East Sussex Healthwatch reports to inform our plans, and engagement with staff, patients and public will continue as we start to develop specific work programmes.

During 2017 we redesigned our website and will provide full and detailed information to help patients to navigate our services and ultimately self-manage their condition. Our aim is to focus more on health promotion and wellbeing and we will give details of the services patients can access in the community.

We plan to further develop Health and Social Care Connect (HSCC) which currently provides information to primary care and patients. We will enhance HSCC by introducing Care Navigators and making this the central source for directory of services and patient information.

Staff engagement

Our goal is to be an organisation which provides care in which the people of East Sussex can be fully confident, and one in which people are proud to work. We know that if the people who work for us feel engaged and involved in developing their services and the work of the wider Trust, then the experience and outcomes of our patients will be better.

As engagement and involvement is one of our core values we have reviewed our whole approach to staff engagement which has a number of underlying principles:

- Every role counts and has a contribution to make towards continuously improving our service
- Colleagues will be involved and engaged in decisions that impact them
- All managers will engage and receive feedback regularly with their team through 1-1's and team meetings.
- Celebrating and sharing success and learning

Our recent CQC inspection, Staff Survey Results, and the Staff Family and Friends Tests demonstrated significant improvements in staff engagement during the past year. This has been further demonstrated by the results of the regular pulses surveys where we seek staff feedback

The improvements are a result of everyone working together to identify areas for improvement and solutions.

Public and Patient Engagement

Public engagement is the active participation of patients and members of the public in how our services are planned, delivered and evaluated. While there are area of public engagement good practice at Ward, Clinical Unit and Corporate level, there is a lack of a systematic embedded approach to ensuring engagement, improvement, measurement and feedback.

ESHT is committed to improve our engagement model. We want to build a new type of engagement based on collaboration, building sustainable relationships and partnerships and holding meaningful dialogue with the public and patients.

We recognise that we need to build trust and confidence with the community we serve and better support patients and the public to actively engage and contribute to decisions that impact on their care and the services they receive, in a way that shows that their contribution is valued and respected.

Feedback tells us that we need to be clearer about the roles that patients and the public can play and the support that we can offer to help them engage more effectively. Our approach to engagement will include:

Public panel: We aim to begin recruiting for members of a public panel. Panel members will be recruited as volunteers and provided with training and support to play an active role helping to shape services, improvements and the future of the Trust and ESBT.

Public Forums and event: We understand that people's time is limited, and that only a small amount of the community can attend public forums and event. However there remains value in providing an opportunity for patients, members of the public and stakeholders to come and talk to us and help shape and improve our services and support, find out more about the work we do and hear from experts about improving health and wellbeing.

You said, we did: This is a well-established method of sharing how feedback has improved services and is an essential part of engagement. We will build this in to our engagement mechanisms and regularly feedback to people about the difference they have made.

ESHT membership: ESHT has a 'membership' of nearly two thousand. We want to promote this further, offering a quarterly digital newsletter and invitations to listening events, forums and new opportunities to get more involved.

Digital engagement : We want to better use the range of digital tools and techniques to find, listen and react to our communities. We are keen to use digital engagement to facilitate conversations online. We know that our digital reach is broad and covers audiences that the Trust does not often engage with. We need to use this better to feed into the work of the

Trust. The Trust launched a new website in 2017, and this will form the basis of our digital engagement.

Working in partnership: Sometimes the best way of getting input from our communities, especially those that are harder to reach, is to go to them. We will work with local organisations, like Healthwatch and other voluntary organisations to facilitate conversations with communities about healthcare, where it is most convened to them.

ESHT will only achieve its 2020 vision by engaging those members of the public and patients who are affected by the care we provide. By working together, we can develop services that are better targeted, more effective and more likely to meet the expectations of the people who use them.

16: Financial plan

ESHT, like many other NHS organisations, is delivering services within a significantly challenged financial environment. Our control total for 2017/18 is £36.4million deficit and we have to deliver cost improvements of £28.7million. Delivering this level of reduction efficiently will be a significant challenge but with support from NHS Improvement and our staff we are developing a 'full and credible' financial plan for our recovery.

Financial Plan Summary		
	2017/18 Plan £m	2018/19 Plan £m
Contract Income	351.9	355.2
Income	38.1	34.3
Pay	(274.8)	(273.9)
Non-Pay	(151.6)	(141.7)
Total	**(36.4)**	**(26.1)**
Financial Improvement Required	**28.7**	**24.5**

Our financial recovery programme will support our ability to maintain and improve the quality of our services and achieve the control target. Work is ongoing on developing our long term financial plan and this will be aligned with our Clinical Strategy.

We are developing a five year, long term financial model to support sustainability within the context of ESBT.

17: Key themes for strategic delivery in 17/18

Theme	Objective	Where
Pathway Redesign	We will develop and implement a GP streaming service in our Emergency departments - The Department of Health confirmed in April 2017, following a successful bid, that Eastbourne DGH and Conquest Hospital have been allocated £985k and £700k respectively. This money will be used to build facilities to provide primary care streaming for patients who arrive in our emergency departments with minor illnesses and conditions.	Acute
	Working proactively with our colleagues in Sussex Partnership Trust and primary care to develop integrated care pathways for patients with mental and physical health needs.	Mental health & Acute
	We will review the opportunity to improve quality and sustainability of clinical services through ongoing pathway redesign.	Whole system
	Greater integration of services and clinical pathways within primary and secondary care with a focus on care being delivered as close to home as possible. We will develop joint clinics, and support a targeted approach to education in primary care	Whole system
	We will develop an integrated patient centred cardiology service that is supported by secondary care and has a single point of contact that directs patients to the right service	Whole system
Self-management	The principle of self-management and maintaining health and wellbeing, is integral to our clinical strategy, We will support patients to better manage their own long term condition, with specific input from clinical teams including AHPs.	Whole system
Service Improvement	We will implement a new medical model to improve the flow of patients through the acute and specialty wards with the aim of reducing emergency admissions and length of stay. This will include increasing the number of patients	Acute

	seen and discharged through ambulatory emergency care pathways and progression towards 7 day working.	
	We will develop a 'one stop' Breast service that will provide same day consultant and diagnostic interventions within a dedicated facility.	Acute
	We will review the oncology networks provision across our acute sites to make sure we use our resources efficiently and deliver a high quality safe service.	Acute
	We will review the opportunity to increase day case surgery provision in Breast, ENT, Gynaecology and Urology to benchmark against our peers.	Acute
	We will take every opportunity to support delivery of referral to treatment targets (RTT) by re-profiling elective and non-elective work.	Acute
	We will update the service model for Acute Paediatrics including the Short Stay Paediatric Unit (SSPAU) on both sites and will determine the number of inpatient beds required and the hours needed for the SSPAU	Acute
	We will merge adult and children's audiology services into a single sustainable community based service.	Acute
	We will invest in diagnostic services to ensure that we are able to deliver key diagnostics in a timely way.	Acute
	We will seek to deliver 7 day provision across our services where this is demonstrated to be best practice and in line with national policy.	Acute + community
	The single point of access (HSCC) will be extended to include care navigators to help patients access the right services.	Whole system
	We will develop and implement an integrated frailty pathway	Whole system

ESHT Clinical Strategy

Meeting information:			
Date of Meeting:	November 2017	Agenda Item:	15
Meeting:	Trust Board	Reporting Officer:	Catherine Ashton

Purpose of paper: (Please tick)			
Assurance and Information	☐	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 East Sussex Healthcare NHS Trust's (ESHT) clinical strategy for 2017 - 2022.

The Board reviewed the Draft Clinical Strategy in July 2017 and comments have been reflected in this final version. The Board also suggested that the draft was shared and discussed with the ESBT Clinical Forum and it was therefore presented and discussed at their meeting in October 2017. It has also been shared with the Senior Management Team at EHS and H&R CCGs who provided helpful comments including the need to reflect the ESBT principle (and that of the NHS Five Year Forward View) of primary prevention and investing in health and well-being as being core to our Clinical Strategy. We have also highlighted that the ESHT Clinical Strategy is part of a wider emerging Clinical Strategy for ESBT.

This Clinical Strategy describes the high level objectives for our clinical services and outlines the key priorities for development in 17/18. We will revisit, review and refresh our priorities each year in order to achieve our objectives and we will use this strategy as a roadmap to achieve our vision to be the lead provider of hospital and community healthcare services in East Sussex and our ambition of 'Outstanding' by 2020.

The Trust's overarching strategy ESHT 2020 describes how as an organisation we will combine community and hospital services to provide safe, compassionate and high quality care to improve the health and wellbeing of the people of East Sussex. The Clinical Strategy 2017-2022 is part of a wider emerging East Sussex Better Together (ESBT) strategy which will align Primary, Secondary, Community and Specialist services in a way that will drive the transformations necessary to meet future health needs of our populations. It will focus our system on development of new models of care and integrated pathways in order to deliver high quality services within the system budget.

The Clinical strategy has been developed at a time that affords us with both challenges and opportunities. Our ambition to provide equitable, comprehensive, high quality healthcare has not changed but the opportunity

available to us through new technologies, innovations and models of care will be key in our ability to deliver our ambitions, in the context of long term chronic illnesses, multi-morbidity and a rapidly ageing population, increased demand for services and limited financial resources.

The NHS Five Year Forward View articulated a consensus about why and how the NHS should change. It described three improvement opportunities: a health gap, a quality gap, and a financial sustainability gap. It proposed a series of measures to bring about the 'triple integration' of primary and specialist hospital care, of physical and mental health services, and of health and social care.
This strategy demonstrates how ESHT, alongside our system partners, seeks to close these gaps and deliver excellent care to our patients. We want to make sure that safe, high quality care is the most important feature of all the services we provide at ESHT. It must underpin everything that we do and we need to show how we are ensuring the delivery of safe, high quality care in our strategy.

Our strategy reflects how we will make best use of the resources that are available to us. We cannot come up with a plan for delivering our vision that relies on resources we cannot access or costs more than we have been allocated. Being clinically and financially sustainable is a key part of the strategy and that is why we have to be innovative, efficient and effective in how we delivery services, so that we can achieve the balance of safe high quality services that are affordable, sustainable and demonstrate best value. We want to provide:

- Services that are evidence based, accessible, safe and effective,
- Care that delivers improvements in health outcomes and reduces inequalities
- Patient centred pathways that optimise resources and are integrated across providers

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

ESHT Senior Leaders Forum. July 2017
ESBT Clinical Leaders Group October 2017

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

For the Board to ratify the ESHT Clinical Strategy 2017-2022.
For the Board to note that this Clinical Strategy will be reviewed, refreshed and recommitted to each year
For the Board to note that further work is being undertaken with clinical teams to develop their five year plans alongside the Business plans for 18/19
For the Board to note that this ESHT Clinical Strategy is part of an emerging wider ESBT Clinical Strategy

Emergency Preparedness, Resilience & Response (EPRR)

Meeting information:			
Date of Meeting:	28th November 2017	Agenda Item:	16
Meeting:	Trust Board	Reporting Officer:	Joe Chadwick-Bell

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

Has this paper considered: (Please tick)

Key stakeholders:		Compliance with:	
Patients	☐	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐

Other stakeholders please state: ……

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

Executive Summary:

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

The Trust is a Category 1 Responder under the Civil Contingencies Act 2004 (CCA 2004) and as such has a number of statutory duties in relation to Emergency Planning. These duties are expanded upon in the NHS England Core Standards for Emergency Preparedness, Response and Recovery (EPRR) 2017.

The Trust and local health system are required to complete an annual self-assessment against a core set of standards. The CCG co-ordinate the local health response on our behalf and as such we work closely with the CCG and NHSE through the year and the annual assurance process to ensure the Trust is able to prepare and respond to a business continuity event; critical incident and major incident.

Following the self-assessment, the Trust is able to demonstrate a **Partial Compliance** against the Core Standards, the same level as the previous year.

The RAG rating for the level of compliance in this EPRR Core Standards self-assessment are as follows;-

- Dark Green – Full compliance
- Light Green – Substantial compliance
- **Amber - Partial Compliance**
- Red – Non-compliant

NHS England require assurance that the Board considers and engages in promoting full compliance with the EPRR Core Standards and is aware of the current level of compliance together with the Action Plan to achieve full compliance.

The Chief Operating Officer (Accountable Officer) and Korron Spence, Hospital Director (nominated deputy) are fully engaged with the process and aiming to deliver full compliance by September 2018.

Mike Stevens has been nominated as the Non-Executive with responsibility for assurance of the Trust's EPRR plans. This is a new responsibility and will develop over the coming months as the new EPRR post is recruited to and plans evolve more fully.

There are 3 key risks and therefore areas for action. These are supported by a more detailed action plan.

- Lack of EPRR capacity to ensure relevant policies, procedures and training are in place. This post has been agreed and is currently being recruited to (advert closes 14 October 2017)
- Lack of comprehensive training analysis and plan, to ensure relevant individuals are able to undertake the necessary and targeted training to respond to an incident. A training need analysis has been partially completed and a training matrix will be produced following this
- No single major incident plan in place, incorporating the two acute and community plans into a single plan, also lessons learned debriefs following the Major Incident in August 2017. This plan is now being revised to provide a single corporate major incident plan at the behest of NHS England.

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

None, but review will be undertaken by the Quality and Safety Committee moving forward.

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

The Board are asked to note the compliance standard achieved following the annual self-assessment, they key areas for development and timescales to achieve full compliance.

The Board are asked to receive assurance about the key risks and actions in place to address these to ensure that the Trust is fully compliant to the EPRR Core Standards by August 2018.

Infection Prevention and Control Annual Report 2016/17

Meeting information:			
Date of Meeting:	28th November 2017	Agenda Item:	17
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth / Lisa Redmond

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

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☐
Staff	☒	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:	.....		
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? Yes Risk Numbers 991 & 1261.	

Executive Summary:

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

- The number of cases of *Clostridium difficile* infections (CDI) remained the same as last year at 46 against 41. Of these 46 cases, 11 were judged as no lapse in care. Of the remaining 35 cases 8 were considered lapses in care that may have contributed to the patient developing CDI and 27 were lapses in care that were unlikely to have contributed to the patient developing CDI.
- 135 patients tested positive for Influenza which was operationally challenging. There was an outbreak of Influenza on a ward at the Conquest site which was also reported as an SI.
- The Haematology ward at EDGH had an SI relating to hospital-associated colonisation of patients with Glycopeptide resistant Enterococci (GRE). We continue to monitor this. (Colonisation is the carriage of an organism without the presence of infection.)

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

Trust Infection Prevention and Control Group 27th September 2017
Quality & Safety Committee 22nd November 2017

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

The Board is asked to approve the annual report and support the implementation of the recommendations with the Trust.

East Sussex Healthcare NHS
NHS Trust

Infection Prevention & Control Annual Report

2016 - 2017

"Infection Prevention & Control is everyone's business"

NHS
ESHT
Infection Prevention and Control

CONTENTS

Executive Summary

This report outlines the infection prevention and control (IPC) activities of East Sussex Healthcare Trust (ESHT) for the financial year 2016/17. It also outlines arrangements made by ESHT to allow the early identification of patients with infections, measures taken to reduce the spread of infections to others and reviews the accountability arrangements relating to IPC, audit, surveillance and education.

The prevention of avoidable infections has been a key priority for the NHS and all NHS healthcare providers for many years. Prevention and control of healthcare associated infections (HCAIs) remains a priority for ESHT and we have a programme of activities to implement national initiatives and reduce infection rates. ESHT employs a team of specialist nurses and support staff to advise and co-ordinate activities to prevent and control infection but it is the responsibility of all staff in the organisation to comply with Trust policies and implement these. The Trust reports performance and activities related to IPC regularly throughout the year to the local commissioning groups (CCGs).

Key points during 2016/17 are:-

- During 2016/17 the number of MRSA bacteraemia cases reported decreased to one case (in December 2016) compared to four in the previous year.
- The number of cases of *Clostridium difficile* infections (CDI) remained the same as last year at 46. Of these 46 cases, eleven were judged as no lapse in care. Of the remaining 35 cases eight were considered lapses in care that may have contributed to the patient developing CDI and 27 were lapses in care that were unlikely to have contributed to the patient developing CDI.
- The Infection Prevention and Control Team (IPCT) have continued to co-ordinate programmes of activity related to IPC within the organisation, provide education and training and clinical advice. The IPCT has also explored new ways of engaging with clinical staff within the organisation to reduce the risk of infection to patients in our care.
- The Trust had two outbreaks of CDI that were reported as a serious incident (SI).
- There was an outbreak of Influenza on a ward at the Conquest site which was also reported as an SI.
- The Haematology ward at EDGH had an SI relating to hospital-associated colonisation of patients with Glycopeptide resistant Enterococci (GRE). (Colonisation is the carriage of an organism without the presence of infection.)
- *Legionella species* continues to be isolated in low numbers from water supplies in several areas at the Conquest site. No patients have developed *Legionella* infection as a result of this. Measures have been put in place to reduce the risk of infection and the issue is monitored by the Trust Water Safety Group.
- The IPCT continued to work closely with other stakeholders in relation to strategies for prevention of infection including Public Health England, East Sussex County Council and Regional Specialist Laboratories and other experts.

Dr Anne Wilson
Consultant Medical Microbiologist and Director of Infection Prevention & Control (DIPC)

Lesley Smith
Lead Infection Prevention and Control Nurse

1 Structure

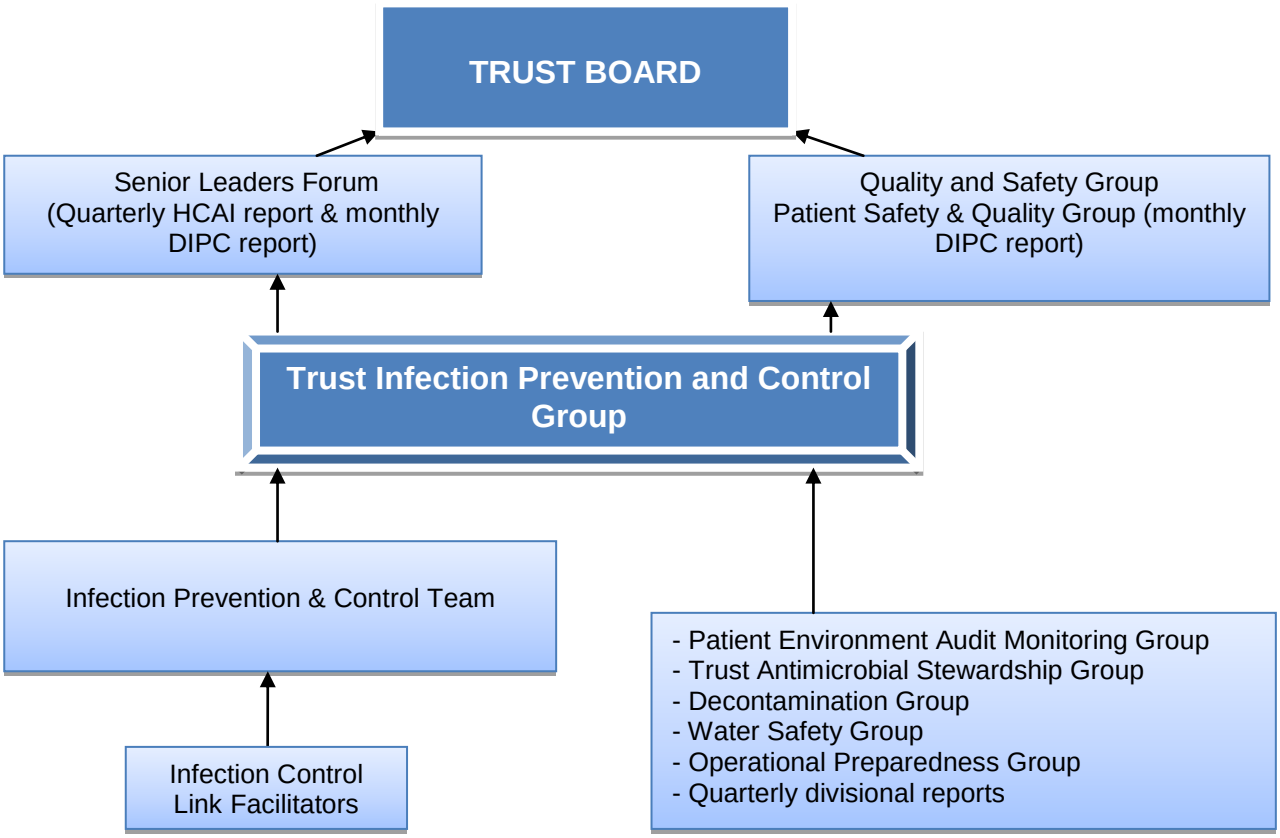
The Director of Nursing is the Executive Lead for IPC within the Trust and sits on the Trust Board.

During 2016/17, there was one main change of personnel with Lesley Smith taking on the role of Lead Infection Prevention and Control Nurse (IPCN) to replace Tina Lloyd who was Assistant Director of Infection Prevention & Control (ADIPC).

The Trust Infection Prevention and Control Group (TIPCG) is chaired by the DIPC or the Director of Nursing. The Group meets monthly and has wide representation from throughout the Trust including from clinical units, occupational health, pharmacy, commercial division and also external membership from the local department of Public Health England (PHE). The TIPCG reports monthly to Patient Safety and Quality Group regarding performance and operational issues and also reports quarterly to the Quality & Standards Group regarding compliance against Outcome 8 Regulation 12 "Cleanliness and Infection Control" Health & Social Care Act 2008. (See reporting structure in 1.1)

Each of the Clinical Units report directly to the TIPCG and report on compliance with regulatory standards for IP&C. Clinical Matrons and Clinical Managers have the responsibility for the prevention and control of infection in their local area in line with national and local policies and guidelines. Each clinical department has appointed an Infection Control Link Facilitator (ICLF) who with educational support and guidance from the IPCT is responsible for cascading and monitoring compliance with Infection Prevention and Control practices at local level.

1.1 Infection Prevention & Control internal reporting arrangements



1.2 Infection Prevention & Control external reporting arrangements

Externally, the Lead IPCN also reports directly on performance to the Clinical Quality Review Group (CQRG) held by two local clinical commissioning groups (CCGs);

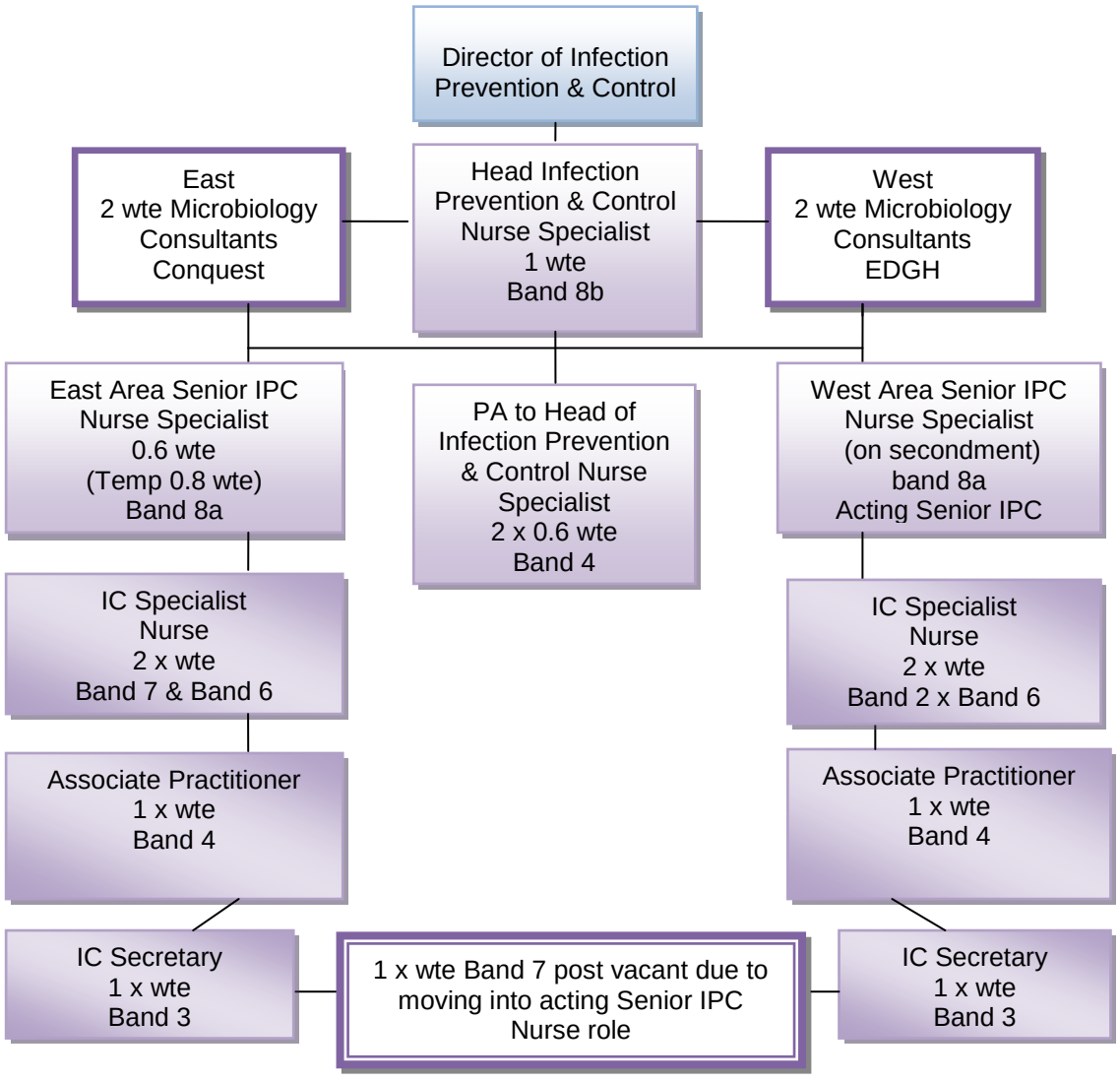
- Hastings & Rother CCG
- Eastbourne Hailsham and Seaford CCG

1.3 Infection Prevention & Control structure

The IPCT comprises of specialist Infection Prevention and Control nurses and administrative staff.

Two area teams (East and West) based in each of the acute hospital sites provide Infection Prevention and Control support to all ESHT services in their local area (acute, community, inpatient and domiciliary). This year saw the introduction of two band 4 Associate Practitioners to the IPCT who are undertaking the Foundation Degree in Health and Social Care which is funded through the apprenticeship levy.

Infection Prevention & Control team structure 16/17



In addition to the IPCT, the Trust also funds 4 x wte Consultant Microbiologist posts (2 on each acute site) based within the Diagnostics Anaesthetics and Surgery Division who work closely with the IPCT, one of whom holds the Lead Infection Prevention and Control Doctor and DIPC responsibility.

1 x wte Orthopaedic Surgical Site Infection Surveillance Nurse is appointed within the Diagnostics Anaesthetics and Surgery Division and 1 x wte Antimicrobial Prescribing Lead post is appointed within the Out of Hospital Division

1.4 Vacancies

At the end of 16/17 the Senior ICN specialist from West (EDGH) was supported on to an external secondment within Public Health. The band 7 ICN from East (Conquest) has been moved into the acting Senior ICN role leaving a vacant band 7 WTE.

On the 27th March the acting Lead ICN was successful in being recruited to the Head of Infection Prevention and Control leaving an 8a WTE vacancy.

One of the part time PAs to the DIPC / ADIPC retired at the end of March 2017 leaving a band 4, 0.6 WTE vacancy. The other PA was on maternity leave from July 2016.

1.5 Infection Control Link Facilitators

At any one time there are between 80 – 100 Link Facilitators across the Trust. Each new ICLF is provided with an induction programme provided by the IPCT. With the educational support and guidance from the IPCT, are responsible for cascading and monitoring compliance with infection prevention and control practices at local level. The IPCT hold monthly ICLF meetings on each acute site.

The ICLFs are provided with education and training from the specialist IPCT and other relevant specialists. In addition the Trust also encourages and supports ICLFs to undertake further training to support them in their role. The ICLFs are responsible for the completion of monthly hand hygiene audits, other Trustwide audits, cascade training and implementation of new policies and initiatives under the guidance of the IPCT.

The results of the monthly hand hygiene compliance audits are readily available on the Trust electronic information system (Meridian). Ward Matrons are required to report regularly to the Director of Nursing to provide evidence of action to improve if indicated. If repeated non-compliance by an individual member of staff is identified, letters are sent out to the non-compliant staff members and it is escalated to their line manager to performance manage.

1.6 Joint working across the local health economy

The Trust IPCT continues to work with the Clinical Commissioning Group (CCG) IPC Nurse and Public Health England (PHE) colleagues towards joint strategies for the reduction of healthcare associated infections which can lead to hospital admission. The Lead IPCN reports to the CCG Clinical Quality Review Group (CQRG) and to the East Sussex IPC in Care Homes Group

The IPC specialist nurses are members of the Infection Prevention Specialists Regional Network Meeting who share and discuss local initiatives, innovations and work towards common goals across Sussex.

The IPCT in collaboration with PHE, East Sussex County Council and the Network Group have continued to focus efforts on the reduction of catheter associated urinary tract infections. This will be of increased importance in achieving the new Quality Premium for reducing *E. coli* bacteraemias (see 10. Annual Programme of Work/Priorities for 2017/18).

2. Compliance with Outcome 8 Regulation 12 "Cleanliness and Infection Control" Health & Social Care Act 2008

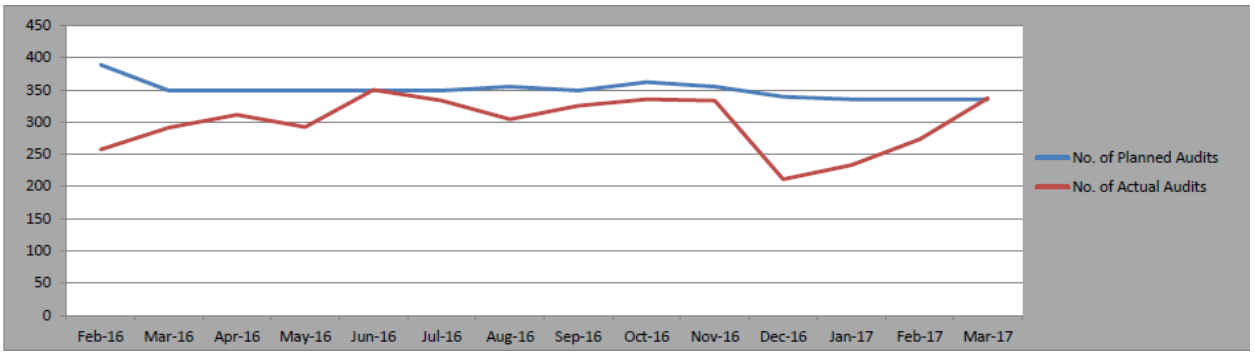
The Trust is required to undertake self-assessment against Care Quality Commission (CQC) standards and regulations, develop action plans for improvement if required and provide evidence of compliance, including against Outcome 8 which specifically relates to cleanliness and infection control.

The TIPCG reviews generic self-assessment against Outcome 8 and receives reports from Divisions as evidence of local compliance and assurance which is then reported quarterly to the Trust Patient Safety and Quality Group.

One of the greatest challenges to the Trust in demonstrating compliance against Outcome 8 is in the provision of isolation facilities to meet the increasing demand due to emerging threats and diseases and for those at most risk. During 2016/17 the on-going programme of refurbishment to hospital wards and departments continued, although the provision of side rooms remains a challenge.

The last CQC inspection in October 2016 reported that Infection Prevention and Control oversight had been significantly strengthened and hand hygiene practice was largely compliant although EDGH emergency department was mentioned as not being of the same standard as other areas.

The National Specification of Cleanliness (NSC) audits continue to be monitored through the TIPCG and the Divisions Nursing and Midwifery and Integrated Performance Review Meetings. (See table below for planned versus actual numbers of audits).



Although the overall Trust NSC scores for Nursing and Housekeeping remain >95%, there continues to be some low scoring areas such as Nursing (patient equipment) and Estates. Where an area has consistently low scores they are asked to attend the Patient Environmental Audit Meeting (PEAM) to provide assurance of the actions being taken to address the low compliance. The introduction of the Clinical Orderly role to support

nursing cleaning has demonstrated a significant improvement in compliance scores and they have proven to be a valuable asset to the teams.

3. Mandatory Surveillance

The Department of Health (DH) requires NHS Trusts to take part in a national mandatory and voluntary surveillance programme. This involves providing information about a number of specific infections including bloodstream infections due to Meticillin resistant S*taphylococcus aureus* (MRSA bacteraemia) and diarrhoea due to *Clostridium difficile* infection (CDI).

Each Trust is set an annual objective for numbers of MRSA bacteraemias and CDI. These were initially set to promote a reduction of these infections over a period of several years. In the five years up until April 2014 ESHT showed a significant reduction in both infections reducing MRSA bacteraemias by 95% and CDI infections by 78%. After this, the DH recognised that not all cases of CDI are avoidable and that the focus should be on the concept of preventing avoidable harm. All cases of MRSA bacteraemia and CDI diagnosed and apportioned to the Trust are investigated by a post infection review (PIR) conducted by a multi-disciplinary team to ensure any potential lessons learnt are acted upon and shared across the organisation. Cases of CDI are reported as being a lapse in care likely to have resulted in CDI, a lapse in care unlikely to have resulted in CDI or no lapse in care.

Since 2011, bloodstream infections due to meticillin sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli* have been added to the national mandatory surveillance. However, these infections are more often community acquired and up until March 2017 no hospital or Trust objectives for reduction have been set hence these have not been included in this report. However, in 2017/18 there will be a new Quality Premium to reduce the number of *E. coli* bacteraemias (community and HCAI) by 10% and mandatory reporting of *Pseudomonas aeruginosa* and *Klebsiella species* bacteraemias will be introduced (see 10. Annual Programme of Work/priorities for 2017/18).

3.1 MRSA bacteraemia

We continue to have a zero tolerance approach to cases of MRSA bacteraemia which could potentially be avoidable. ESHT reported one case of MRSA bacteraemia in 2016/17 compared to four cases in 2015/16. The PIR showed that the bacteraemia might have been a blood culture contaminant.

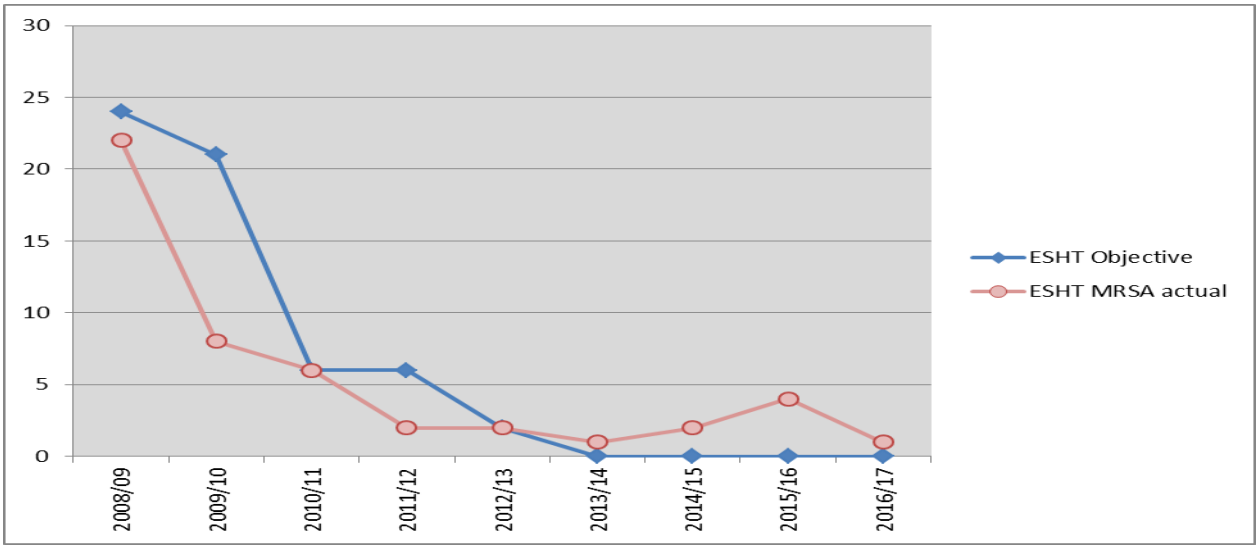
MRSA – 2016/17	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Post 48hrs	0	0	0	0	0	0	0	0	1	0	0	0	1
Trust attributable cases	0	0	0	0	0	0	0	0	1	0	0	0	1

Trying to improve compliance with the current Trust MRSA policy has again been the subject of much work by the IPCT this financial year. Preventing patients with MRSA colonisation of the skin developing subsequent infection is challenging, particularly in patients who have severe underlying conditions, skin problems or require the insertion of intravenous lines and other devices as part of their treatment. For many years we have had in place regimes to screen all admissions and give topical antiseptics to the

skin for patients with known MRSA colonisation. In 2014/15 new guidance was published by the DH that recommended a move away from routine MRSA screening of all admissions towards a risk based screening strategy whereby only those at high risk of MRSA would be screened. We reviewed the guidance and decided to continue screening all admissions to ESHT throughout 2016/17.

The table below shows the number of cases of MRSA bacteraemia reported since 2008. It should be noted that prior to 2011 the data reported was for the previous acute organisation (East Sussex Hospitals NHS Trust) only.

Reduction of MRSA cases reported between 2008/09 and 2016/17



3.2 Clostridium difficile infection (CDI)

The number of *C.difficile* infections reported annually within ESHT is shown in the chart below. In 2016/17 the Trust reported 46 cases of CDI against an objective of no more than 41. Six patients diagnosed with CDI that were attributed to the Trust had symptoms of diarrhoea within 72 hours of admission but no stool sample was sent for CDI testing. It is possible that if stool samples had been sent earlier then the patients would have been diagnosed and treated earlier and the cases would not have been attributed to the Trust.

Each case of CDI diagnosed beyond 72 hours of admission undergoes a post infection review (PIR) investigation. Findings of these PIRs are presented to the DIPC who agrees with a representative from the local CCG if each case constitutes a lapse of care likely to have resulted in CDI, a lapse of care unlikely to have resulted in CDI or no lapse of care. In 2014/15 the DH revised the objectives for reduction of CDI for Trusts so that where no lapses in care have been identified Trusts may appeal to their local commissioners for these CDI cases not to count towards annual objectives. ESHT worked with the local Commissioners and agreed a process and criteria for review of all cases. Of the 46 cases of CDI, eleven were judged as no lapse in care. Of the remaining 35 cases, eight were considered lapses in care that may have contributed to the patient developing CDI and 27 were lapses in care that were unlikely to have contributed to the patient developing CDI.

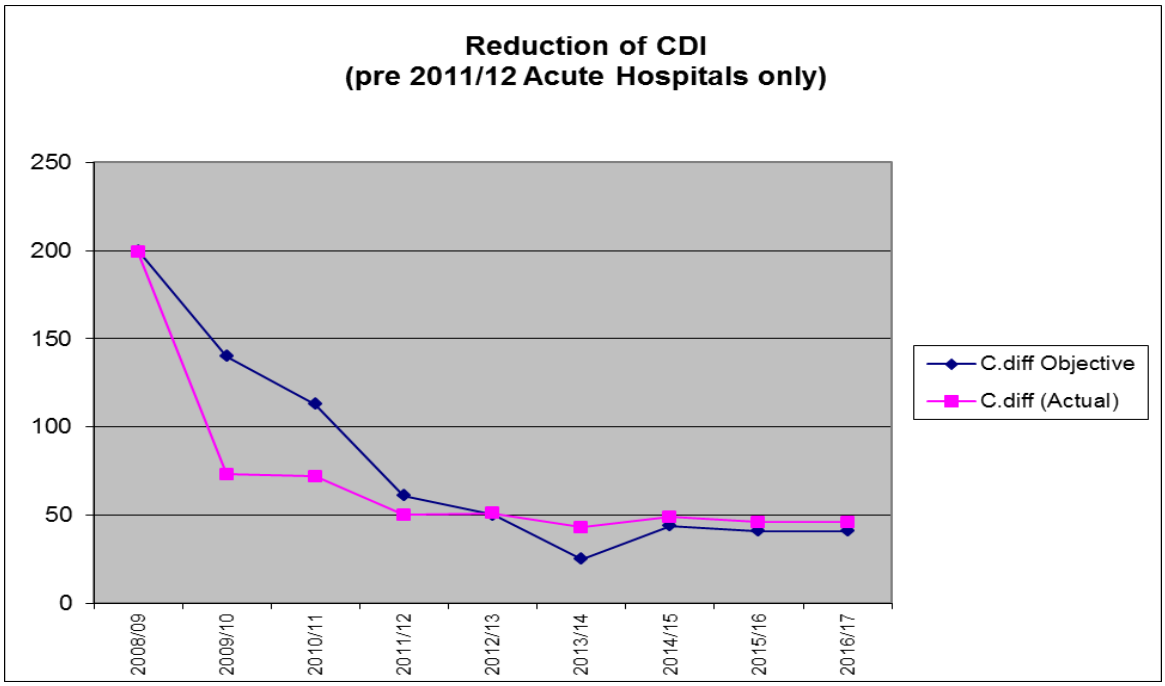
In line with national guidelines, if there are two or more cases of CDI identified on the same ward within 28 days of each other these are investigated as periods of increased incidence (PIIs). Further tests are performed at a specialist reference laboratory to

compare the *C. difficile* bacteria and to see if they are the same type (known as ribotyping). Any found to be the same ribotype are considered to be outbreaks.

There were two CDI outbreaks at ESHT during 2016/17. Both were small and involved the transmission of *C. difficile* from one patient to one other. These cases were classified as lapses in care and reported as SIs.

Of the 35 cases considered lapses in care that were unlikely or likely to have contributed to the patient developing CDI the most common area for improvement was related to NSC audit scores not reaching the expected level (24/35 cases).

Reduction of CDI cases reported between 2008/09 – 2015/16



Please note that prior to 2011/12 the number of cases reported are related to acute inpatients only. From 2012/13 onwards the number of cases also includes cases reported from the additional community inpatient beds following integration.

3.3 Surgical Site Surveillance

Since 2004 all NHS Trusts undertaking orthopaedic surgery are required to complete the mandatory surveillance study program devised by the Surgical Site Infection Surveillance Service (SSISS) Public Health England (PHE) for a minimum of three consecutive months per year. ESHT have maintained this recommended gold standard since January 2010 and practiced a continuous study to establish any patterns or trends over time. A standardised set of demographic and operation-related details are submitted for every patient undergoing Hip and Knee Prosthetic Replacement Surgery including re-surfacing and revision (excluding 1st stage revision where spacer implant is used) as well as the surgical procedure, inpatient stay, post discharge reports and complete relevant data of any case readmitted with a SSI during the first post-operative year.

Please note: PHE SSISS studies are undertaken prospectively and submitted quarterly but results are published 12 months retrospectively as infection rates are influenced by performance and readmissions within the audit population over each 12 month surveillance period.

Finalised results are therefore only available up until end March 2016 although data from April 2016 onwards is within the surveillance system and continues to be analysed and officially reported by the PHE at the end of the following year.

Core data 1st April 2015 – 31st March 2016

Category of surgery	Number of procedures	Number of infections	Infection rate	Mean infection rate for all participating Trusts (data April 2011-March 2016)
Total hip replacement	307	2	0.7%	0.6% (95% CI 0.6-0.7%)
Total knee replacement	343	1	0.3%	0.6% (95% CI 0.6-0.6%)

Surgical site infection rates for prosthetic hip surgery were marginally higher than the national average which stands at 0.6%. For prosthetic knee surgery ESHT remains lower than the national average of 0.6%.

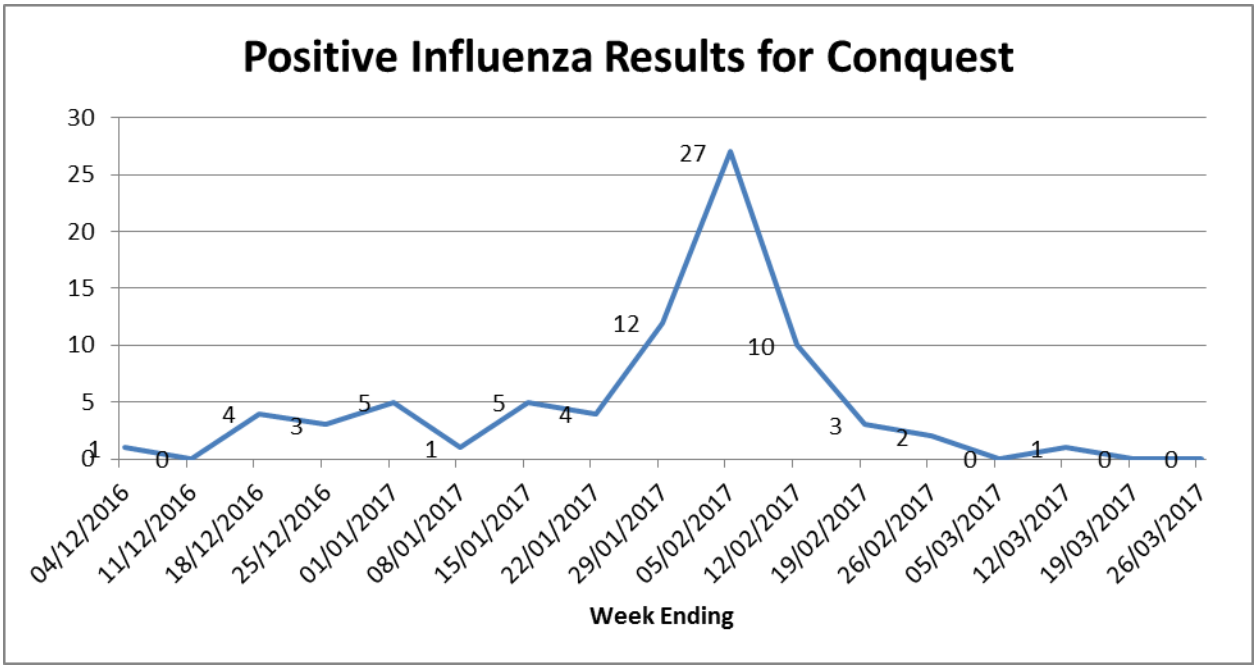
3.4 Influenza

There is no national surveillance programme for Influenza. However all acute trusts are required to report on a weekly basis during the Influenza season the number of cases of Influenza requiring admission to intensive care to determine the burden on critical care units nationally.

At ESHT a total of 114 cases of Influenza were diagnosed (see graph). 111 were Influenza A, 3 cases were Influenza B. 78 cases occurred at the Conquest Hospital (CH) and 36 cases at Eastbourne District General Hospital (EDGH). The Influenza season occurred earlier this year than the previous year.

A total of six patients were admitted to critical care due to the severity of their Influenza infection.

The IPCT responded to each case of Influenza to assess the risk and provide advice to patients and staff. In January, two bays in Newington Ward were used temporarily as a cohort area to assist in managing Influenza cases following an outbreak of the infection on the ward (see section 4 below). The majority of confirmed Influenza patients presented to the Trust with flu like symptoms on admission indicating that they had acquired the infection in the community (incubation period 1-4 days) but a total of 11 patients on Newington Ward presented with symptoms after the maximum four day incubation period suggesting hospital acquired infection. Each Influenza case was investigated by the IPCT. An SI investigation was carried out on the eleven cases on Newington Ward because they all developed symptoms of Influenza A (non-H1N1) on the ward indicating that cross infection is likely to have occurred. The outbreak of Influenza A occurred at the peak of the local season as demonstrated in the graph below.



4 Incidents related to infection

4.1 Incidents managed by the Infection Prevention & Control Team

ESHT reports outbreaks of infection as SIs to the local CCGs. These include incidents where there has been a significant impact on the running of the Trust's services (ward closures for example), or where there has been a severe impact on patient outcome.

In 2016/17 the Trust reported five serious incidents that were investigated and managed by the IPCT. The PIR/RCA investigations and subsequent recommendations and completion of actions are monitored by the TIPCG.

The table below provides a brief outline of these incidents.

Month	SI No	Incident
May 2016	2016/19629	Outbreak of *Clostridium difficile* infection, Sovereign Ward EDGH
June 2016	2016/16793	GRE colonisation Pevensey Ward, EDGH
September 2016	2016/25474	Outbreak of *Clostridium difficile* infection, MacDonald Ward CH
December 2016	2016/25150	MRSA acquisition MacDonald Ward, CH
January 2017	2017/3570	Outbreak of Influenza, Newington Ward, CH

4.2 Norovirus

During the winter months Norovirus is often circulating in the community and the risk of outbreak related to Norovirus increase. During 16/17 there were 6 ward closures related to confirmed Norovirus affecting 100 patients, 35 staff and 5 visitors.

5 Emerging threats and operational preparedness

5.1 Carbapenemase-producing *Enterobacteriaceae*

Carbapenemase producing *Enterobacteriaceae* (CPE) are bacteria that are resistant to Penicillin, Cephalosporin and Carbapenem antibiotics and often have resistance to multiple other antibiotics. This means that there may be only one or two antibiotics that can be used to treat them. They are a potentially major problem because these bacteria cause common infections such as urinary tract and intra-abdominal infections. ESHT does not currently have a problem with these bacteria and has seen very few cases of infection with these bacteria to date. However appropriate IPC measures are required to be in place to manage the risk should a case arise. The CPE policy was developed during 2015/16 and the IPCT is continuing to work on embedding the required actions into routine practice. This includes recognising patients admitted to the Trust who are at higher risk of being colonised/infected with CPE and isolating and screening these patients for CPE.

5.2 Operational preparedness

The operational preparedness group established initially in response to the threat of Ebola continues to function within the organisation to ensure ongoing plans are in place for potential Ebola cases and other emerging threats and diseases including Pandemic Influenza and CPE.

6 Infection Prevention Activities and Innovation

6.1 Hand Hygiene Promotion

The Trust IPCT continues to co-ordinate an annual programme to promote effective hand hygiene throughout the Trust including;

- Monitoring of compliance by clinical staff with monthly audits.
- Monthly hand hygiene promotional posters
- Series of focussed hand hygiene promotion events for staff and patients including participation in the International World Hand Hand Hygiene Day on 5th May 2016.
- Training of ICLFs to facilitate cascade training at local level of practical hand hygiene technique.
- Providing training of all staff on induction (joining the organisation) and at regular mandatory updates.
- Ad-hoc training when indicated for focussed improvement.

6.1.2 Hand Hygiene Compliance

Monthly hand hygiene audits are undertaken by ICLFs measuring compliance by healthcare staff in direct contact with patients. Observations are made in each clinical area and feedback is given at the time of audit by the ICLF. Staff responses are noted as part of the audit and results are monitored to detect trends and act where frequent non-compliance occurs.

From July 2015 any staff member identified as non-compliant was sent a letter copied to their line manager outlining any improvement required. Repeat non-compliance results in Performance Improvement Plans being implemented and disciplinary procedure where appropriate. This is also escalated by email to the Director of Nursing if it is a nursing member of staff or the Medical Director/DIPC if a member of Medical staff is observed. For other units the appropriate Manager is informed.

The chart below provides details of the overall Trust compliance and the number of observations undertaken each month, the number of non-compliance and the number of letters sent to non-compliant individuals where they are identifiable.

The ICLFs should complete and submit 10 observations every month. If an area doesn't return an audit for one month the matron is contacted, if for two consecutive months the Head of Nursing for that area is contacted and if there is no audit for three consecutive months it is escalated to the Director of Nursing and the DIPC.

Results: 2016/17
(data obtained from Meridian)

	Apr 2016	May 2016	June 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017
Overall Trust compliance (%)	96.75	97.29	97.79	97.21	95.89	95.80	96.36	97.12	96.39	97.04	96.58	97.73
Number of audits undertaken	739	637	586	645	779	787	760	696	673	768	795	655
Number of Non Compliance	24	17	19	18	22	19	25	16	19	23	21	27
Number of letters sent	6	11	10	9	7	9	11	11	13	10	15	0
Areas which submitted 0 audits	2	8	4	7	14	13	8	10	12	7	12	13

The hand hygiene audit data above were completed by ICLF undertaking observations on their colleagues on the wards where they work. In order to validate this data and provide assurance of its accuracy the ICLFs have undertaken peer hand hygiene observations quarterly on wards that they don't work on. The initial peer audit undertaken in April demonstrated a low compliance of 61.70% .This improved over time to 81.11% in December. These audits will continue to be completed and monitored during 17/18

6.2 Audit activity

The IPCT co-ordinates a number of planned and unplanned audits throughout each year to monitor compliance with core infection prevention and control standards and any areas of risk or concern which may arise as a result of incidents.

The planned programme of audits outlined for 2016/17 was reviewed during the year to ensure the highest priority audits were completed. These were:

- Monthly staff hand hygiene audits (see above)
- Quarterly Peer hand hygiene audits
- National Specification of Cleanliness audits reported and monitored monthly at TIPCG
- Audit of compliance with Control of Carbapenemase Producing *Enterobacteriaceae* (CPE). Audit no. 4027
- Audit of compliance with Diarrhoea Assessment Tool Audit no. 4095
- Re-audit of compliance with the Trust MRSA policy for management of emergency admissions with a known history of MRSA. Audit no.3890
- Audit of compliance with best practice guidelines to minimise the risk of *Pseudomonas aeruginosa* and *Legionella* contamination in augmented care. Audit no. 3972

6.3 Training and Education

The IP&C specialist nurses provide a comprehensive training and education programme for all Trust staff and volunteers related to all aspects of infection prevention and control, both planned and as required. For example;

- Mandatory training on induction for all staff and volunteers
- Annual mandatory training for all clinical staff.
- Annual updates for clinical staff, patient facing staff, food handlers and other high risk groups
- 3-yearly mandatory training for non-clinical, non-patient facing staff.
- Training is provided monthly to ICLFs on the control and management of key infections for cascade to clinical teams.
- Focused training has been delivered directly to ward staff on control and management of CPE, CDI, MRSA and decontamination of beds and equipment.
- Train the trainer sessions in Hand Hygiene and Fit Testing of FFP3 masks (cascaded by ICLFs)

Compliance with attendance at mandatory induction and update sessions is monitored by the Trust along with other mandatory components of the Trust mandatory training programme.

6.4 Professional Development

All specialist nurses within the team maintain professional competence and attend relevant study and training. Networking with other clinical specialists is supported through attendance at regional meetings.

As well as utilising the in-house Learning & Development training programme team members have been supported in attending other essential specialist training and conferences required to maintain their professional practice to enable them to provide education and training to others in the organisation including:-

- Infection Prevention Society, London South Branch development days
- Annual infection Prevention and Control Conference
- Visiting other Trusts to learn from others experiences in implementing programmes of improvement
- Mentoring skills development workshop
- Foundation degree in Health and Social Care
- Public Health Practitioners Register Course
- NVQ in business administration
- MSc in Infection Prevention and Control

6.5 Talentworks

The IPC team have been supported by an external company called SilverMaple (formally TalentWorks) who completed 6 staff engagement workshop. SilverMaple is a TDA funded company that has worked with the IPCT to support the setting of clear and achievable IPC objectives with involvement of Trust staff. The outcome of these events was very valuable to the IPC service and will be incorporated into the Annual Programme of Work for 17/18.

There were a high number of recommendations that came from the groups. Some of the key points for consideration included:

Improved communication strategy:	• Create a communication strategy to ensure that IPC stakeholders have more clarity including updating and utilising the IPC intranet page. This needs to be an open one stop shop for information • Consider new channels for communication such as “fit to fly” & safety huddles • IPC strategy to be widely communicated with an emphasis that it was driven by a bottom up approach with full engagement from staff
Provide more clarity and direction on the IPC Link role:	• IPC Link conference to introduce the strategy • Use the IPC link work plan as a simple and effective way to guide follow their objectives • Consider ‘Link doctor’ role to engage Doctors

Create clarity about the existing tool kit:	• It was acknowledged that many of the suggestions raised at the workshops already exists but teams have differing ways of accessing information and can sometimes find themselves access old documents – a quick win would be to provide a 'how to guide' to accessing the correct information from the right place • Create a front page – summary of key points from policies
Consider the patients journey through the Trust:	• Evidence of staff working in vertical silos rather than horizontal processes. This was evident with the bed space cleaning process that required staff to clean a bed in a set time to meet the turnaround time when the process requires longer to ensure that it is done to the required standard
Systems and processes:	• Feedback from VitalPac suggests that the system needs to be improved to meet the expected standard and the system is not utilised in the community settings
Sustaining the plan:	• It is essential that the plans developed from these workshops are utilised and kept alive. They require regular review and they will provide an opportunity for positive reinforcement as they are planned, created, owned and delivered by the teams. This is recognised as fundamental to the need to create a sustainable behavioural shift.

7 Housekeeping Services

The housekeeping services for ESHT are provided by an in-house team within Estates and Facilities. The housekeeping service has undergone a full review and standardised working practices to meet the objective of achieving a more productive, efficient and cost effective cleaning service which meets the clinical service demands and patient care. As a result of this service review a modernisation plan was created and given full approval by the board and the management team. The implementation of the plan began in February 2016.

7.1 Deep clean programme

An important part of housekeeping services is to support the reduction of infections and meeting CQC regulation 12 "Cleanliness and infection Control". The housekeeping service has been unable to undertake a structured deep clean plan of patient areas as recommended in the, Revised Healthcare Cleaning Manual (2009) due lack of decant areas (vacant ward to allow emptying of wards that require a deep clean) and operational demand. Deep cleaning continued to be carried out in response to infections and where opportunities arose. The housekeeping team works in close partnership with IPCT and has worked on alternative ways of ensuring cleanliness standards are maintained, this includes the introduction of an enhanced cleaning team, and by introducing weekly quality meetings to discuss standards in partnership with IPCT, maintenance, and clinical partners and actions are drawn up to address low standards if needed in any areas until a structured deep clean plan can be established.

7.2 Activity

Housekeeping continued to receive demands from all areas for cleaning support from the Rapid Response Team including single rooms, bed space cleans, and others this

averages at about 200+ calls per month per acute site. To meet this demand calls for cleans are prioritised and communication and support is structured from the IPCT and clinical site leads and clear plans are in place at all levels to ensure patient disruption is minimised

7.3 Service development

The Housekeeping department continues to use HPV Hydrogen Peroxide Vaporisation units to support the reduction of infections by destroying organisms, this process is undertaken by the rapid response team who are on site 24hrs and can be deployed to any site if called upon this will be sustained in the modernisation plan.

8 Antimicrobial Stewardship Activities and Innovation

The Trust has an established Antimicrobial Stewardship Group (ASG) which has a core membership of an antimicrobial pharmacist, consultant microbiologist, medical consultant, Clinical Pharmacy Manager and a CCG representative. The purpose of the ASG is to support the prudent prescribing of antimicrobials to reduce antimicrobial resistance rates. It does this by:

- Developing and maintaining evidence based antimicrobial policies and guidelines for use in secondary and primary care
- Ensuring safe and cost effective use of antimicrobials taking local, national and international bacterial resistance rates into account.
- Monitoring antimicrobial usage (reviewing daily divided doses, antimicrobial expenditure data and compliance to guidelines using a point prevalence audit) and addressing any issues that may arise.
- Providing advice to other specialist groups/committees on use of antimicrobials
- Providing education to staff on all matters relating to prescribing and administration of antimicrobials.
- Educating patients and members of the public on antimicrobial stewardship
- The lead antimicrobial pharmacist providing feedback from lesson learnt, following a Post Infection Reviews to the pharmacy team.

During the last financial year the activities of the ASG were as follows:

8.1 Antimicrobial Prescribing Policy

During 2016/17, the Antimicrobial Prescribing Guidelines for Adults and Children (which contains the antimicrobial formulary of drugs) was updated. The use of piperacillin/tazobactam was reviewed and restricted as it is a broad spectrum antibiotic which our local data has shown to be associated with developing *Clostridium difficile* infection. The guidance contains peer-reviewed, evidence based guidelines on common infections and a large number of specialist Consultants are involved. Additional chapters such as Ophthalmology and Intensive Care were included. The antimicrobial guidelines are now available on a smartphone app so that prescribers can download it onto their smartphone and use it as required. This innovative approach has been taken up by a number of Trusts nationally and has improved access/compliance with the guidelines as well as help with guidance updates.

8.2 Multi-disciplinary Ward Rounds

The antimicrobial pharmacists and Consultant Microbiologists (CM) continue to participate in daily Intensive Care ward rounds and weekly *Clostridium difficile* infection ward rounds at both acute sites. This ensures specialist input into the highest risk/most critical patients in the hospitals. In addition, a ward round also takes place every week at EDGH to support the Urologists with the treatment of complex urological infections.

8.3 Training

There is a Trust e-learning module on antimicrobial prescribing available on the internet. It includes an assessment that all new doctors have to pass at induction and all Trust doctors have to undertake every three years. In addition, the Consultant Microbiologists provide face to face teaching about antibiotic prescribing for FY1 and FY2 doctors. The Trust Pharmacist antibiotic training pack is used to help support the development of rotational pharmacists in relation to antimicrobial prescribing in line with Royal Pharmaceutical Society antimicrobial training guidance.

8.4 European Antibiotics Awareness Day and World Antibiotic Awareness Week

The lead antimicrobial pharmacist led a campaign in November 2016 to promote European Antibiotics Awareness Day and World Antibiotic Awareness Week. The aim was to educate patients and the general public on antibiotics. Activities undertaken were posters in common areas, articles in local bulletins/paper, on the intranet and handing out of leaflets.

8.5 Antibiotic prescriptions / algorithms

The lead antimicrobial pharmacist has also created algorithms for clinical pharmacists to follow when presented with antimicrobial prescriptions on their wards. These are meant to aid pharmacist's to query prescriptions, appropriately switch from intravenous to oral antibiotics and how to dose toxic antibiotics. This helps reduce inappropriate prescribing, switching early to oral antibiotics and reduces risk to patients from side effects, multi-drug resistant bacteria, healthcare associated infections and has proved a useful tool to aid pharmacists in the clinical screening of prescriptions.

8.6 Audits

The lead antimicrobial pharmacist continues to conducts monthly snapshot audits to monitor the quality of antimicrobial prescribing within the Trust. This is done at ward level by clinical pharmacists and helps ascertain any issues with prescribing that is then dealt with by the ward pharmacist. The audit data is given to the TIPCG and fed back to the clinical divisions by a divisional pharmacist.

8.7 Antibiotic Incident reports

The lead antimicrobial pharmacist is also involved in reviewing of incidents reported on Datix involving antimicrobials and also participates in the Post Infection Reviews of

patients who have come to harm where antimicrobials may have directly or indirectly been involved such as PIRs of *C. difficile* cases.

8.8 Innovation

8.8.1 Antibiotic intervention system on eSearcher

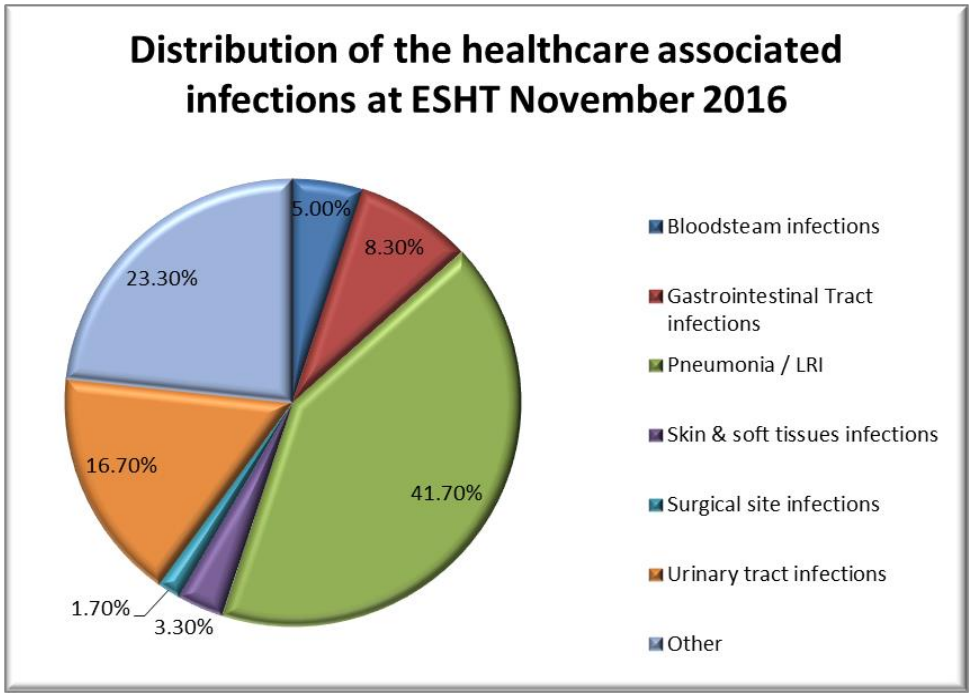
During 2016/17 monitoring of restricted antibiotics using the Trusts eSearcher system was introduced. This is used by ward Pharmacists to alert the Consultant Microbiologists to restricted antibiotics that are not being used in line with the Trust antimicrobial prescribing guidelines. This allows the Consultant Microbiologists to be able to “police” the use of restricted antibiotics and advise alternatives where possible.

8.9 Antibiotic CQUIN 2016/17

In 2016/17 the DH introduced a new antimicrobial stewardship CQUIN for acute NHS Trusts. This aimed to reduce total antibiotic use by 1% as well as give 1% reductions in the use of Piperacillin-tazobactam and Carbapenems. The reductions were against a baseline of 2013/14 usage levels. The CQUIN also had targets for the number of audits carried out and ensuring that antibiotic prescriptions are reviewed within 72 hours of starting them. The use of the baseline data from 2013/14 meant that reductions of approximately 30% were required compared to 2015/16 use. This was an extremely challenging target. The Trust partially achieved the reduction in Tazocin (reduction of 21%) and Carbapenem (reduction of 11%) and fully met the target for review of prescriptions, number of audits completed and data upload. However it has not met the reduction in total antibiotic use (increase of 13%). The increase in total antibiotic usage may be partially due to the need to use two or more antibiotics to give the same antimicrobial cover as Tazocin or Carbapenems which are used as single agents.

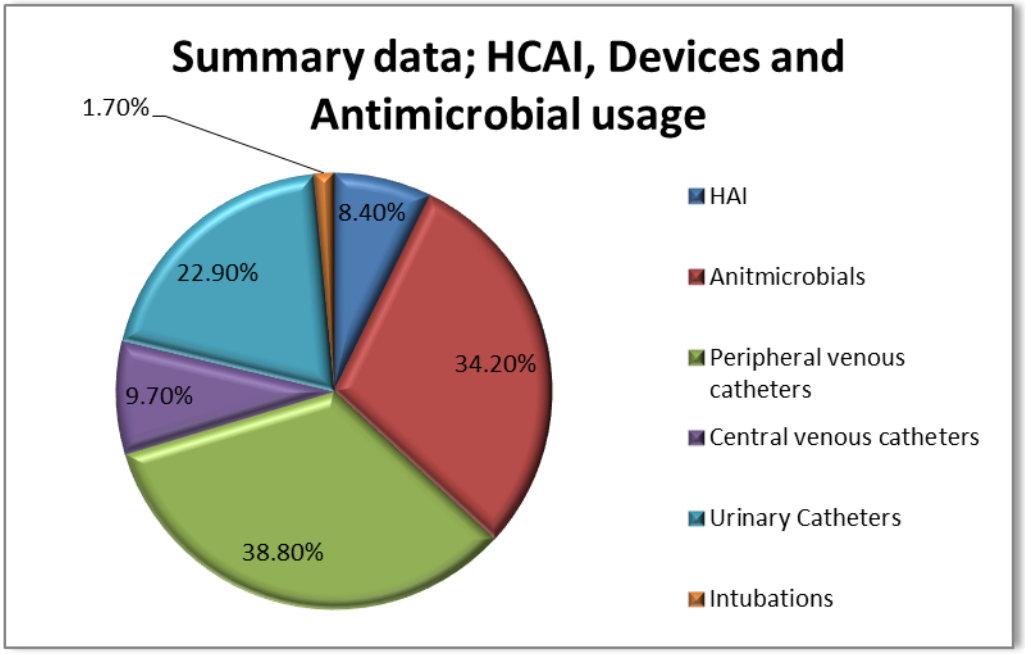
8.10 5th National Point Prevalence Survey (PPS) on Healthcare-associated infections (HCAI) and 2nd National PPS on antimicrobial prescribing quality indicators

During November 2016 the IPC team worked with the Antimicrobial pharmacists to undertake the national PPS on HCAI and antimicrobial prescribing. A total of 693 patients were surveyed. The chart below shows the distribution of HCAIs at ESHT.



When comparing the % distribution against the last PPS undertaken in 2011. ESHT had higher rates of HCAI related to pneumonia / LRT with 41.70% compared to the national average of 22.8% this higher rate is likely to be partly due to demographics. All other HCAI were lower than 2011 national average data.

The chart below shows the % of HCAIs, devices and Antimicrobial usage at ESHT. When compared to the last PPS undertaken in 2011 ESHT had a higher rate of HAIs with 8.40% compared to a national average of 6.4%. The antimicrobial usage was lower than the national average with 34.2% compared to 34.7%.



9. Water Safety Incidents

9.1 Elevated *Legionella* counts in water sampling, Conquest Hospital, Hastings

As reported previously, elevated counts of *Legionella species* were reported at Conquest Hospital in July 2015. Initial actions and investigations were implemented in line with National guidelines and Trust policy and Public Health England (PHE) was notified. Despite additional control measures there continues to be low levels of mainly non-pneumophila isolated from several areas. A meeting was held with PHE water safety experts and representative from the Estates department, IPCT and the DIPC to seek assurance on the actions taken to date and advice on any further actions required. The situation continues to be monitored by the Water Safety Group. It is believed that insufficient flushing of taps is a factor in the on-going problem with *Legionella species.* However a decision may have to be made in the future to consider a chemical dosing system if it cannot be resolved.

No cases of hospital-acquired *Legionella* infection have been detected.

9.2 Isolation of *Pseudomonas aeruginosa* in augmented care

Routine water testing carried out in augmented care detected *P. aeruginosa* in tap water from several areas. This meant there was a risk of patients acquiring the organism from water (colonisation or infection is possible). Affected taps were cleaned, chlorinated and point of use filters used where appropriate. Repeat testing continued until outlets tested negative. There were no outbreaks of *P. aeruginosa* infection in augmented care areas.

10. Clean care award

The quarterly clean care award was introduced during the end of 16/17 with Littlington at EDGH and SCBU at Conquest winning the award. To win the award they had to demonstrate the following:

- No preventable/avoidable infections
- 10 hand hygiene observations submitted each month
- Compliance with average monthly National Specifications for Cleanliness (NSC) audit scores
- Consistent attendance at the monthly Infection Control Link Facilitators meetings.

This was well received and promoted and celebrated in the ‘Connect’ newsletter

11. CQC report

The latest CQC report in October found that the Infection Prevention Control oversight had been significantly strengthened and hand hygiene practice was largely compliant. Some non-compliance with hand hygiene was noted in the Emergency Departments (ED). The IPCT has requested and identified IPC champions within ED to support an improvement in compliance.

12 Annual Programme of Work / Priorities for 2017/18

Taking into account the performance delivered by the Trust in 2016/17, the lessons learnt from the PIR investigations of MRSA bacteraemia, *Clostridium difficile* infections, and audits, work priorities for 2017/18 will include:

(i) Programme of improvement and audit to demonstrate assurance of compliance by all staff with Infection Prevention and Control policies

(ii) Reduction of healthcare associated infections

(iii) Support the delivery of the local Antimicrobial Resistance Strategy, initiatives and CQUIN

(iv) Meet mandatory reporting and surveillance requirements related to HCAI

(v) Robust procedures to identify and respond where a need for improvement is identified.

(vi) Further patient involvement and feedback from Infection Prevention and Control experience

(vii) Lessons learned from incidents, root cause analysis investigations and post infection reviews to disseminated and imbedded for shared learning

(viii) Seasonal influenza preparedness planning to focus on increasing staff awareness and vaccine uptake

(ix) Peer auditing of hand hygiene compliance to be undertaken to provide further assurance of data provided

(x) Review and update all Infection Prevention and Control polices to reflect latest best practice guidance and recommendations

The above will be incorporated into the Infection Prevention and Control's Annual Programme of Work for 2017/2018 with key performance indicators. This will be monitored through the Infection Prevention and Control's integrated action plan.

We endorse the Infection Prevention Society's vision that:
"No person is harmed by a preventable infection"

Health and Safety Annual Report 2016/17

Meeting information:			
Date of Meeting:	28th November 2017	Agenda Item:	17.2
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth

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 annual report is to provide the Trust Board with a summary of activity and outcomes relating to the promotion and management of Health and Safety within East Sussex Healthcare Trust. The reporting period is 1st April 2016 to 31st March 2017. The report contains an executive summary.

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

This Annual Report has been reviewed by the Quality and Safety Committee.

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

To review this annual report and seek assurance around health and safety monitoring, compliance and the actions the Trust is taking.

East Sussex Healthcare NHS
NHS Trust

Health and Safety Annual Report

1st April 2016 – 31st March 2017

Executive Summary

This annual report details the activities and provides a summary of progress towards achieving the planned objectives undertaken by the Health and Safety Team supported and monitored by the Health and Safety Steering Group.
Further work is required by the H&S Team to provide more assurance and detail on the roll out of the Assure Software for the H&S risk assessments. This will be addressed during 2017/18.
Core requirements outlined by the Health and Safety Executive (HSE) for 2017/18 are to review, reduce and monitor Work-related stress, musculoskeletal disorders and occupational lung disease. The latter will have minimal impact within the Trust but both other requirements will be covered within the 2017/18 work plan.

Key highlights (achievements and improvements required) from this report are as follows:

- No prosecutions for the Trust by the H&S Executive due to non-compliance to the Health and Safety at Work Act 1974 or Management of Health and Safety at Work Regulations 1999;
- Health and safety work plan requires more detail and monitoring for 2017/18 on key performance indicators and the roll out of the Assure system for health and safety risk assessments;
- 50% of the planned activity of workplace assessments were completed during the year which need to improve during 2017/18;
- Health and Safety Policy in date;
- 87% year end compliance to mandatory H&S training;
- 89% year end compliance to Moving and Handling Training;
- The first Sussex Back Exchange conference hosted at Conquest Hospital;
- New profiling beds purchased;
- Training programme for new infusion devices in place and being delivered but attendance requires improvement;
- Bariatric pathway in development for 2017/18;
- Staff incident reporting figures increased during 2016/17;
- 20% increase in sharps incidents resulting in 63 injuries to staff from sharps;
- Moving and handling incidents decreased during 2016/17;
- A total of 47 incidents were reported to the Health and Safety Executive (HSE) related to Reporting of Injuries, Disease and Dangerous Occurrences Regulations (RIDDOR). 15 were from moving and handling injuries, 3 violence and aggression and 14 from slip, trip and falls;
- 14 staff claims were related to health and safety issues.

The Health and Safety Steering Group work plan for 2017/18 supported by the Health and Safety Team outlined in section 12 of this report will deliver clarity on the compliance within the trust to core requirements across the trust on Display Screen Equipment assessments, control of substances hazardous to health, lone working and workplace assessment compliance. In addition it will also provide details on trust compliance to medical device training in each department for all core devices used by staff.
Training for Health and Safety, medical devices and moving and handling will continue to be delivered by the H&S Team on a regular basis as outlined in the trust training programme.

Contents

1 Introduction

The purpose of the report is to provide the Trust Board with a summary of activity and outcomes relating to the promotion and management of Health and Safety within East Sussex Healthcare Trust. The reporting period is 1st April 2016 to 31st March 2017.

The programme of work that was delivered by the Health and Safety department aimed to achieve further improvements in health and safety management, whilst also highlighting and mitigating associated risks. An important focus of current activity is to encourage and support an organisational culture in which positive and proactive approach to health and safety management is developed and maintained.

Paramount are the Trust Values that the Health and Safety department continues to embody and communicate across the organisation and at all levels, the values are:

Working Together
Respect and Compassion
Engagement and Involvement
Improvement and Development

The Health and Safety department as stated in the Overarching Trust Health and Safety at Work Policy will:

- Conduct all of our undertakings so as to avoid, or control to an acceptable level, risks to the health and / or safety of all of our employees, all users of our services, all members of the general public who are exposed to our activities and all other people who work on, or visit, our premises;
- Create and maintain a positive health and safety culture within all areas of our organisation, so that there is a continuous, improvement in our health and safety performance;

2 Background and Context

As at 31st March 2017, the permanent staff headcount was 6519 staff. The average across the year, the headcount on 1st April 2015 was 6566 (source: ESHT Workforce Department).

The Trust Health and Safety Steering Group is chaired by the Director of Nursing (DON) and Governance or the Associate Director for Estates and Facilities. The Group receives reports from Trust wide services in Divisions and Departments, Fire, Security and Waste. See the Trust Risk and Quality Delivery Strategy for the reporting structure.
All organisations have a legal duty to put in place suitable arrangements to manage Health and Safety. Ideally, this should be recognised as being a part of the everyday process of conducting business and /or providing a service, and an integral part of workplace behaviours and attitudes. Notwithstanding a comprehensive legislative framework exists, within which the main duties placed on employers are defined and enforced. This

report addresses the management of Health and Safety within the Trust incorporating Medical Devices Educators and Moving and Handling Team. Annual reports for the management of Fire Safety and Security are presented as separate items to Board.

Health and Safety Executive Guidance

Guidance for the management of Health and Safety is published by the Health and Safety Executive: Management for Health and Safety (HSG65) 2013 which explains the Plan, Do, Check, Act approach and shows how it can help an organisation to achieve a balance between the systems and behavioural aspects of management. It also treats health and safety management as an integral part of good management generally, rather than as a stand-alone system.

In addition, Leading Health and Safety at Work: (INDG 417) guidance sets out an agenda for the effective leadership of health and safety; it is designed for use by all directors, governors, trustees, officers and their equivalents in the private, public and third sectors. It applies to organisations of all sizes. Protecting the health and safety of employees or members of the public who may be affected by an organisations activity is an essential part of risk management and must be led by the board. Failure to include health and safety as a key business risk in board decisions can have catastrophic results. Many high-profile safety cases over the years have been rooted in failures of leadership. Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached: members of the board have both collective and individual responsibility for health and safety. By following this guidance, it would help the organisation find the best ways to lead and promote health and safety, and therefore meet its legal obligations.
In order to appreciate and enable discussion of this published guidance, Non–Executive Directors received IOSH awareness for Board members and the Trust Executives received a full day IOSH training for Executives during 2016.

3 Legislation

The key pieces of legislation and guidance are:
The Health and Safety at Work etc Act 1974 provides a legislative framework to promote, stimulate and encourage high standards of health and safety at work.
In particular it requires organisations to:

- Provide a health and safety policy
- Provide safe and secure working environment
- Provide safe suitable work equipment
- Provide information, instruction, training and supervision
- Provide adequate welfare facilities.

Management of Health and Safety at Work Regulations 1999 which extends the provisions of the Health and safety at Work etc Act 1974 in particular the requirement to undertake suitable and sufficient risk assessments. The legislative requirements are interpreted into Trust Policy.
Working Together with Trade Union

Staff-side is made up from members of East-Sussex HealthCare NHS Trust Staff who are members of a Trade Union or Society, recognised by the Trust. The Staff-side members have been elected and / or appointed into their role of Health and Safety Representatives, through their Trust recognised organisations.

These staff members undertake training through their Unions in Health and Safety, and also may have undertaken further training via the Trade Union Confederation (TUC) which runs more in-depth courses which are College/University accredited.
Staff-side Health and Safety representatives are governed by “The Safety Representatives and Safety Committees Regulations 1977”.
Staff-Side Health and Safety representatives are part of the consultation process into Health and Safety policies written by the management side of the Trust.

Staff Side Health and Safety Representatives, are involved in Investigations, and may be consulted by the Health and Safety Executive (HSE) during Site Inspections, and when necessary they also have the legal duty to consult with the HSE.
Health and Safety Executive

4 Health and Safety Executive

The Health and Safety Executive regulates and enforces Health and Safety in the National Health Service with key formal interventional powers including prosecution.

4.1 Memoranda

A Memorandum of Understanding (MOU) between the Health and Safety Executive (HSE) and the Care Quality Commission (CQC) came into effect on the 1st April 2015, to reflect the new enforcement powers granted to the CQC by the Regulated Activities Regulation 2014. It reflects the 2012 Liaison Agreement between the CQC and HSE that applied solely to healthcare,
The purpose of the MOU is to help ensure that there is effective, co-ordinated and comprehensive regulation of health and safety for patients, service users, workers and members of the public visiting these premises. It is one of the measures taken by Government to close the ‘regulatory gap’ identified by the Francis Report into failings at Mid Staffordshire NHS Foundation Trust.

4.2 Prosecutions and Interventions

There have been no formal interventions in this Trust by the Health and Safety Executive (HSE) during April 1st 2016 to March 31st 2017.
During a routine follow up visit after a RIDDOR incident on the Conquest Hospital site a contractor was admonished by the HSE for poor practice whilst undertaking window repairs whilst on Trust property.

4.3 Corporate Fines

Total corporate fines for contraventions of health and safety nationally have increased by 43%to £54m following tougher sentencing guidelines introduced by the Sentencing Council in February 2016 according to Thomson Reuters.
The average fine has now almost trebled to an excess of £90,000. However East Sussex Healthcare has not been fined as a result of an intervention by the Health and Safety Executive

4.4 Health and Safety Executive (HSE) Consultations

4.4.1 Fees For Intervention

HSE has consulted on a revised and fully independent process for considering disputes in relation to FFI with regard to proportionality of the issues involved and amount of the fees.
Since implementation approximately 30% of disputes have been upheld by the HSE. Duty holders argue that there is often insufficient information provided by the HSE in order to make proper representation in the dispute.

4.4.2 Ionising Radiation Regulations

HSE has consulted on changes to the Ionising Radiation Regulations 1999 (IRR1999), the majority of which are brought in by the implementation of the EU Basic Safety Standards Directive (BSSD). Briefly the main changes are:
Dose Limit for exposure to the lens of the eye and implementation of the Directive – the Directive introduces a reduction of equivalent dose from 150 mSv to 20 mSv in a year. Currently exposure to ionising radiation is calculated and assessed on a calendar year basis, this would require individual dose limits to be re-calculated for the remainder of the year. HSE propose to transpose the BSSD early, on 1st January 2018, to avoid confusion and any additional cost burden to businesses.
Graded Approach - introduction of a new three tiered risk-based system of regulatory control. The Directive refers to these levels as notification, registration, and licensing - the higher the radiation protection risk associated with the work, the greater the requirements. It requires HSE to have in place a positive system of authorisation whereby permission is granted to duty holders for higher risk activities through registration and licensing.

4.5 Health and Safety Executive Work Plan

The annual work plan for the Health and Safety Executive has been published and has identified Work-related stress, musculoskeletal disorders and occupational lung disease as priorities for the Public Sector 2017/18.

Work-related stress

The second most commonly reported cause of occupational ill health in Great Britain, accounting for 37% of all work-related ill-health cases, and 45% of all working days lost due to ill health. (source: www.HSE.gov.uk)

Musculoskeletal disorders

The most common reported cause of occupational ill health in Great Britain, accounting for 41% of all work-related ill-health cases and 34% of all working days lost due to ill health. (source: www.HSE.gov.uk)

Occupational lung disease

It continues to lead to an estimated 12 000 deaths each year. (source: www.HSE.gov.uk).
Not currently found to be a problem for the Trust and is monitored via the Occupational Health Surveillance programme.
The aim of the HSE is to work in partnership with employers, employees and the wider health and safety community to reduce the incidence rate and number of new cases for these priority areas. (source: www.HSE.gov.uk)

Key Performance Indicators (KPIs) and Work Plan for 2017/18 have been developed and reflect the HSE work Plan. The KPIs are being monitored by the Trust Health and Safety Steering Group.

5 Staffing within Health and Safety Department

The Health and Safety Team works within the central Governance Team structure and has an appointed Health and Safety Lead. The team has expertise and manages health and safety, moving and handling and medical devices for the trust.

6 Key achievements on Work Plans for Health and Safety

6.1 The following details progress against the 2016/17 Health and Safety objectives

As a result of a gap analysis utilising the PLAN, DO, CHECK, ACT of the management of Health and Safety aspects within the Trust an action plan was developed (the action plan for 2016/17 is available on request) For ease of reporting within this annual report it has been presented in the following objectives:

Objective 1 - A Health and Safety Policy in place that's sets a clear direction for the organisation - Achieved

An overarching Health and Safety Policy is in place that reflects legislative requirement, clear roles and responsibilities and accountability for Health and Safety, this is consulted on through the HSSG and presented to Board. The Policy is supported by a suite of Health and Safety Policy arrangements the majority of which are written by the department supplemented by the Estates directorate. All Policy arrangements are consulted on through the HSSG and require dissemination through the management structure.

To assist in communication, Health and Safety Policy Arrangements written by the department have a summary sheet embedded so that staff are aware of the general principles and scope of the policies. The department maintains a Health and Safety Policy manual. Whilst the Trust has a Driving for Work Policy that scopes the general principles of staff driving for the purposes of work it was identified that a Transport Policy was required to specifically scope industrial driving for work and fleet management.

The Health and Safety department also maintains the Trust wide database of policies which are monitored for review dates and relevance.

Objective 2 - IT system for the centralisation of risk assessments - Partially achieved

The centralised system using Assure Software will give the organisation clarity and a more robust process of the undertaking, ownership and review of essential documentation. The system is cloud based with no impact on Trust servers giving managers the oversight of key health and safety risks, compliance and staff the ability of a high access system for risk assessments in their area. Implementation of the system is progressive in line with a specific schedule and progress is reported on to HSSG including deviations. The department has worked well in the roll out although further work is required to clearly detail and report updates of the implementation plan and progress to the Health and Safety Steering Group.

Objective 3 – Develop Key Performance Indicators for Health and Safety service - Partially achieved

Clear Key Performance Indicators (KPI's) were not in place explicitly in the early part of the financial year. Whilst a gap analysis on Health and Safety Management had been undertaken through health and safety audits this focussed on the resultant actions for direct intervention. There was not a clear trust wide improvement plan with demonstrable key performance indicators. These were slow to develop but progressed during the year and were reviewed by the Trust HSSG in March 2017 to move forward incorporating all aspects of Health and Safety including Security, Moving and Handling, Conflict Resolution and Moving and Handling.

Objective 4 - A robust system for the identification, evaluation and control of all Health and Safety risks – Partially achieved

The IT (Assure) system will enable a greater rigour to risk assessments in terms of quality, review, accountability and corporate history. In addition the Trust has mandated a minimum of 4 health and safety documents in each department which are examined as part of the Occupational Health and Safety Management Audits; reported on to both Division/ Directorate Health and Safety Governance leads and Trust HSSG. The department will achieve delivery of the system by the end of 2017/ 18 however during the interim the organisation does not have an effective means on monitoring whether all health and safety risks have been identified, evaluated and control effectively. The audit cycle for the workplace assessments should identify risks from non-compliance which should be linked where required to the corporate risk registers.

Risk registers are presented to divisions on a monthly basis by the Risk Department for review and action in accordance with the Risk Management Policy. Risk registers are also presented to Trust HSSG.

Clarification was sought in how the Board can be assured that health and safety is integrated into business planning processes: the Trust Health and Safety remain authorised signatories for Capex which ensures that equipment purchased by the Trust using this means is subject to risk assessment with advice. Minor Improvement forms are also sent to Health and Safety who monitor that the risk is neither transferred nor increased as a result of the works.

The department has a known 'Open Door Policy' frequently accessed by staff requiring assistance with comprehensive return to work assessments, specialist risk assessment of new clinical technology prior to purchase

A gap analysis utilising the topic inspection pack published by the Health and Safety Executive for Work Related Dermatitis was undertaken and proactive inspections on wards took place with Occupational Health department. The Occupational Health Department is now leading on the implementation of the recognition and prevention of work related Dermatitis.

The identification of risks is through the Occupational Health and Safety Management Audits as described below;

The undertaking of Occupational Health and Safety Management audits is a key component in the organisations ability to identify risks; due to the challenging year in terms of staffing within the department there were only a total of 33 audits completed (just over 50% of those required) during the fiscal year in comparison to 2015/16: 65 and 2014/ 15: 87.

There are currently 210 departments registered on the audit schedule that have had an audit completed. Whilst the department anticipates completing a minimum of 60 audits in any one year this is governed by the risk factor presented by the department: a department may be audited once in 3 years and a different department with a higher risk factor is visited 4 times. It is therefore not possible to anticipate precisely the number of audits needing to be completed as any restructure within the organisation will also vary the number of departments requiring an audit as services evolve.

Process

Elements of the Occupational Health Service Management Standards (OHSMS) relevant to the service are objectively scored against compliance criteria based on legislation and trust policy through identifying evidence within the departments.
The audit tool comprises 18 standards which are designed to examine;

- ✓ Structure and Roles/ Responsibilities
- ✓ Consultation, Communication and Reporting
- ✓ Hazard Identification, Risk Assessment and Control of Risks
- ✓ Hazardous Substances, Infectious Materials and control of waste.

All areas audited are subject to a further audit the frequency of which is currently dependent on risk rating of the preceding audit as indicated below.

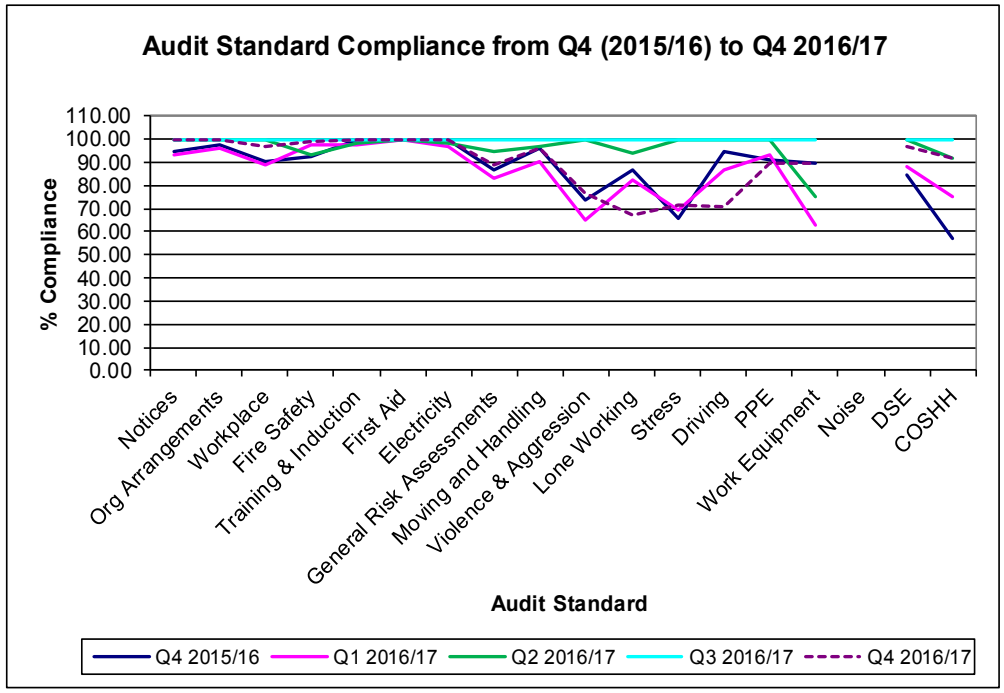
% Compliance	RISK RATING	Re audit
0-50	Very High	0 – 6 months
51-70	High	6 – 12 months
71-90	Medium	12 - 24 months
91-100	Low	24 - 36 months

Whilst there were a reduced number of audits undertaken in 2016/ 17, initial results indicated there has been an overall improvement in those areas audited. However, the standards that revealed the poorest results in audit overall were Violence and Aggression, Lone Working and Stress. Particular problems also included the lack of an adequate assessment in place for Lone Working, Violence and Aggression, Moving and Handling and the allocation of control measures. Other examples include the ability to identify a potential problem and the location of lone workers; actions to take on raising concerns. This work to ameliorate the concerns as far as reasonable and practicable is reflected in the Health and Safety work plan and HSSG KPIs for 2017/18.

Audit Standard Compliance

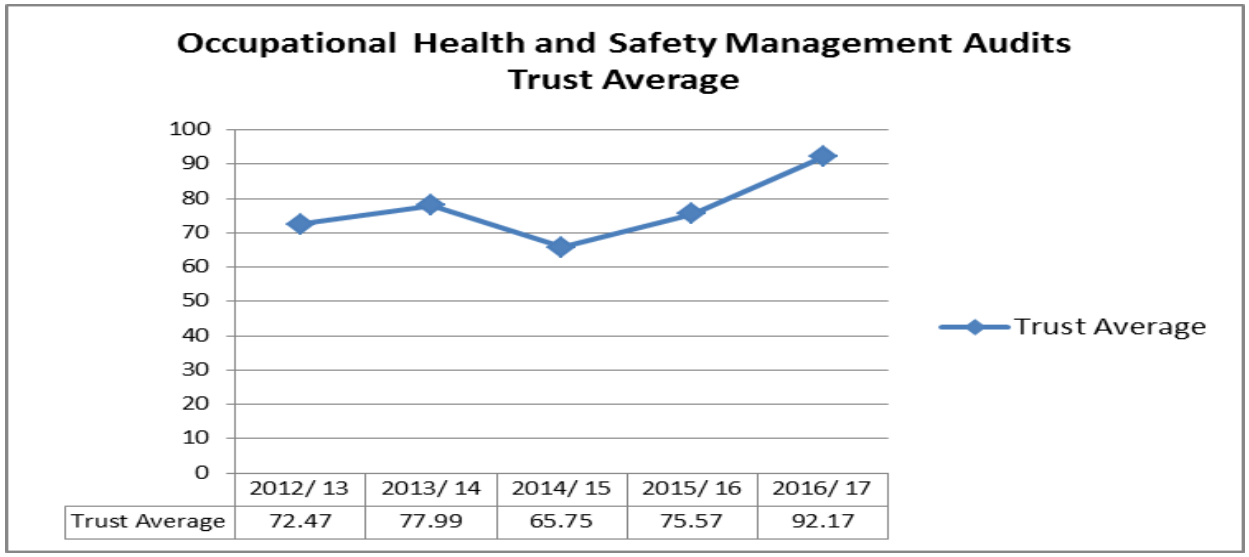
This graph indicates average results of audit across 5 quarters. Although an upward trend of improvement is indicated. There is no data against the noise requirement because it was not relevant for the areas audited.

	Audit Scores	
	Lowest	Highest
Quarter 1	42	100
Quarter 2	81	100
Quarter 3	100	100
Quarter 4	63	100



For an improvement to be sustained, systems must be fully understood and embedded in all departments regardless of the nature of service and the frequency of audit. Therefore improvement targets will continue to be set and interventions including training undertaken.

At the end of 2016/ 17 a progressive improvement was seen in organisational arrangements for the local management of health and safety including training compliance. Although quarterly results may due to the areas being audited for example lowered compliance in the completion of risk assessments around Moving and Handling and specific effective control measures around lone working there is a general overall improvement in the attitude and management of health and safety issues at a local level. Staff actively seek audits to ensure not just compliance but good visible management which is seen as an integral part of the work process.



Compliance to the audits has improved since 2012 when they were first started.

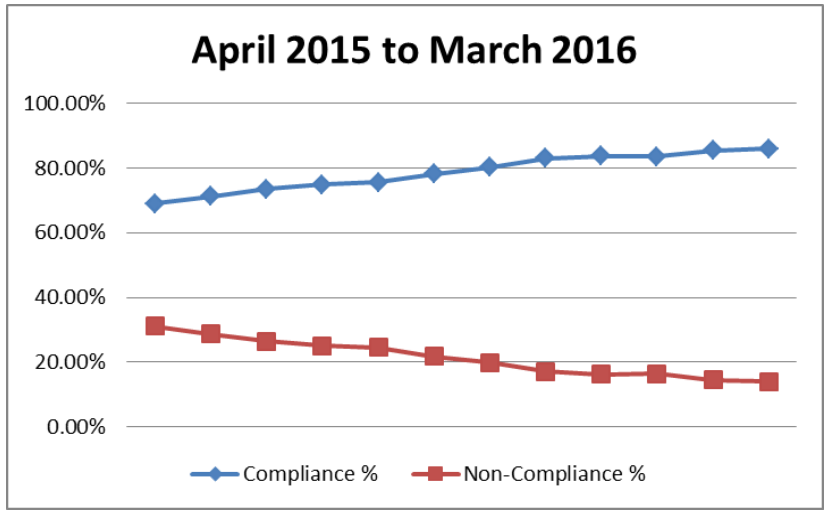
Objective 5 - Review of all Health and Safety training to determine relevance and compliance for Trust - Achieved

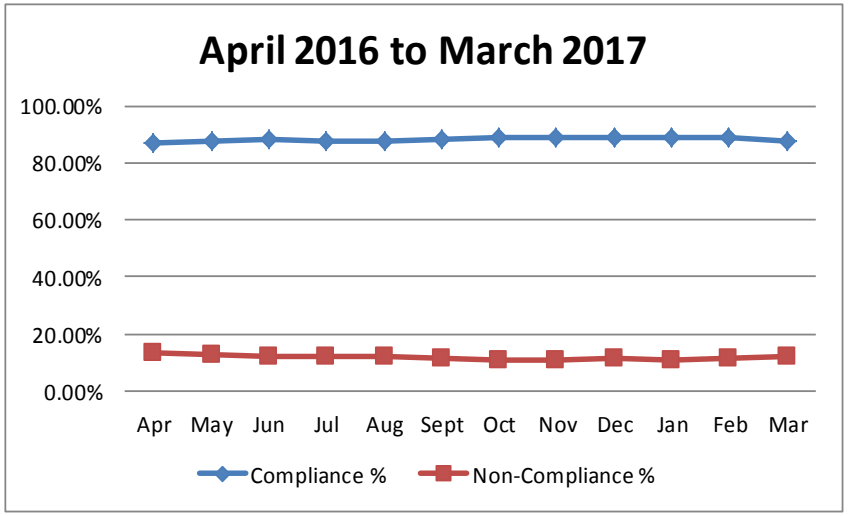
The Trust has provided multiple levels of training in Health and Safety since 2012, it is recognised that a one size fits all approach was not suitable and sufficient for a complex organisation of this size. Throughout 2016/ 17 the department concentrated on reviewing the current provision of health and safety training and determined that the 1 day Health and Safety training previously externally accredited would be brought back in-house. This enabled the department to focus content and outcome on the needs of the Trust making sure that top priorities were delivered on aspects such as Violence and Aggression, Lone Working, Driving for Work and Sharps injuries.
During this year we have re-written and improved the following in house courses plus associated refresher courses making them more reflective of our Trust and Health and Safety nationally. The aim is to embed what is being taught and inspire staff to put into use; including *class exercises and handouts:

- ✓ Level 1
- ✓ Level 2 Managers and Team Leads
- ✓ Risk Assessment

In addition the department provides risk assessment training and specific coaching in undertaking risk assessments using Assure; the Trust Health and Safety risk assessment and audit software. Courses accredited by the Institution of Occupational Safety and Health (IOSH) are also funded by the department.
Health and Safety training is mandatory for all staff regardless of role. During 1st April 2016 to 31st March 2017 a total of 84 classes were provided giving a potential of 2196 Health and Safety training places. In addition and in order to support departments who find it difficult to release staff for training or had high numbers of low compliance, we scheduled an additional 82 open training classes sessions out of normal working hours to avoid disruption to work patterns and clinical service delivery.

Trust Health and Safety Training Compliance





At end of 2016/ 17 Trust compliance was at 87.63%: low of 86.80%, high 89.15%, compared with the previous at a year-end high of 86.02%.

7 Key achievements on Work Plans for Moving and Handling

Moving and handling (M&H) impacts a patient's care and experience from admission to discharge. The Moving and Handling Team (MHT) realise that human factors has a strong relationship with staff practices, relating to avoidable accidents, pain and Musculoskeletal Disorders (MSDs) .Stress, depression or anxiety and MSDs account for just under 40% of days lost due to work-related ill health in ESHT. Higher stress levels lead to muscle tension; in turn this causes fatigue, which increases the risk of MSDs (HSE 2016).
Clinical Matrons, managers, supervisors / team leaders and staff hold responsibility for ensuring required Moving and Handling training is completed in combination with local team requirements i.e. task specific. Responsibility includes ensuring that suitable equipment is in place, with required maintenance and sufficient training has been completed with the relevant training team.

The Moving and Handling team (M&H) remain on target for delivery of its 5 year strategy presented in 2015/6. Progress made is reflected in the quarterly reports submitted to the Trust Health and Safety Steering Group (HSSG). Reduced staffing has impacted on service delivered during the last 12 months. Positive outcomes have included:

7.1 The following details progress against the 2016/17 Health and Safety objectives

Objective 1 - Comprehensive review of Moving and Handling training for competency and relevance - Achieved

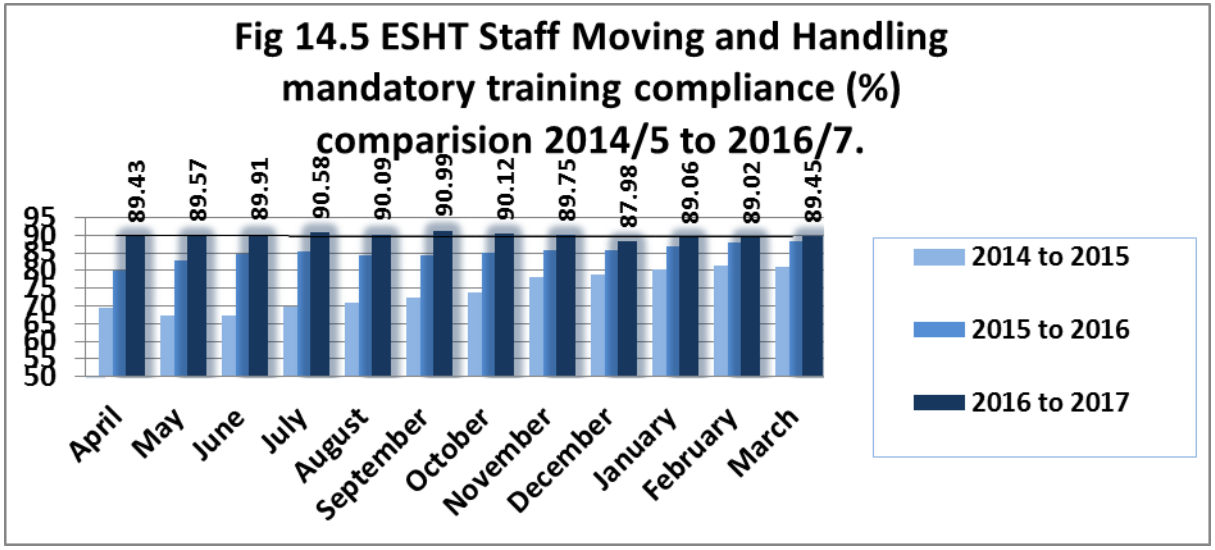
M&H refreshed all training materials to ensure relevance, lessons learnt and new equipment elements were captured and shared
M&H achieved the highest training compliance from mandatory subject training teams, receiving excellent evaluations from all sessions
Hoist and Sling competency assessed workshops were planned, delivered and well attended in the acute and community
Stretches to music was included in all training sessions, support staff health and wellbeing
A focus on level working equipment, has enabled a selection of suitable equipment to be recommended for purchase
Closer working with the Mortuary team, improving training compliance, supported their accreditation.

The Moving and Handling team are open to change and innovation. The training programme reflects Trust and staff needs and requirement. Currently this includes:

- ✓ Mandatory training on Trust Induction for all Clinical (including FY1s), Non-Clinical staff, and Volunteers
- ✓ Mandatory Clinical refresher training (as part of the Learning and Development programme, 110 days per year)
- ✓ Competency assessed Hoist and sling workshops (proactively introduced following MHRA alert)
- ✓ E-Learning (mandatory on joining the Trust)
- ✓ Annual refresher training for targeted non-clinical staff teams in the acute and community settings
- ✓ 3 yearly refresher training for low risk non-clinical staff and Volunteers
- ✓ Skill station drop in sessions (a refresh on targeted equipment, mass inductions or mandatory training)
- ✓ Bespoke sessions on request e.g. Community teams, ESHT Nurseries, Team days, Deskercises
- ✓ Bespoke Train the Trainer programmes
- ✓ Supporting relevant training events e.g. Health and Safety open days, Sussex Back Exchange events, Tissue Viability events.

Training Compliance

The Moving and Handling team achieved an end of year training compliance rate of 89.45%, a great achievement considering staffing was at 66% for Q3 and Q4. Fig 14.5 shows a compliance comparison between 2014/5 to 2016/7. Between August and November training compliance exceeded 90%. The team continued to target key areas with moving and handling concerns as well as teams with low compliance



Moving forward into 2017/ 18 the teams objectives are to:

Exceed 90% mandatory training compliance with fresh best practice materials, whilst continuing to receive excellent evaluations
Roll out a phased Moving and Handling Link Trainer programme, to include clinical and non-clinical staff
Assess and support appropriate equipment trials, reviews and introduction as needed
Plan and continue to develop consistent, effective, competency based training

Objective 2 - Deliver compliance for the provision of Bariatric Equipment and Training

It was identified in 2015/2016 that a training room large enough to accommodate bariatric equipment was required soonest. This project has been supported however due to Trust needs the identified room was required by admin staff until the Medical Records reconfiguration had been completed. This overdue work will be completed during 2017/2018. Trials of Bariatric dental and conveyance powered chairs have been completed. To move this objective forward a bid was made to Charitable Funds for the purchase of Bariatric rehab suits. The suits will be used in all clinical mandatory training sessions, and are available for use by teams in their own departments, as well as being recommended for teams supported local refurbishments.

Moving forward into 2017/ 18 the teams objectives are to:

- Develop a bariatric pathway which will include improved bariatric equipment accessibility
- Maximise opportunities to attend and attain training resources externally
- Have use of a training room which is kitted out with suitable and sufficient equipment to enable appropriate training to be delivered
- Work closer with EME, Contracts and Community equipment providers to ensure consistency in services and equipment provision

- Work closer with procurement to ensure that products purchased are best practice, are fit for purpose and financially viable.

Objective 3 - Develop direct input into patient safety and experience through engagement - Achieved

- The first Sussex Back Exchange conference being well attended and hosted at Conquest Hospital
- Articles have been published in the National Back Exchange publication, The Column
- Engagement to share the team vision i.e. HSSG, TNMAG, Site Managers away day
- The M&H patient assessment form was updated and now needs to be completed within 6 hours of admission.

Moving **forward into 2017/ 18 the teams objectives are to:**
Incorporate the ESHT 2020 vision with a focus on providing safe, compassionate and high quality care
Closer working with departments that receive patient complaints or suggestions to enable improvement in service provision
Contribute as a stakeholder with the hybrid mattress project group.

Objective 4 - Engagement with key stakeholders to reduce the incidence of Musculoskeletal Disorders

- The updated M&H patient assessment form enables staff to identify sooner services and equipment needed.
- The replacement bed programme (all electric/ profiling) has been a huge benefit for patients and staff
- Targeted department air assisted equipment trials have been completed i.e. Radiology. These have demonstrated that risks to staff and patients can be significantly reduced
- Deskercises, exercises for desk workers with music have been very well received, and are available on request
- Sit to stand desks have been added to procurement recommended purchase list, following required trials

Moving forward into 2017/18 the teams objectives are to:
Review options to improve purchase and use of air assisted equipment i.e. HoverJack
Develop closer working with suppliers in regards to support, equipment and training provision
Improving support to key stakeholder groups meetings i.e. Pressure Ulcer, End of Life
Review all M&H assessment forms to ensure they are fit for purpose and accessible.

8 Key achievements on Work Plans for Medical Device Educators

As part of developing the service, to ensure that we meet the CQC essential standards, we will be reviewing our current methodology of medical device training. This will allow us to look at what are current goals for staff compliance are and how these figures compare to the national average. In turn this will allow us to ensure we are implementing the correct level of training to the appropriate staff groups and will assist in the revalidation process for clinical staff

8.1 The following details progress against the 2016/17 Medical Devices work plan

Objective 1 - Complete Training Needs Analysis (TNA) with each clinical area and prioritise according to risk stratification and category with competencies.

The manual for the management of medical devices acts as a working document for clinical staff to follow in relation to the medical devices most commonly used in their clinical area/field. The manual must contain an inventory of all medical devices used in the department and records associated with the competence of staff in the use of the equipment.

An audit was undertaken in all clinical areas using medical devices against a checklist to determine compliance. Findings included the majority of areas had a device folder in place although quality was inconsistent. From this a further intervention was undertaken to make sure vital components were contained in the folders and current with Trust Policy.
This work will continue for the future across the Trust to provide assurance that this standard is compliant.

As result of the audit of Medical Device manuals further work was undertaken to categorise devices in terms of clinical risk to inform the competency requirements for the area and a resultant Training Needs Analysis (TNA). Each individual department has a specific TNA according to the devices and the activity/ discipline of the department.
Retention of TNA's will be part of the objectives for 2017/ 18 to ensure a corporate history.
A full inventory of medical devices is retained by Medical Device Educators categorised according to risk to ensure this work ties with Electrical Mechanical Engineering (EME) department and information is consistent in term of risk category and both departmental and Trust inventory.
As part of developing the service, to ensure that we meet the CQC essential standards, we will be reviewing our current methodology of medical device training. This will allow us to look at what are current goals for staff compliance are and how these figures compare to the national average. In turn this will allow us to ensure we are implementing the correct level of training to the appropriate staff groups and will assist in the revalidation process for clinical staff. Through this objective, relationships and consolidation has been established with community areas

Objective 2 - Provision of mandatory training for Infusion and Oxygen delivery devices for all clinical staff – Partially achieved

The role of the Medical Device Educators team is to provide essential training and support to front line clinical staff in the safe use of medical equipment. To ensure that staff are competent to use equipment and investigate and monitor areas of risk. We work closely with EME, finance and procurement to ensure that equipment is fit for purpose and meets relevant clinical specifications.

National Infusion Devices standards require current and relevant policies, procedures or guidance, auditable competency based training. Training content must be annually reviewed making sure that these are current, evidenced based and best practice.

Infusion Devices are classed as a high risk Medical Device by the Medical Devices Regulatory Agency (MHRA). Devices used in the delivery of Oxygen are also an area of risk as indicated in the Nursing and Midwifery Council (NMC): Fitness to Practice 1999.

A programme was compiled for competencies by staff in the use of the devices with initial training delivered via face to face sessions across the two acute sites on a monthly basis. Training is mandatory for nursing and allied healthcare professionals (AHP's). Competencies are valid for three years before requiring an update: staff may use this training as part of NMC revalidation.
Through this objective, relationships and consolidation have been established with community areas. We currently provide medical device training in two main ways. Pre booked classroom based sessions and ad hoc ward based training.

The figures give an overall average of training compliance for the medical devices included in the mandatory training sessions.
At the time the data was collected for the full financial year 2016/17 (source: Electronic Staff Record July 2017) there were several areas that had staff who had recently become out of date but were booked on upcoming sessions. For this reason figures are slightly lower than expected. We will look at addressing this in our forward looking plan with planned discussions with the Trust workforce and ESR leads so the accuracy of the data can reflect the training provided.

These figures do not include the Healthcare Assistant (HCA) training for oxygen (O2) devices

Eastbourne DGH	Conquest Hospital
Alaris pumps 50% Baxter pumps 54% O2 (Qualified staff) 51% McKinley syringe drivers 66%	Alaris pumps 54% Baxter pumps 57% O2 (Qualified staff) 51% McKinley syringe drivers 60%

Objective 3 - Support clinical areas with risk reduction in relation to the use of Medical Devices – Partially achieved

Multiple objectives of the Medical Devices 2016/ 17 programme of work implicitly link to risk reduction. During 2016/ 17 an incident triage system and central email was developed ensuring that all incidents involving a medical device were effectively triaged. Reporters of incidents are required to input specific information into the Datix incident reporting system so that batch and serial numbers are identified quickly and either recalled or reviewed. Automatic notification is prompted by an incident involving medical devices.
The team work across sites so they are responsive and review the device in line with competencies, training levels and determine whether further development is required.
The Health and Safety Lead also has the role of Medical Device Safety Officer receiving information on Alerts issued by the MHRA copying Medical Device Educators into equipment/ system alerts. As part of the Health and Safety department, Medical Devices Educators attend meetings to advise on the procurement of new or replacement devices and assist in specific risk assessments as needed.
Through this objective, relationships and consolidation has been established with community areas and link educators for medical devices.

Objective 3 - Demonstrate compliance with National Infusion Device Standards - Achieved

National Infusion Devices standards require current and relevant policies, procedures or guidance, auditable competency based training. Training content must be annually reviewed making sure that these are current, evidenced based and best practice.
This objective has been partially addressed by those previously indicated:
Policies with associated procedures or guidance are maintained centrally and reviewed
Competencies are maintained centrally of all staff completed Infusion Device training
Training is reviewed annually as part of a peer review, lesson plans and previous competencies along with learning materials are maintained electronically so the Trust has a corporate history

Medical Device Educators 2017/18 Work Plan

As part of the review process the service has taken forward 2016/17 work plan into 2017/18 and will continue to develop and embed:

- ✓ Clinical risk categories for medical devices
- ✓ Audit and review of Medical Device Manuals to ensure inventory, competencies and training records are accurate
- ✓ Implementation of medical device link trainers (ward based) currently set up at Conquest.
- ✓ Review of Electronic Staff Record systems in relation to recording medical device competencies
- ✓ Review of current competency paperwork and compliance time frame
- ✓ Ensuring that training material/sessions are mirrored on all sites of ESHC to ensure a uniformed approach to training
- ✓ Development of the medical device web page on the intranet.
- ✓ Processes for monitoring quantitative data are established
- ✓ Develop mattress service at EDGH and community in-patient sites
- ✓ Work towards replacement mattress programme i.e. hybrid mattress Trust wide

9 Care and management of static and pressure relieving mattresses

In March 2017 the Trust employed their first Mattress Technician post to manage the Trust mattress service. The main purpose for this role being developed is to provide an efficient and effective access to mattresses (static and pressure relieving) across the in-patient facilities within the Trust. The role of mattress technician works collaboratively with other departments e.g. Procurement, Infection Control, Tissue Viability, General Porters, Ward Matrons, trained ward staff, orderlies and Healthcare Assistants (HCAs).

10 Incident Reporting data

10.1 Introduction

This section gives the number of health and safety related incidents and also describes the nature of incidents that occurred in East Sussex Healthcare Trust between 1st April 2016 and March 31st 2017 to staff and others. Full reports are given by departments responsible for

leading on the implementation of their subject matter; Moving and Handling, Occupational Health, Security, Waste, Infection Control (Sharps incidents) and Fire.

Patient Safety incidents are reported to the Patient Safety and Quality Group however, where patient incidents are defined as reportable to the Health and Safety Executive within the context of RIDDOR; these are also reported to the Health and Safety Steering Group.

A restructure took place in the middle of the financial year therefore it has not been possible to fully align those incidents that occurred in quarters 1 and 2 with the new structure. However incidents are compared across the Trust.

Information on incidents were extracted from Datixweb on 1st June 2017 and is based on the actual date of incident to enable trends analysis

10.2 Classification of Severity

The Trusts Incident Reporting Policy and the Risk Management Policy reference the National Patient Safety Agency (NPSA) risk matrix for consistency. The matrices identified in both policies are used for grading incidents in terms of severity and the potential for recurrence.

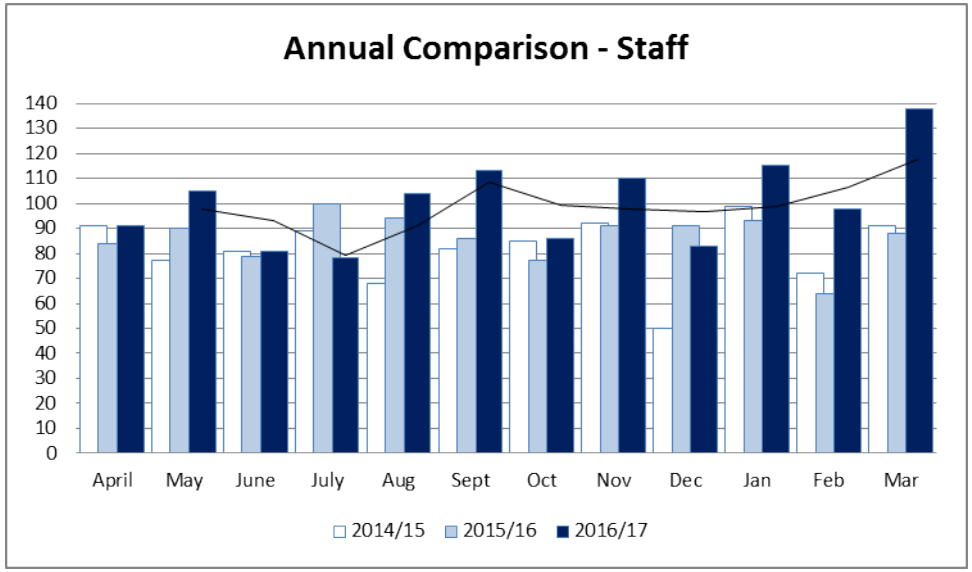
10.3 Annual Comparison

The graph and table below represents the incidents reported by month for the full calendar year relating to staff and others.

The graph on the following page indicates a month on month trend compared with the previous year. The average monthly incident figure for 2014/15 was 81.42 increasing in 2015/ 16 to 86.42 and further to 100.17 in 2016/ 17.

Whilst there has been a 15% increase in incidents reported this year from 2015/ 16 however it must be noted that the NHS Staff Survey 2016 indicates an increase in the number of staff reporting incidents (KF29) whilst KF28 states the level of staff witnessing incidents, errors and near misses stayed the same. This appears to be indicative of a strengthening of a reporting culture enabling lessons to be learned from those incidents reported and also influenced by (KF30) a more positive perception in terms of staff treatment when reporting incidents, errors and near misses.

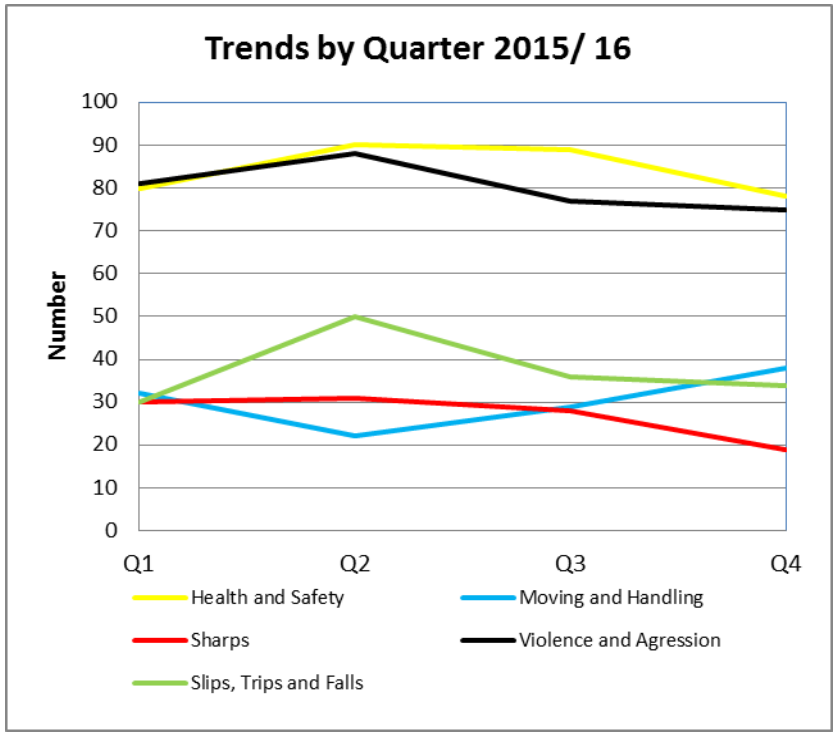
The survey is sent to staff in September 2016 and the results published in February 2017.

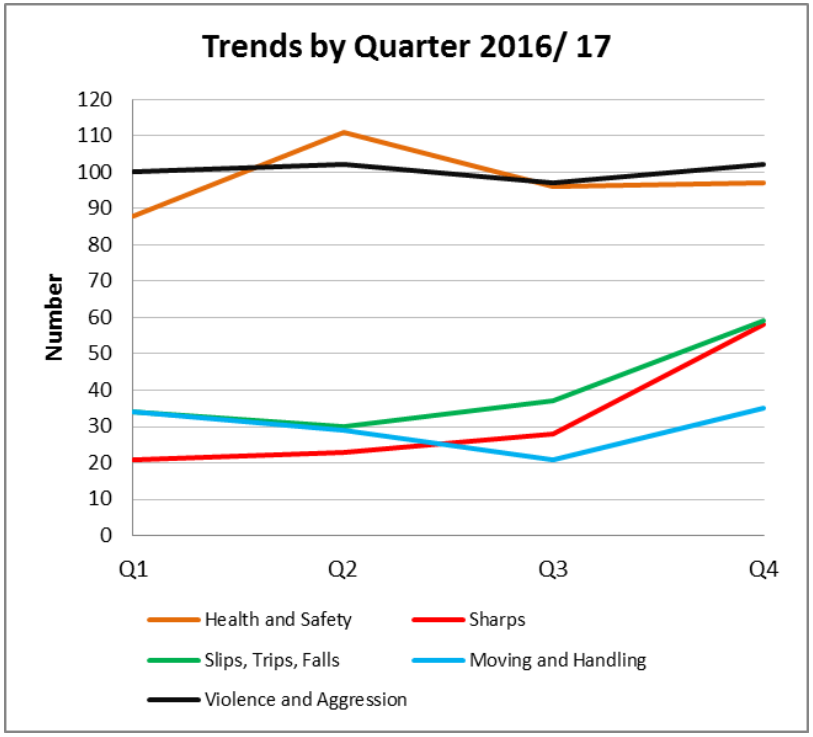


Since 2014/ 15 incidents in community areas (not hospitals) have increased by 23.4 %, Incidents reported have also increased at Eastbourne and Conquest Hospital by 27.3% and 38.3% respectively. Analysis of the incident spikes has not revealed any trends in terms of incident trends.

Staff Incidents	2014/ 15	2015/ 16	2016/ 17
Totals	977	1037	1202
Monthly Average	81.42	86.42	100.17
% Increase/ Decrease	3.17	6.14	15.91

10.4 Incident trends by Quarter





Sharps

Since the implementation of the Sharps Directive 2013 into UK legislation requiring the use of safer sharps where practicable the Trust experienced a general reduction in the number of injuries involving needle stick injuries for the first 2 years.

There has been a 20% increase in incidents on last year and of 130 sharps incidents this year, 68 resulted in an injury from a sharp contaminated with blood or bodily fluid. 14 injuries were received by staff not involved in the clinical procedure 11 of which were at Conquest. A further 22 incidents involved dirty sharps being found where the end user had either left blades exposed or left the sharps in open containers.

During initial implementation of the Sharps Directive a trend was identified regarding incidents due to issues with safety catches although this is not currently reported as a problem as safety devices manufactured have developed. The trend in healthcare nationally was noted to have extreme effect: either increasing incidents or a very definitive drop in incidents.

Analysis indicates that approximately 70% of 2016/ 17 incidents could have been avoided by following good standard clinical and waste disposal procedures. As incidents are triaged by the Health and Safety Department are responded to appropriately; including immediate follow up phone calls where a contaminated sharp was involved to make sure the staff member had the correct treatment and identify causal factors for further action.

Slips Trips or Falls – including Falls from Height

This type of incident has increased very slightly over the last three years by 5%. An analysis of incidents revealed that the Shattered Lives campaign continues to be effective with the causation of incidents less likely to be as the result of wet or contaminated floors.

There were several incidents of staff slipping on ice in Trust car parks (Q4) one of which resulted in a RIDDOR event and Estates were asked to review the gritting procedure.

Storage of articles and management of cables in areas where space is restricted is problematic in some areas. Areas are physically reviewed with recommendations made the Trust has also held ‘Dump the Junk’ weeks.

Moving and Handling

Reported incidents have decreased by 1% since 2015/ 16. There is a decrease throughout 2016/ 17 in clinical staff Moving and Handling incidents by severity. It is likely that a contributing factor is attributable to the purchase of 256 profiling beds in Quarter 3. The result of this action is that staff have reduced risks in supporting patient manoeuvres and patients have control of bed functions with their own handset i.e. height adjustment, cardiac chair, light under-bed etc.

Staff Moving and Handling incidents have continued to reduce incidents compared to the previous two years. Contributing factors may include recognised improvements in training content and delivery as evidenced in Learning and Development and training evaluations.

The only area with an increase is EDGH. The identified issues include: non-clinical – handling of heavy medical records, scanning of medical records, linen distribution continues to affect the Laundry Team – a review of activities are planned to be undertaken by the Moving and Handling Team. Clinical – patient mobility and transfers on commodes (a solution proposed are wards to have appropriate transport chairs); an increase in air assisted equipment Trust wides, including falls equipment (a solution under discussion currently for 2017/18 is more accessible equipment for all areas).

The overall findings from the moving and handling incidents show no serious areas of concern. Further improvements have been identified and will be a focus in 2017/18 team work plan.

Health and Safety

Health and safety related incidents have increased significantly (16%) from last year across the range of subcategories. Concerning is the general number of incidents in community service areas including 11 road traffic accidents and 4 dog bites.

Violence and Aggression

Reported incidents falling within this category indicate a sustained upward trend in terms of number of incidents including the number of intentional physical assaults.

- 2014/ 15 identified a total of 264 incidents including 63 intentional physical assaults and 51 clinical incidents.
- 2015/ 16 a total of 321 incidents occurred including 85 intentional physical assaults and 48 clinical incidents
- 2016/ 17 indicated that staff reported 401 incidents; 95 intentional physical assault and 59 categorised as clinical incidents.

More detail can be found in the Trust Security Team Annual Report. The Trust does actively encourage incident reporting with the key message that unless incidents including near misses are reported the Trust is unable to identify accurate priorities. The Health and Safety Department are further engaging via open workshops across the county, Health and Safety 'surgeries' and Conflict Resolution/ Personal Safety training to ensure that rich data can be obtained from staff to learn from events and identify potential solutions. In addition, the Security department relaunched their existing Violence and Aggression Policy.

10.5 Incidents by Severity

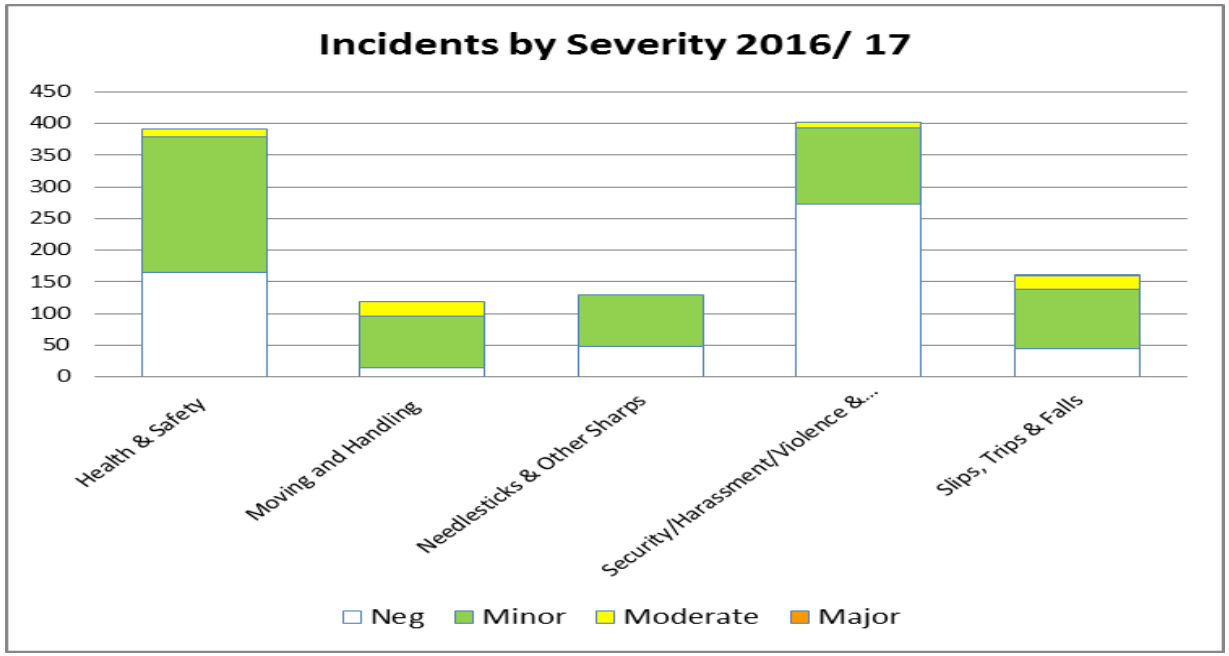
There were a total of 65 moderate rated incidents reported:

13 categorised as health and safety incidents including an accumulative work injury of which 4 resulted in a RIDDOR event: absence in excess of 7 days. These incidents have been followed up within the divisions and the respective departments. Lessons learned included a redesign of process to negate further risk, conversations with staff to ensure that user checks take place on equipment prior to use and staff make managers aware of any health conditions that may impact on their ability to act in the full scope of their role.

24 incidents were categorised as moving and handling 13 of which resulted in absence to staff in excess of 7 days and a subsequent RIDDOR report. 5 incidents involved patient handling activities including the use of hoists and injuries caused by staff compensating for unexpected patient movements. Work load and staffing places a lot of strain on community staff where further incidents occurred and staff are encouraged by their managers to take full breaks which allows for muscle recovery.

8 incidents categorised as the result of violence and aggression was reported. Whilst none of these resulted in a RIDDOR 5 clinical incidents resulted in harm to staff as a result of the patients clinical condition such as diabetes, dementia and recovery from anaesthesia. 2 incidents were stated to be intentional and aggressive patient where security attended and a fight between contractors on site; this matter has been referred to the police.

20 incidents as the result of a slip, trip or fall including falls from height occurred 2016/ 17; 11 required a RIDDOR report. There were 4 fractures: a community staff member tripped whilst carrying equipment to a patient's home. A member of the public was on Trust property when they diverted from the path and fell. A member of staff also caught their shoe lace on the brake of a trolley who then went on to require surgery. RIDDOR incidents are further discussed in section 10.



10.6 RIDDOR events

The Reporting of Incidents Disease and Dangerous Occurrences Regulations (RIDDOR) (as amended) 2013 requires the Trust to report certain categories of incidents to the Health and Safety Executive.

The update to the Regulations amended the requirement for incidents involving an absence of 3 days or more to 7 days or more however, the Regulations stipulate that those incidents falling into the category of 'over 3 days' must be formally recorded by all organisations. In 2016/ 17 the Trust was unable to effectively record all absences incurring 3 days absence or more as the result of a work related accident. This was previously indicated as a risk for the Trust and is coloured yellow in the table below. This will be taken forward again into 2017/ 18 as a priority to resolve.

Across the full year, a total of a total of 47 staff incidents defined within the RIDDOR Regulations were reported to the Health and Safety Executive: there were no patient RIDDOR events.

	Health and Safety	Moving and Handling	Sharps	Violence/ Aggression	Slips Trips and Falls	Total
Over 7 day	11	15	0	3	14	43
Specified Injury					4	4
Fatality						0
Dangerous Occurrence						0
Disease						0

Over 7 day Incidents
Health and Safety: 2 road traffic collisions in Community, 3 involving the transfer of goods and equipment (Moving and Handling) and a further caused by a burn.
Moving and handling incidents reported 24 including 12 patient moving activities; 2 of which were working alone with non-compliant patients
Security; 2 intentional and 2 non-intentional physical assaults
Causes of trips were not always identifiable; in 4 cases there was no direct cause observed or reported and it is observed that these may have been the result of a pre-existing health condition. 2 incidents occurred in car parks, trailing wires resulting in falls on floors, down steps or stairways. There was 1 slip on a wet floor.

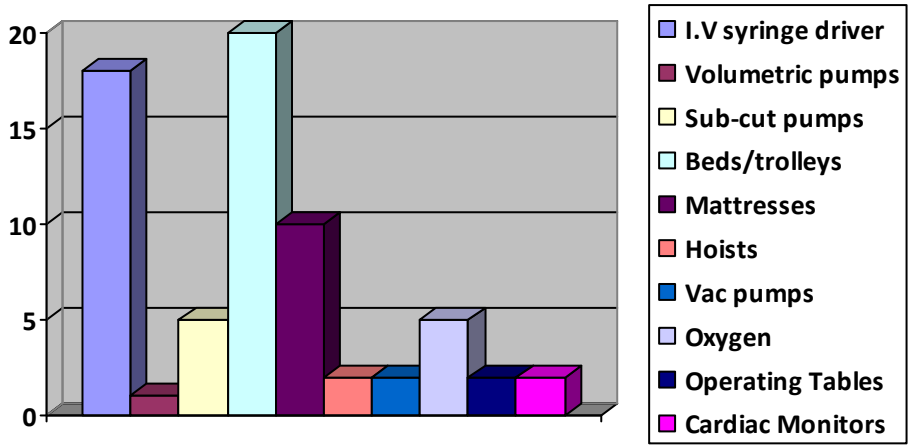
Specified Injuries
There were 4 incidents all as the result of a slip, trip or a fall from height.
A health visitor fell whilst working in the community resulting in a fracture and a further member of staff caught their foot on an obstacle. Two members of the public uninvolved with a work process at the time of the incident also suffer fractures as a result of falls.

10.7 Medical device incidents

Data from Datix shows that there were a total of 307 reported incidents classified in the category of medical devices. A large percentage of these incidents have been eliminated from this report as they were not medical device incidents. Examples include staff walking into shelves, sinks not working, fridges/freezers not working, telephone systems and bleeps and I.T software issues. Incidents relating to surgical instrumentation/equipment and Point of Care Devices were also not included in the report.

There were 67 relevant medical device incidents which have been divided into device type:

I.V syringe driver	18
Volumetric pumps	1
Sub-cut pumps	5
Beds/trolleys	20
Mattresses	10
Hoists	2
Vac pumps	2
Oxygen	5
Operating Tables	2
Cardiac Monitors	2
	67



After analysis of the incidents there were some key actions implemented:

Broken beds: the majority of broken beds reported involved broken knuckle joints on the safety rails (cot side). This was due to a combination of factors. Firstly inappropriate use of safety rails to steer the beds around corners. Secondly the knuckle joints involved were made from an inferior plastic which has been recognised by the manufacturer.

Actions taken:
1). Porter service has been updated on the correct steering/ transportation of beds. Beds to be steered from the foot end and safety sides are not to be used to pull the bed around corners.
2).Replacement products have been organised across all relevant beds for the cot sides by the EME department.

Mattresses: Incidents included breeched mattresses and unavailability of pressure relieving mattresses when required by clinical services.

Action taken:
The process for dealing with breeched mattresses is now being monitored and maintained by our new Mattress Technician, although this is predominantly at Conquest Hospital at the moment with EDGH to follow shortly.
The EME Equipment Librarians are monitoring the use of pressure relieving mattresses with the Tissue Viability Nurses (TVNs) in ensuring mattresses are returned to the library when not required.

Intravenous Venous (IV) pumps and Driver: the incidents include staff being unfamiliar with the use of the pumps and incidents of extravasation.
Action taken: The MDT has increased the amount of training sessions on the I.V pumps and has moved towards standardisation of pumps across the Trust to reduce unfamiliarity.
All Extravasation incidents have been handed over to the I.V team to investigate.

11 Claims

The Trust legal department have identified that the number of claims are quite low and that there is nothing in relation to trending to show except to say that slips/trips/falls remains the category for the largest number of the Trust's non-clinical claims.

Whilst the number of claims received is stated to be low, it is of concern to the Health and Safety department that a loss has occurred due to potential failings: 14 of 15 non-clinical claims were successful and attributed to health and safety related issues. These claims are those that are paid out in the fiscal year yet may have occurred up to 3 years prior to the injury becoming known.

Whilst a separate report is available from the Legal Services department, further information is not given in this report due to the potential ability to identify those concerned in accordance with Data Protection, brief details are offered below:

- 2 members of staff suffered injury when they were struck by a falling object
- 1 member of staff claimed repetitive strain injury (RSI)
- 2 members of staff received moving and handling injuries
- 2 members of staff slipped on contaminants on the floor
- I member of staff was assaulted
- I member of staff suffered an electric shock
- 4 staff tripped over cables or obstacles
- 1 member of staff claimed for lack of personal protective equipment

Objectives for the Health and Safety department 2017/18 will include the development of a specific incident reporting template encouraging immediate remedial measures as far as is reasonably practicable, identifying lessons and mitigating the potential of recurrence.

12 2017/18 Work Plan

The following are the main areas the H&S Team and H&S Steering Group are working towards in the financial year;

- To establish that the planning and implementation of services including redesign have considered and mitigated risks to the Health and Safety of staff and others who may be affected;
- To roll out the Assure system to all areas of the Trust by March 2018 (include compliance to Control of substances hazardous to health (COSHH), lone working and Display Screen Equipment assessments);
- For risk assessments are recorded, monitored and managed on the Assure system;
- To reduce incidence and severity of Violence and Aggression;
- To provide an active and valid Health and Safety policy;
- To identify and manage the risk of Medical Devices (ensure each department has a clear list of devices used and completed record of staff familiarised in these – compliance figures for the organisation);
- Management of the Central Alert System;
- To support the active management of stress;
- To ensure the core requirements outlined by the Health and Safety Executive (HSE) for 2017/18 are managed appropriately (reduce and monitor Work-related stress, musculoskeletal disorders and occupational lung disease).

Compiled by and completed by:

Nicky Creasey, Trust Lead Health and Safety, Jennifer Newbury, Deputy Trust Lead Health and Safety
Susanna Marsden, Specialist Practitioner Lead Advisor Moving and Handling
Wayne Parsons, Medical Devices Educator, Bernadette Monaghan, Medical Device Educator

Annual Review of Governing Documents

Meeting information:			
Date of Meeting:	28 November 2017	Agenda Item:	18
Meeting:	Trust Board	Reporting Officer:	Lynette Wells, Director of Corporate Affairs

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

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

Executive Summary:

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

It is best practice to undertake an annual review of the Trust governing documents: A review has been undertaken of the Standing Orders, Scheme of Delegation and Standing Financial Instructions

- Standing Orders cover all aspects of the conduct of the Trust, including governance, committees and their duties and responsibilities.
- The Scheme of Delegation lays down in detail the specifics of committee responsibilities and duties together with that of the executive and the officers to which delegated authority has been designated.
- The Standing Financial Instructions detail the financial conduct and governance of the Trust and requirements therein.

Revisions to Standing Orders are attached; the other two documents have been reviewed and remain fit for purpose with no revisions.

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

Audit Committee 22 November 2017

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

The Board is requested to note that a review has been undertaken and approve the revisions to the Standing Orders.

Appendix A

Annual Review of Corporate Documents

Page Number	Point	Revision to **STANDING ORDERS**
13	3.5	**Revision of Chief Executive to Company Secretary** **Notices of Motion** 3.5.1 Subject to the provision of Standing Orders 3.7 and 3.8, a member of the Board wishing to move a motion shall send a written notice to the **Company Secretary** who will ensure that it is brought to the immediate attention of the Chairman. 3.5.2 The notice shall be delivered at least 5 clear days before the meeting. **The Company Secretary** shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not present any motion being withdrawn or moved without notice on any business mentions on the agenda for the meeting.
27	7.3.3	**Removal of typo under (i) did state:** [name] Trust ("the Trust"),, **Waiver of Standing Orders made by the Secretary of State for Health** (3) Application of waiver A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest. It will apply to: (i) A member **of the Trust,** who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of
22 28	6.2 7.4.1	**Specific Legislation, Policy and Guidance and Trust Policy and National Guidance** Revision to recognise any subsequent revisions to legislation and policy. Addition of: **and any amendment thereto:**

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Wednesday 26th July 2017 at 11.00am in Committee Room, Conquest

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

In attendance
Mr Dan Bourdon, Deputy Director of Finance
Ms Janine Combrink, Director, BDO
Mr Stephen Hoaen, Head of Financial Services
Mr Chris Hodgson, Associate Director, Estates (item 041/17)
Mr Tim Leakey, Divisional Governance DAS Division (item 040/17)
Mr Chris Lovegrove, Counterfraud Manager, TIAA
Mr Adrian Mills, Audit Manager, TIAA
Mrs Emma Moore, Clinical Effectiveness Lead (item 044/17)
Mr Damien Paton , ESHT Digital Services
Mr Jonathan Reid, Director of Finance
Mr Mike Townsend, Regional Managing Director, TIAA
Mr Darren Wells, Director Grant Thornton
Mrs Lynette Wells, Director of Corporate Affairs

Action

035/17 Welcome and Apologies for Absence

Mr Stevens opened the meeting and introductions were made.

Apologies for absence were received from:

Mrs Sue Bernhauser, Non-Executive Director
Dr David Walker, Medical Director
Ms Sharon Gardener-Blatch, Deputy Head of Nursing

036/17 Minutes of the meeting held on 31st May 2017

i) Janine Combrink had some minor revisions to auditors section and would forward these to Peter Palmer. Subject to these amendments the minutes of the meeting held on 31st May 2017 were reviewed and approved as an accurate record.

ii) Matters Arising

National Adult Diabetes Audit
A paper was received updating on the issues with the Trust's participation in the National Diabetes Audit. Mr James Wilkinson provided additional information via email that the issue with sourcing a cost effective solution to complying with the National Diabetes Audit had finally been resolved and

additional resource funded. A partial audit return had been agreed with the National team and a submission made on 27th June and a full submission will be made in 2018. The Committee recorded their thanks to Imran Yunus (Service Manager Diabetes & Endocrinology) for finding and implementing the alternative solution.

Pharmaceutical Write Offs
Mr Hoaen had contacted neighbouring Trusts but received a limited response. It was noted that NHS Benchmarking would be producing data in October.

Declarations of Interest
Mrs Wells updated that Mr Zaidi had written to individuals who had been identified as not completing a declaration by auditors. A number of declarations had subsequently been received. Declaration requirements have changed and it is now a requirement to declare all private practice. Mrs Wells advised the Trust's new electronic declarations system, MSE Declare, would be launching shortly and would automatically chase and record declarations for all members of staff who are Band 7 and above – more than 1,600 – who would be contacted to make declarations this year.

Cybersecurity Update
A paper was received that provided assurance that ESHT Digital teams are effectively managing Cyber Security and addressing risks and issues. A Cybersecurity Group exists for Sussex which the Trust participated in. The Committee supported the actions outlined in the paper. A more detailed programme of work would be presented to the Committee at the next meeting. Mr Reid would check that Cybersecurity was on the department's risk register. **JR**

038/17 Board Assurance Framework and High Level Risk Register
Mrs Wells presented the BAF and it was noted that this had been reviewed at the Quality and Safety Committee and Trust Board. Revisions were noted.

The high level risk register was received and the covering sheet outlined changes and challenges by the central risk team. Mrs Wells commented that she had greater assurance about the robustness of the Trust's risk management processes.

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.

039/17 Risk Appetite
Following the Board Seminar on 21 June it was agreed that each Board sub-committee would review the draft risk appetite proposals in respect of the areas within their remit. This will then be amalgamated for submission and agreement at the Board.

The Committee considered that the financial and compliance risk appetite should be 'cautious' and Estates 'open'. Members were asked to review

the schedule with risk appetite mapping to the ESHT 2020 objectives and contact Mrs Wells with their thoughts. **ALL**

040/17 Diagnostics and Surgery Clinical Audit & Risk Register

Mr Leakey presented two reports and advised all national audits were underway and there was full compliance with NCEPOD.

The Division had 48 open risks. The highest rated at 20 related to histopathology vacancies. Mr Reid advised there is some dialogue with Frontier Pathology about histopathology.

Mr Leakey advised Diabetic Screening IT issues would be escalated to a 20. This was due to ESHT digital set up and impacted the ability to record patient details following screening. Damien Paton agreed to follow up.

DP

041/17 Fire Safety Annual Report

Mr Hodgson advised the Annual Report followed guidance and provided assurance of controls in place in respect of fire compliance. He highlighted the implications to fire safety following the Grenfell Tower disaster. However, it was noted the Trust does not have high rise, cladded buildings.

He drew attention to the issues with fire compartmentation at Eastbourne DGH. East Sussex Fire and Rescue had visited and were planning to visit again and would be likely to advise that Phase 1 compartmentation at DGH should be expedited. This would require additional funding in the region of £1million and have an operational impact due to the need to decant wards. Scoring had been increased on the risk register.

A desk top exercise was being planned to test the adequacy of the fire evacuation.

The Committee noted the report and the compartmentation requirements at DGH. It endorsed the escalation of actions and an update would be presented to the Committee at the next meeting.

042/17 Research & Development Annual Report Strategy

The Committee noted the R&D Annual Report which highlighted enhanced engagement with research activity and the R&D Steering Group. Risks were acknowledge due to reduced funding allocation from CRN KSS and that commercially sponsored research studies overall to fund shortfalls in core funding was planned. The report would be presented to the Trust Board

043/17 Digital Strategy

A progress update had been provided to a previous meeting. Mr Reid advised that the strategy was nearing completion and would be presented to the Trust Board.

044/17 Clinical Audit Update

Mrs Moore reported that the Clinical Audit Awards Seminar had taken place and was a positive event.

The 7 day service audit opens in September and clinical engagement is key to completing this. Mrs Moore had contacted divisions to identify leads and it was agreed Dr Walker should raise engagement with DAS, Medicine and A&E. Mrs Moore would send a note to Mr Stevens and he would pass it on to Dr Walker. **EM/MS**

045/17 Internal Audit Progress Report

Mr Mills updated that there had been six final audit reports issued. Two give "Limited" assurance, one "Reasonable" assurance and the remaining two were operational reviews not carrying an opinion and one was a follow-up report.

"Limited" assurance reports related to data quality audits reported since the last meeting. These related to Mixed Sex Accommodation Breaches and the A&E four hour trajectory. These were reviewed and it was noted actions were being implemented.

Mr Reid would check with Mrs Chadwick-Bell whether the tolerance levels for recording breaches in A&E had been reviewed with NHS England. **JC-B**

In response to a question from Mr Stevens, it was noted an audit on clinical coding would be commissioned.

Internal audit plans were reviewed and the good progress on delivering the current year plan noted. Audit of stock locations and consumption and the risks associated with this were discussed. The results of an audit were pending.

The Audit Tracker was reviewed and 59 actions recommended for closure, 41 were due and 53 not due. Mr Stevens commended the team on the robust process.

The Audit Committee received assurances from the reports issued, noted progress against the approved plan and reviewed the briefing updates provided.

046/17 Local Counter Fraud Service Progress Report

It was noted that NHS Protect would be undertaking an inspection for counter fraud at the Trust on 5th and 6th September. The Committee would receive a copy of the inspection report.

Mr Lovegrove updated on a new referral regarding missing money. Informal interviews had taken place and there would be some recommendations following the review.

He highlighted that counter fraud were still seeking clarification as to whether the missing Declarations of Interest were as a result of a training need or intentionally not completed. **PP**

047/17 External Audit Progress Report

Quality Account
Mrs Combrink advised on the results of the auditors limited assurance review of the Trust's Quality Account. The content and consistency of the report were good and any minor issues addressed. However, the statement was qualified for the indicator reporting the percentage of admitted patients risk-assessed for Venous Thromboembolism as auditors were unable to conclude that it met two of the six dimensions of data quality for validity and completeness.

The assurance report was circulated to Audit Committee members on 29 June 2017, before the limited assurance statement was issued on 30 June 2017. The Quality Account was uploaded to NHS Choices by 30 June deadline.

Annual Accounts
The Annual Accounts were submitted on the required day but exceeded the DH 5pm deadline. The Annual Audit Letter was produced and summarised the 16/17 audit year. This would be noted at the AGM and uploaded on to the Trust's website.

Mr Stevens commented there was learning from the audit, particularly in reaching earlier agreement with the CCG.

The Charitable Funds audit was being organised.

The Committee thanked Mrs Combrink and bdo for their work.

The Audit Committee approved the Annual Audit Letter for publication on the Trust's website and submission to PSAA.

048/17 Information Governance

i) Toolkit Report & Registration Authority Report

The Committee received the report which encompassed:

- Summary of Information Goverance incidents for 2017/18
- Information Governance Toolkit requirements for 2017/18
- Progress towards compliance with incoming General Data Protection Regulation (GDPR)
- Progress being made by the Registration Authority team

NHS Digital had issued v14.1 of the toolkit and there were no changes to any of the requirements. However, a new toolkit for the following year would be issued and include the requirements of the Caldicott3 Report and the GDPR. Unlike in previous years, for 2017/18 there was no requirement to make a benchmark submission at 31st July.

Mrs Wells advised that the Trust had a good incident reporting culture. The ICO had been contacted regarding one incident involving misfiled patient records identified following a subject access request. This was a single

incident but misfiling in notes was a concern, reminders were sent to staff and the move to electronic documents would reduce the risk.

ii) **Information Governance Annual report**
It had been a productive year for IG and the auditor's "Substantial" assurance for the IG Toolkit was a significant achievement.

Additional resource had been identified to support the IG lead as increasing IG requirements such as the privacy officer role and compliance with the GDPR would require greater support.

The Committee reviewed and approved the annual report noting this would be uploaded as evidence to the IGT

049/17 **Date of Next Meeting**

The next meeting of the Audit Committee would be held on:
Wednesday 20th September 2017 at 1000 in Committee Room, Conquest.

Mr Stevens suggested future meetings could align with the F&I Committee and this would be reviewed **PP**

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on
Wednesday 30 August 2017 at 8.30am - 11.30am
In St Mary's Board Room at Eastbourne DGH

Present:
Mr Barry Nealon, No-Executive Director, Chair
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Mr David Clayton-Smith, Trust Chairman
Dr Adrian Bull, Chief Executive
Mr Jonathan Reid, Director of Finance
Mr Ian Miller, Director of Financial Improvement
Miss Tracey Rose, Associate Director of Planning & Business Development (representing Catherine Ashton)

In attendance:
Mrs Sandra Field, Associate Director of Operations, Medicine
Mr Richard Boyce-Stones, NHSI
Mr Matthew Fox, NHSI
Miss Chris Kyprianou, PA to Director of Finance (minutes)

130/17	**Welcome and Apologies for Absence** Mr Nealon welcomed Richard Boyce-Stones and Matthew Fox from NHSI to the Finance & Investment Committee meeting and introductions were made. Apologies were received from Mrs Joe Chadwick- Bell, Mrs Lynette Wells and Mr Dan Bourdon.	**Action**
131/17	**Minutes of the Meeting of 26 July 2017** The minutes of the meeting held on 26 July were agreed as an accurate record.	
132/17	**Action Log** (i) IPR Finance Report – M3 The Committee had asked for assurance that there was timely reconciliation between the Trust contractual position and the CCG position. Mr Reid confirmed that the 16/17 process was now complete with some ongoing issues which were discussed under item 135/17 below. Mr Reid explained that the formal process this year was to have quarterly reconciliation for quarter 1 and quarter 2, to be complete by the end of September, and then this would move to monthly conciliation from September.	

	(ii) iMSK update Mr Reid reported that a brief update on iMSK was included in the Contracts paper discussed under item 135/17 and there will be a more detailed update at the September meeting. (iii) Securing Additional Capacity There is a risk that the Trust does not have the capacity to be to be ready for 18/19 planning and it was noted that this was on the finance risk register initially for discussion within the finance team. The Committee noted that Capacity and Capability is a standing item on the FISC agenda. (iv) Progress on Clinical Services Review It was noted that Mrs Darwood had attended the GM meeting and a new process for reconciliation between Divisional and CSR CIPs had been agreed. A full reconciliation is underway and will be presented to the September meeting. (v) Future meetings The Committee noted that meetings had been extended by a further 30 minutes until December 2017 to allow further discussion while the Divisions were being invited to attend.	
133/17	**Integrated Performance Report (IPR)/Finance Report – Month 4** The Committee received the Integrated Performance Report for Month 4 and Mr Reid highlighted the following key issues in relation to the performance section: - The Trust had achieved the standard for RTT waiting times for the third consecutive month. - A&E waiting times continue to improve. - Delayed transfers of care performance continues to improve - A&E attendances remain at the highest levels in over a year, adding pressure to the 4 hour target - The higher than expected number of non-elective admissions is impacting on flow through the hospital - Equipment failures and staffing issues impacted the diagnostics standard - The number of patients waiting over 62 days for cancer treatment is higher than expected Mr Reid gave an update on the finance position as of month 4 and highlighted the key issues.	

	It was noted that the Trust was reporting delivery of its FSM plan, which was slightly ahead of the ledger plan. The Trust continues to forecast full delivery of both the CIP targets and the year end control total. The Trust was still reporting a £0.2m adverse variance against STF driven by Q1 A&E performance. It was noted that this was another challenging month operationally; The Trust continues to see higher than anticipated levels of non elective activity. Mr Reid drew the attention of the Committee to the variance analysis tables and summarised the operational highlights. It was noted that overall the five operational divisions were below plan by £1.1m. The impact of the new tariff HRGv4 was being worked through. It was noted that a detailed forecast had been done with each of the divisions and it was agreed that Mr Reid would include the detailed information on the forecasts and trajectories for each of the divisional teams in the report for next month. Mr Reid referred to the Income & Expenditure variances table. The Committee noted that the pay was encouraging, however there was some work to be done on non pay. Mr Reid reported that this was being reviewed in some detail with the Procurement team in the weekly grip and control meetings. The Committee was pleased to note that future loans would be at the reduced rate of 3.5% interest (previously 6%). Mr Reid confirmed that this was good news and that this was dependent on the delivery of the first quarter. Cashflow remained challenging resulting in increased creditor values and poor performance against the BPPC. The Trust had started reporting weekly on those creditors who had placed the Trust on stop or were threatening legal action. In addition to drawing down loan funding to support operational deficits, in line with the financial plan, the Trust was proposing to draw down £3.4m additional cash in September in lieu of STF funding, to be repaid when STF funding is received. The Trust continues to forecast full delivery of its £28.7m CIP plan for 2017/18. The governance structure is in place, and managing the overall programme, reporting to FISC which meets fortnightly. Mr Nealon expressed his concern over the high level of full time support staff in the Trust. Mr Reid reported that there were an additional 54 colleagues supporting the wider financial delivery and there was a plan for transitioning this. Mr Nealon asked if the Committee could look at the workplan and sustainability of this at the next meeting. Mr Miller explained that there was a transition plan for	**JR** **JR**

	each of these. Mrs Churchward-Cardiff expressed her concern over the increased level of staff turnover and queried whether there was a link between staff taking early retirement and coming back on the bank. Mr Reid confirmed that there was a lot of this happening. Dr Bull reported that Ms Green was reviewing this through the Integrated Performance Reviews as the divisions had been asked to look at turnover rates. Mr Stevens reported that he was encouraged by the agency rating. Mr Reid reported that the Trust was undertaking an extra review on waiting list initiative spend. It was noted that the overall capital programme had a significant level of over commitment as a result of demand for infrastructure and equipment requirements. The Capital Review Group (CRG) was closely monitoring capital spend and was forecasting delivery. **Action** **The Committee noted the performance for Month 4 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.**	
134/17	**Activity Review** Mr Reid presented a paper showing the main activity trends and advised that this paper would contain a bit more detailed narrative in future months. It was noted that activity was lower than plan against the plan and previous year which was due to the timing of the Easter Holidays and the Bank Holidays. The team were working on an adjusted format which will show activity based on daily records and will be presented at future meetings but should allow a more in depth comparator. Day case, electives and first outpatients were below plan to date. Non elective (including maternity and births) and follow ups were above plan. Income in total was on plan. For all lines, the Trust had assumed a 1% increase in activity in year. Significant increases were required to meet plan later in the year due to the phasing of the impact if the CIPs. The Committee acknowledged that this was valuable information and looked forward to receiving broader information on this for future meetings. **Action**	

	The Committee noted the Activity Review	
135/17	**Contracts – Monthly Review** Mr Reid provided the Committee with a detailed update on the M4 2017/18 contract income position. The Trust had set an income plan for 17/18 based on 16/17 activity levels and a prudent 1% growth assumption. The plan contained increases in income for a number of Trust initiatives including those detailed in the FRP. It was noted that the plan was delivering at month 4 but emergency and urgent care work was reducing the ability to deliver elective work. For 17/18 the reporting of income and activity was more granular. It was noted that weekly activity reviews against plan were now undertaken alongside the PTL (waiting list) meetings with Clinical Units. The impact of HRG4 was still being worked through but initial indicators were that this was in line with Trust plans. A number of significant contract risks were being managed and mitigated. Mr Reid presented a report setting out the approach to mitigation, and describing the latest challenges position with CCGs and setting out the potential risk to the year end position. Mr Reid reported that the Trust had agreed with the CCG that it would do a full reconciliation up to month 5 by the end of September 17. Mr Reid updated the Committee on the iMSK contract which the Trust had won and commenced delivery during July 2017. It was noted that the Trust were slightly adrift from plan against the Sussex MSK. A more detailed update will be provided at the September meeting. Mr Reid confirmed that the Trust had reached agreement with the CCG on the proposed arrangements for contact reconciliation. **Action** **The Committee noted the detail on the income position of the Trust.**	**JR**
136/17	**Cashflow – Monthly Review** Mr Reid presented an update on the cashflow position at month 4 which gave a breakdown of creditors and debtors and the movements since the last month. Mr Reid highlighted the following key actions that the Trust were taking to try and work through this: ***2016/17 Cash Bridge*** - As reported last month, the Trust had completed a template	

	provided by NHSi, the premise was that the Trust could claim the working capital elements as a separate draw-down of cash (£10.6m). A meeting was held on 22 August to review this with NHSi. The proposal was that NHSi would be able to present to DoH a full picture of the cash requirement for the current financial year. At present further work was being undertaken by the Trust to fully analyse the movement of creditors in 2016/17. ***Submit a claim for "exceptional working capital"*** - The Trust had previously applied for exceptional working capital. NHSi's starting point was that only values relating to "non-NHS" creditors could be drawn-down and previously only values over 90 days were considered – using values as at 21 August the negotiating starting point was £12.2m. ***Draw down Capital Funding (PDC)*** - The Trust was successful in a capital bid for PDC for A&E/GP Streaming at both sites. The award was for £1.685m and the first tranche of this £0.919m was drawn in August. ***Convert debtors in to cash*** - As at the end of July there remained £24m of outstanding debt. The Committee reviewed the values which make up the majority of this debt. Mr Reid reported that there was a colleague seconded to the Trust who was supporting a number of key areas throughout the Trust including cashflow management and cashflow forecast. The Committee noted that 2017/18 looks to be even more challenging than the previous year as the Trust continues with a significant value of aged creditors, strained trading relationships and a significant CIP target, where any slippage could quickly generate pressure on cash. Mr Fox raised a query on a CCG debt which Mr Reid explained. The sum queried was the disputed balance of money from the CCG. Mr Fox said he would discuss this with Ms Moody. In order to have real leverage on this, the Trust would need to show that it was running its cash as well as it possibly could. Mr Nealon asked for a bridge for next month showing movements in cash in the past two years to be included in the next cash report. **Action** **The Committee noted the ongoing management of cash within the Trust.**	**JR**
137/17	**Divisional Assurance – Medicine** At the June Finance & Investment Committee meeting, it was agreed that each Division would be invited to a meeting to present their plans and to explain the actions being taken to achieve their year end	

forecast.

Mrs Field was welcomed to the meeting. She thanked the Committee for the invitation and advised that she wanted to give assurance that the division was doing everything it could to stay within its budget and deliver its CIPs.

Mrs Field summarised the financial position for the medical division. It was noted that the full year budget for expenditure (as of July 2017) was £64.5m. Of this £8.5m (13%) related to non pay and £56m (87%) relates to pay (workforce). It was noted that recruitment was a huge issue for medicine and relying on agency staff was causing the division its biggest risk.

The position at M4 (year to date) was an increased contribution of £480k, provided by additional income of £1,231k which offset an overspend on expenditure of £751k.

It was noted, that in terms of Contract Income, the division were 4% above plan. Non elective activity was on plan, DC below plan and Outpatients were above plan.

The year to date position was an overspend of £386k due to the need to cover substantive posts/vacancies shifts at premium rate.

Included within the Budget Plan was the full year CIP target of £3.2m. At M4, actual achievement was off plan by £134k.

The Committee reviewed the financial position of the division by specialty.

Mrs Field gave an overview of the following work that was going on in the division:

- Impact of HRGv4+ is masking overspends (the income team are working through this but early estimate suggest medicine plan should be £4m higher due to the changes in tariff so over performance values are overstated). Division is keen to work with the income team.
- Decision on escalation and Winter funding and patient flow Length of stay .
- Medical Model, bed allocation, day case unit, frailty pathways.
- Medical agency overspends – overall medical is showing £690k overspend by year end– need further review to the overspends and recruitment plans to reduce agency & locum costs –
- Ongoing work with service managers and Liaison to review TempRE data on medical agency as mth1-4 costs were overstated in some specialties so hopefully this will improve Forecast.
- Waiting list ad hoc payments – forecast assumes these continue and total spend £430k by year end – action for Division to

reduce.
- To commence forecasting with each specialty. Started at the beginning of August, going through each speciality/staff member for every department within medicine.

Mrs Field gave an update on the projects that were being done that would make the biggest difference to balance the financial position. These included:

Cardiology
- Clinical Coding
- Cath Lab utilisation
- Admin
- Recruitment
- Recruitment of substantive staff

Long term
- Options appraisal
- ESBT (Community Cardiology)

Rheumatology
- PbR
- Commissioning intentions
- Working differently

Gastro/Endoscopy
- Procurement
- Pathway Management
- Staffing

Long term
- Strategy to manage workforce model

Escalation
- Medical Model/Bed Allocation/LoS

Mrs Churchward-Cardiff queried how long it would take to turn some of these services round, or was there anything else the Division could do perhaps using Carter data. Mrs Field reported that in Cardiology, they would be looking at how to reduce the costs. There was a risk in Cardiology with the Cath Labs breaking down and the division were looking at a business case for supporting the Cath Labs.

Mrs Field reported that Cardiology and Endoscopy were the Division's pressurised areas and a lot of that was due to vacancies at Consultant level.

Mr Miller raised a query with regard to workforce and pay costs. It was agreed that this would be discussed outside the meeting.

Dr Bull reported that one of the things that the Medicine Division was doing really well was the review of each individual service which ties in well with the work that Ms Rose has been doing with each individual

	service producing their clinical plans on a page. Mrs Field reported that the Division holds speciality performance reviews where the management team invite all specialities (ie. Head of Nursing, Clinical Lead etc) and go through an IPR type agenda for each of the services. Mr Nealon expressed his interest in attending one of these meetings. Mrs Field said he would be more than welcome to attend. Mr Nealon thanked Mrs Field for an excellent presentation. **Action** **The Committee noted update from the Medicine division and the actions in place to bring the Trust closer to plan.**	
138/17	**Financial Recovery Plan – Progress update (including securing additional capacity)** Mr Reid presented a Financial Recovery Plan progress update. The report presented highlighted the value of projects approved by FISC and that the Trust was delivering the plan to the end of July and the showed progress on securing additional capacity. The report contained some of the key performance indicators and lead indicators that had been developed with the workstreams. The key risk was delivering the stepped change in August. It was noted that there was a gap on pay; However, providing all projects deliver in full, the profile included in the project documentation, the Trust will deliver the total cost improvement required. Mr Reid reported that the progress update had been circulated to a wider group of stakeholders for comments and would be reviewed with NHSI colleagues later today. It was noted that there was a formal review meeting with the FSM team in London on 7 September 2017 to get a status update. The overall message was that there was good progress but there were some areas of concern that the Trust needed to focus on. The Committee noted the workstream performance. Some of the areas were showing delivery ahead of plan, such as CSR, Grip & Control and Workforce and there are others, such as Data Quality and Elective Pathways, were behind plan. Mr Reid reported on the reasons for the larger adverse variances and explained that weekly meetings were taking place with each of the workstream leads. Mr Miller drew the attention of the Committee to the tables which showed the project variances +/- £10k for each of the workstreams, which were grouped by the Executive Lead.	

	Mr Reid reported that the Trust will continue to manage the programmes that are not delivering to plan, and there will be a more targeted report for the next meeting for those workstreams setting out where the variances are. **Action** **The refreshed financial plan was noted.**	**JR**
139/17	**Financial Planning Timetable 2018/19** A key lesson from 2017/18 was the need to focus on in-year delivery and financial planning. With the additional capacity within the Trust to support in-year delivery, the finance team alongside the Director of Financial Improvement were working on a robust planning timetable and process for 2018/19 The Committee received a paper setting out a high level timetable for the planning process and noted a number of high level assumptions for review. A monthly update on progress in the development of the plan was provided. The Trust had a good understanding of the key issues to be addressed in planning for 2018/19 and these were described in the paper. Arrangements were being put in place to deliver a robust plan for 18/19, linked to a more refined strategic financial plan for the next five years, by December 2017. **Action** **The Committee noted the report, and considered the emerging issues in the development of the financial plan for 2018-19.**	
140/17	**Developing a Long Term Financial Model (LTFM) for ESHT** The Committee noted that the Trust has a long term financial model (LTFM), but this is primarily used to support loan applications with the Department of Health. A series of planning exercises from 2016 need to be refreshed and supplemented to enable the development of a Trust LTFM to inform the planning process. The LTFM development will need to take into account the emerging assumptions of ESBT (ESBT partners have challenged the need for a Trust LTFM in the past, which is a reasonable query to raise, and the model will evolve into a system model) but will need to have sufficient flexibility to allow for the modelling of different scenarios so that it supports the Trust's planning processes, as well as wider system financial planning. Mr Reid presented a paper setting out some of the key areas of focus	

	for the developing LTFM, which will be developed during September through December alongside the Trust planning process. **Action** **The Committee noted the report and considered the emerging issues in the development of the LTFM for the Trust.**	
141/17	**ESBT/Alliance Executive Financial Plan 2017-18** Mr Reid presented a paper on the ESBT financial position and actions needed to achieve financial balance. It was noted that the financial position of the ESBT Alliance was challenging, and was considered on a regular basis by the Alliance Executive. At the last meeting of the Alliance Executive, the Directors of Finance presented a paper setting out the challenges facing the system and the actions in train to address those challenges. A programme of work was agreed, and the ESBT Finance Group was progressing each of the actions and steps. **Action** **The Committee noted the report and actions needed to achieve financial balance.**	
142/17	**Sussex and East Surrey STP Financial Plans** Mr Reid presented the Committee with a Sussex and East Surrey STP status report. It was noted that the Susses and East Surrey STP Executive continues to meet regularly, supported by a number of key groups. The Finance Directors have been reviewing the operational risk gap (for the Trust and ESBT, this is the £48m gap between income and expenditure) and reviewing both planning assumptions and approaches to resolution. There are no new issues for the Trust in this respect, although the Trust has adopted some of the approaches utilised in other localities to provide insight into supporting ESBT. The Trust continues to participate fully in this process. Alongside this, there is extensive work ongoing in respect of Getting it Right First Time (which is covered in a separate report) and mental health (in which the Trust is represented). A refresh of the STP financial plan is anticipated in October 2017. **Action** **The Committee noted the latest developments within the Sussex and East Surrey STP.**	

143/17	**Lord Carter Operational Productivity Programme** The Committee received a report providing an introduction and overview of the NHSI's Operational Productivity Programme and in particular the wealth of information that is now available to help the Trust identify true potential efficiency improvement opportunities through the Model Hospital portal and the Getting it Right First Time (GIRFT) Programme. The report detailed the approach that the Trust had taken in response to the programme and provided a high-level update on the 15 Lord Carter recommendations linking to the Trust's FRP workstreams. The Finance & Investment Committee noted the contents of the report and the further assurance provided. It was recommended that two further reports are presented at the Finance & Investment Committee; a Board Level Oversight report highlighting the Board level data available in the Model Hospital portal, and a report on the Getting It Right First Time (GIRFT) programme, which is now no longer a pilot and will be rolled out to more than 30 specialties. **Action** **The Committee noted the contents of the report and the further assurance provided.**	
144/17	**Business Cases** No business cases had been received this month.	
145/17	**2017/18 Work Programme** The Committee reviewed the 2017/18 work programme. **Action** **The Work Programme was noted**	
146/17	**2018 Meeting dates** The Committee noted the meeting dates for 2018. It was agreed that the start time for next year's meetings would be moved to 8.30am. **Action** **The 2018 meeting dates were noted.**	**CK**
147/17	**Date of Next Meeting** The next meeting will take place on Wednesday 27 September 2017 at 9am – 12pm in the Committee Room at the Conquest.	

148/17	**Minutes to note – for information only** The Committee received the minutes of the following meetings for assurance and information: • Financial Improvement & Sustainability Committee – 17.7.17 • Capital Resources Group - 20.7.17 • Business Development Group – 20.7.17 • Digital Steering Group – 7.7.17 **Action** **The Committee noted the above minutes.**	

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on
Wednesday 27 September 2017 at 9am – 12pm
In the Committee Room, Conquest

Present:
Mr Barry Nealon, Non-Executive Director, Chair
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Mr David Clayton-Smith, Trust Chairman
Dr Adrian Bull, Chief Executive
Mrs Joe Chadwick-Bell, Chief Operating Officer
Mrs Lynette Wells, Director of Corporate Affairs
Mr Jonathan Reid, Director of Finance
Mr Dan Bourdon, Interim Deputy Director of Finance
Miss Tracey Rose, Associate Director of Planning & Business Development (representing Catherine Ashton)

In attendance:
Mrs Abi Turner, Associate Director of Operations, OOH
Mrs Jenny Darwood, General Manager, Transformation
Mr David Hoppe, NHSI
Mr Matthew Fox, NHSI
Miss Chris Kyprianou, PA to Director of Finance (minutes)

149/17	**Welcome and Apologies for Absence** Mr Nealon welcomed David Hoppe and James Anderton from NHSI to the Finance & Investment Committee. Apologies were received from Ian Miller. It was agreed to focus today's meeting on the following priority areas: • NHSI review of the CIP programme • Adverse variance at month 5 • CCG income position • Cash & Capital	**Action**
150/17	**Minutes of the Meeting of 30 August 2017** The minutes of the meeting held on 30 August were agreed as an accurate record.	
151/17	**Action Log** (i) IPR Finance Report – M4 It was noted that detailed information on the forecasts and trajectories	

	for each of the divisional teams was included with main month 5 IPR report. It was noted that a deliverability assessment was underway which will support an Executive Director evaluation of resources required. (ii) Contracts - Monthly Review An iMSK update was given under the contracting item below. (iii) Cashflow A more detailed cash breakdown over the last couple of years was discussed under minute item 155/17 below. (iv) Financial Recovery Plan including Securing Additional Capacity A Financial Recovery Plan monthly report was included within the papers setting out where the variances were across the workstreams. (v) 2018 Meetings Meetings for 2018 had been moved to an 8.30am start.	
152/17	**Integrated Performance Report (IPR) Month 5** The Committee received the month 5 Integrated Performance Report which had been discussed in detail at yesterday's Trust Board. The report highlighted that the Trust achieved the RTT standard but remained challenged against the key constitutional targets and trajectories. • RTT incompletes achieved the standard for the fourth month - 92.03% against the 92% standard. • A&E performance was 92.5% against the 95% standard. This was an increase from July. • Diagnostics declined slightly from July, and did not meet the standard – 2.3% against the 1% target • Cancer 62 Days achieved 74.7% against the 85% standard (for July, one month in arrears). Mrs Chadwick-Bell gave a brief overview of the items which had a financial impact on performance. An update was given on productivity around outpatients and theatres. Mrs Chadwick-Bell explained that there were plans to put additional activity through existing capacity by booking in a different way. Mrs Churchward-Cardiff queried whether there would be a cost implication if the Trust was to get back to target on the underperformance on diagnostics. Mr Reid clarified that there were no contractual penalties around diagnostics and that this was a key	

	performance standard. **Action** **The Committee noted the performance update for Month 5.**	
153/17	**Finance Update - Month 5** The finance section of the IPR was noted. Mr Reid presented a separate finance update highlighting the following key messages: *NHSI Review of CIP Programme* NHSI had undertaken a line-by-line review of the CIP programmes on 22 September, and highlighted a number of key areas for action to strengthen the programme. The Committee noted the feedback from NHSI and the Trust response to this feedback, and next steps. Dr Bull reported that NHSI were complimentary to all of the teams in terms of the level of engagement in the programme. Mr Reid reported that the Trust had commenced a reforecast of all of the schemes based on some of the feedback received. *CCG Discussions* It was noted that the Trust had progressed discussions with the CCG on an 'ESHT cost centre' approach to system finances. The CCG financial position had significantly deteriorated, and the Trust & CCG were developing a system FRP. The Committee reviewed the full year 'CIP free' activity forecast. It was noted that the CCG was forecasting an adverse variance to their plan and was working with the Trust on recovery actions. There was a series of risks not included in the CCG forecast or the Trust forecast and the Trust was working with the CCG to develop a shared plan for mitigation. Dr Bull highlighted the key issues and reported that the Trust and the CCG will jointly present their proposal to NHSI and NHSE on 29 September 2017. *Adverse Variance at M5* The Committee noted that the Trust had moved off plan in Month 5. The key drivers of the movement were in respect of reduced elective and trading income, additional VAT costs from 2015/16 and formal	

	recognition of the first component of the 16/17 credit notes issued by the Trust. The total adverse movement was £1.2m. Anticipated elective income was expected to cover the additional pressures from the 2016/17 output. Mr Reid advised that he would provide a brief summary of the VAT arrangements for the next meeting. The Executive Directors reviewed the position the previous week and agreed a series of actions to address recovery. A key action was to understand the recovery of elective income in Month 6. Weekly indicators were positive, showing a recovery in delivery across all planned care PODs. However, it was too early to establish whether the level of recovery was sufficient. It was noted that the Finance Department was working with all key budget-holders to undertake a full reforecast across all areas. The headline risk within expenditure lines was £7m (unvalidated) predominantly in pay and non-pay, with approximately £5m pay risk echoing the anticipated benefits from pay workstream within the CIP. The non-pay risk at £2m reflected cost pressures outside the CIP programme, predominantly in respect of pharmacy expenditure and CSR savings. The Committee did not feel assured that the Trust were on plan for the year and the half year review was the appropriate time to reassess the risks associated with delivery and present a robust refreshed forecast. Mr Reid reported that the full reforecast would be presented to the Executive Directors the following week and to the October Finance & Investment Committee. Mr Reid highlighted the income movements at month 5 YTD. Overall the income was £0.1m adverse to FIMS plan in M5 and £0.3m adverse to FSM plan, with the key variance in Surgery. Medicine, Emergency Care and iMSK had delivered additional income (note HRG4+ impact) supporting the overall Trust position – although with significant cost associated. However, a significant reduction in elective activity – offset by iMSK benefits – had driven the YTD adverse variance. Mr Reid gave the Committee his overall assessment of the CIP delivery and advised that some of the major CIP programmes were not currently delivering. It was noted that the Committee needs to continue to test, challenge and explore to what extent it can robustly address the risks that are being highlighted, and the shortfall in month 5. Dr Bull reported that the Trust had highlighted a number of risks in the position and was working to ensure that the risks were covered, both in cash and I&E, and these will be presented at the next meeting so that	**JR** **JR**

	there is a more focused discussion on the robustness of the position. *Cash* The Committee noted that the detailed cash review work is continuing. The Trust had identified a significant component of cash tied up with a small number of high value debtors and was working closely to recover these at the earliest opportunity. The cash update was discussed in further detail under item 155/17 below. *Compartmentalisation concerns* Mr Reid reported that following Grenfell, the Trust undertook a joint review with East Sussex Fire and Rescue Authority on all key sites. A briefing was presented to the Board on 26 September 2017. The estimated cost of the work to address the risks identified was £12m over three years. The Trust had commissioned expert advisers to support the preparation of a business case to NHSI/DH for capital loan funding to support this work. The Committee noted that this was in train, and there is a joint agreement with ESFRA and NHSI Fire Advisers to have the case ready by November, to submit for funding. The works are likely to take up to three years, with a rolling programme of decant and ward closures. Detailed planning is in train with operational and estates colleagues. Mr Reid reported that the capital programme was already oversubscribed, with the Trust having potential expenditure £2m above the CRL. A full review of all the schemes had been requested by the Chair of the Capital Review Group and this will be presented to the Executive Directors at their meeting on 3 October 2017. This will propose delays/deferrals and re-scoping to ensure that the Trust does not overspend against CRL, and to provide space within the capital budgets for in-year work. **Action** **The Committee noted the finance update noting the key messages.**	**JR** **JR**
154/17	**Contracts - Monthly Review** This item was discussed in detail in section 153/17 above. **Action** **The Committee noted the income position of the Trust.**	

155/17	**Cashflow – Monthly Review** Mr Bourdon presented the Committee with a detailed cash and working capital 'movements' report. It was noted that the Trust was proactively reviewing its cash forecasting and working capital management processes as well as understanding the key drivers of the deterioration of the cash position which are set out in this update. Pressure on working capital had been increasing since the end of Q3 FY16/17. This had been predominately driven by cash tied up in accrued income which had increased by £12.1m over month 1-5 of this financial year. The Committee noted that the Trust had employed a new credit controller and had a renewed focus on debt collection particularly older debts as well as the conversion of accrued income to receivables, and dispute resolution with local commissioners. As a result, trade receivables had decreased by £7.6m from month 1-5. Overall payables had been steadily increasing over the past 16 months, largely driven by trade payables. The trade payables balance had remained stable in the first four months of FY17/18 however the ageing has deteriorated as the Trust does not have sufficient cash to meet supplier payments on fixed terms and those where the Trust is on stop/threatened to be put on stop. It was noted that cash was also being impacted by accruals for FY16/17 costs being too low and therefore additional costs were impacting FY17/18. These are being unwound evenly throughout the year as per the Trust's policy. The Trust recognises that there is significant further work required to ensure improvements are made to the treasury and cash management processes, and will require additional support to the Trust's team. The Trust was also working with commissioners, as a matter of priority, to resolve the cash pressures. The Committee noted that the finance team were working on a recalibration cashflow forecast and this analysis would be reviewed together with an action plan by the Executive Directors within the next few weeks. A further update would be provided at the next Finance & Investment Committee meeting. **Action** **The Committee noted the ongoing management of cash within the Trust.**	**DB**
156/17	**Divisional Assurance – Out of Hospital**	

At the June Finance & Investment Committee meeting, it was agreed that each Division would be invited to a meeting to present their plans and to explain the actions being taken to achieve their year end forecast.

Mrs Turner was welcomed to the meeting to present the report from the Out of Hospital (OoH) division.

It was noted that OoH were currently off plan by £246k year to date. High risk areas for the Financial year end included PMU and Drugs.

Pay underspend of £720k was due to ESBT vacancies, year to date of £685k. Therapy and District Nursing vacancies absorbing the Divisional vacancy factor. Non pay overspend of £164k was due to Drug activity maintaining 16/17 levels, currently showing £428k. Partially offset by continence contract savings of £73k and ESBT non pay underspend of £193K.

For income there was an underachievement of £264k, due to PMU change of business to purely over labelling of £126k, plus an internal £122k due to Milton Grange (offset in pay with vacancies).

It was reported that the Contract Income position was still being reviewed as current £1.1 million overachievement in FOT.

Contract income underachieved by £539k, this is made up of;

- £464k block/DA overachieved
- £1,087k ESBT underachieved
- £84k iMSK overachieved

Mrs Turner gave an overview of the forecast with worst case/best case assumptions and highlighted the main drivers of the financial position.

The Committee noted the risks and opportunities, the CIP detail by scheme.

Mrs Turner assured to the Committee that the following Divisional Governance and controls were in place:

- IPR each month with Chief Executive
- Divisional IPR with all service leads
- Regular meetings with FBP
- One to ones with ADO for Service Managers/Budget holders
- VCP and No PO no pay
- Healthroster scrutiny
- OoH dashboard in Development

Mrs Turner was thanked for her well presented report.

Action

	The Committee noted the update from the OoH and noted that the Division was working with all internal and external agencies to achieve FRP and CIP schemes and find extra schemes to help financial position.	
157/17	**Financial Recovery Plan – Progress update (including securing additional capacity)** The Committee received the formal FRP Progress Update which was presented at the last FSM checkpoint meeting. Mr Reid reported that NHSI colleagues had expressed satisfaction that the Trust was on plan, concern around the level of the financial gap, and concern about the deliverability of all income. An internal audit had been requested around the income process which was all in train. NHSI had also requested some further supporting information. The Committee noted that arrangements were in place to ensure that the Trust meets all of those requirements. Dr Bull explained the project 'hopper' status and explained that, throughout the work that has been going on with the FSM team, the Trust has been describing a process of taking ideas and opportunities from an early stage to a worked up point in which it has a PID and an attached value. This was shown in purple, yellow and green on the 'hopper'. It was noted that the original aim was to get the governance process and project descriptions in place and Dr Bull stressed that this was not the Trust's reporting mechanism to track of all progress with the projects. There is a separate report tracking progress of projects which goes to FISC which is the progress tracker, this assesses both the KPI progress and the financial position of the projects. Mr Hoppe reported that there appeared to be a misunderstanding around what the Trust reports as a "green" scheme and Dr Bull said he would be happy to have a discussion with Mr Hoppe outside of this meeting. It was agreed that there would be a definitive view for next month of what was on track and what was off track, explaining how the Trust will get back onto plan and whether, as a consequence there is any need re-setting the plan. **Action** **The refreshed financial plan was noted.**	**DB**
158/17	**Clinical Services Review - update** Mrs Darwood gave a brief update on the Clinical Services Review.	

	The Committee received a summary of the milestones achieved since the last update. Mrs Darwood reported that there were 12 schemes which were ready to go, and had everything in place ready to deliver, and they were looking at the possibility of brings some schemes forward for earlier delivery. It was noted that this item was discussed at length at the FISC on 25 September. The Committee noted the risks to delivery and next steps. **Action** **The Committee noted the CSR update.**	
159/17	**Financial & Business Planning Update** Mr Reid presented the Committee with some slides giving them assurance that the Trust was progressing the business planning process. An update on the timetable had been presented to the Committee at last month's meeting. It was noted that the outcome of the forecast will drive what the business planning process will look like for next year. A full a paper on business planning will be provided for the next meeting. **Action** **The Committee noted that the business planning process was progressing and a full paper will be provided at the next meeting.**	**JR**
160/17	**ESBT/Alliance Executive Financial Plan 2017-18** Mr Reid updated the Committee on the Alliance Executive Financial Plan. The Committee noted that the Trust and its partners are making strong progress towards the development and delivery of an integrated financial statement for the Alliance Executive, covering the financial position of ESBT. The Committee received the latest Alliance Financial Report, setting out the actions being taken at the Alliance to manage the system financial position. At Month 5, ESBT was reporting a YTD deficit and working on a	

	realistic forecast for the overall financial challenge.. The Alliance Executive agreed to progress the development of the financial recovery plan for the system at pace, before the end of September. **Action** **The Committee noted the update on the Alliance Executive Finance Plan.**	
161/17	**Sussex and East Surrey STP Financial Plans** Mr Reid gave a brief update on the Sussex and East Surrey STP. The Committee noted that the Sussex and East Surrey STP has continued to work to develop a refreshed STP plan for the system, including a series of linked plans for the individual places. The Finance Directors also continue to work to refresh the collective understanding of the system financial gaps (both across the STP and within the three/four places). No formal date has been set nationally for refresh of the STP plans, and a change in the management arrangements is anticipated, which is likely to lead to a full refresh of the plans. In recent months, the STP has focused on working to understand the operating risk within the financial plans across all organisations, and to develop mitigating strategies. In terms of impact on the Trust, there are no immediate issues of priority emerging. **Action** **The Committee noted the ongoing work within the STP.**	
162/17	**Market Developments Quarterly Report** Ms Rose presented a schedule providing a summary of business cases and tenders. The planning and business development team continue to support divisions to align cases and tenders with Trust strategic priorities, divisional business plans and finance. Business cases and tenders are monitored by the Business Development Group. **Action** **The Committee noted the update.**	
163/17	**Estates Plan** This item was deferred to the October meeting.	**MP**
164/17	**2017/18 Work Programme** The Committee received the updated 2017/18 work programme.	

	Action **The Work Programme was noted**	
165/17	**AOB** *(i) BDO Review of the Finance Function* Mr Reid reported that he had agreed with the Finance Team to ask its previous external auditors to undertake a review of the finance function. The Committee received a copy of the BDO report for information, which will be discussed and reviewed with the team on 9 October 2017. A summary of the report and the management response will be shared with the Committee in due course. **Action** **The Committee noted the external review of the finance function and looked forward to seeing the management response in due course.** *(ii) Pathology* Mr Reid reported that a letter had been received from NHSI around establishing and implementing 29 Pathology Networks across England, asking the Trust to review its proposed network and confirming its commitment to move towards this Hub and Spoke model. Dr Bull explained that the Trust wants to consider a couple of options with a view to fully assessing the situation before making a decision. **Action** **The Committee noted the letter from NHSI regarding the pathology networks and endorsed the Trust's anticipated response.**	**JR**
166/17	**Minutes to note – for information only** The Committee received the minutes of the following meetings for assurance and information: • Financial Improvement & Sustainability Committee – 21.8.17 • Capital Resources Group - 16.8.17 • Business Development Group – 16.8.17 **Action** **The Committee noted the above minutes.**	
167/17	**Date of Next Meeting** The next meeting will take place on Wednesday 25 October 2017 at 8.30am – 11.30am in St Mary's Board Room at Eastbourne DGH.	

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

Minutes of the People and Organisational Development (POD) Committee meeting held on Thursday 15 June 2017, 3.00 – 5.00pm Princess Alice Room, EDGH with v/c to Committee Room, CQ

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 Lynette Wells, Director of Corporate Affairs (LW)
Mrs Kim Novis, Equality & Human Rights Lead (KN)
Mrs Moira Tenney, Deputy Director of HR (MT)
Dr David Walker, Medical Director (DW)
Mr Jamal Zaidi, Associate Medical Director – Workforce (JZ)
Mr Salim Shubber, Director of Medical Education
Mrs Lorraine Mason, Assistant Director of HR - OD (LM)
Mrs Jan Humber, Staff Side Chair (JH)
Mrs Lesley Houston, Deputy General Manager – Medicine (LH)

In attendance:
Dr Debbie McGreevy, Assistant Director – Revalidation (DMcG)
Miss Sarah Gilbert, PA to Director of HR (SG) - Minutes

No.	Item	Action
1)	**Welcome, introductions and apologies for absence** The Chair welcomed all to the meeting and noted a quorum was present. Apologies for absence were received from: Mrs Joe Chadwick-Bell, Chief Operating Officer (JCB) Mrs Alice Webster, Director of Nursing (AW) Mrs Michele Elphick, General Manager – DAS Division (ME) The Chair confirmed she had written to the Divisional General Managers requesting a representative from each Division to join the membership. Michele Elphick had been confirmed as the Diagnostics, Anaesthetics & Surgery representative and Lesley Houston as the representative for Medicine. SG to chase responses from Women & Children and Out of Hospitals Divisions.	**SG**
2)	**2.1 Minutes of the last meeting held on 30 March 2017** The minutes were reviewed and agreed as an accurate reflection of	

	the meeting. **2.2 Review of Action Tracker:** The outstanding items on the Action Tracker were reviewed: <u>Lord Carter work</u> Jo Brandt would be asked to provide an update on this work via Workforce Resourcing group. <u>BME recruitment</u> LM advised there was no additional funding available for unconscious bias training at present. KN agreed to provide an update on figures at September meeting. <u>GMC visit/medical engagement</u> DW/LM met regarding medical engagement today. LM confirmed mentorship to new consultants would be rolled out. MG suggested approaching HEE for funding to support this and also roll out of mentorship training. LM agreed to take forward. LM advised that consideration was being made to run in-house leadership training package for junior doctors including chief registrars and educational fellows, and offer places for others who may be interested. As part of this, junior doctor representation on relevant committees and meetings would be encouraged. The Committee agreed with this approach. LM to develop a package for this and provide an update at the December meeting. MT advised the risk of removal of training posts would be covered under the GOSWH report. MT agreed to expand existing risk relating to the junior doctors contract rather than enter new risk. <u>Leadership Strategy</u> LM to present leadership strategy to BME network in July. Update to be provided at the next meeting.	**MT** **KN** **LM** **LM** **MT** **LM**
3)	**Terms of Reference: Review of purpose of the Committee** JCC requested junior doctor representation to be added to the membership. All members present agreed junior doctor membership should be extended to other board sub-committees. MG agreed to check with the chairs of each sub-committee and contact Medical Education to nominate representatives.	**MG**
4)	**Annual Workplan for the Committee** The annual workplan was reviewed. The committee considered what was required for each meeting and the following amendments were agreed:	

	• Workforce risk register to be added to each meeting. • Remove revalidation policies from September meeting as this would be covered under the Trust's policy ratification process • Remove Lord Carter work from December meeting (covered by WRG) • National updates to be deferred to December meeting • Workforce assurance tool to be populated and circulated with September agenda for information • Add Equality reports annually • Feedback from BME network to be added every 6 months The updated workplan would be circulated with the minutes. The committee discussed whether the committee was meeting its purpose. Overall, members agreed that the committee was meeting its purpose, however, it was agreed to review this again in conjunction with the CQC well-led domain at the December meeting.	**MT** **SG** **SG**
5)	**Feedback from sub-groups:** **5.1 – Engagement and OD Group** LM provided an update. She noted that the staff survey corporate priorities were not filtering down to all staff. Work was continuing to be undertaken to improve organisational resilience and staff engagement. JCC commented this was also being reviewed by Quality & Safety Committee. LM noted 100 suggestions had been received from staff regarding financial savings and work would be undertaken with finance to feedback to staff, emphasising the excellent suggestions made and savings value to the Trust. **5.2 – Education Steering Group** MG provided an update. She highlighted all education would be integrated under HR including medical education by April 2018. MG also confirmed that HEE KSS had now made an allocation of training monies to the Trust for 2017-18 although due to the financial position of last year, a third of this funding would be used for payment of outstanding training invoices. **5.3 – Workforce Resourcing Group** MT provided an update. She advised that the structure of this group would be reorganised so that there would be separate groups for Medical, Nursing and AHP resourcing with an overarching group to oversee this. The next meeting being held on 20 June would focus on development of a protocol based on the new roles analysis work undertaken by South Central CSU. An action plan would also be drawn up to include the following; provision of a workforce metrics pack at service level rather than Division level and training offered to those involved with workforce planning.	

	Physician Associates (PA) was also discussed, and MT advised an event had been held today with consultants who were interested in hosting a PA student in September. JCC highlighted the importance to provide a clear description of new roles to patients as there appeared to be some crossover with new roles and nursing responsibilities. The chair raised whether the patient pathway perspective had been considered in conjunction with workforce planning. MG advised this was being looked at via the East Sussex Better Together work and Accountable Care Organisation. **5.4 – HR Quality & Standards Group** MG provided a verbal update regarding the Risk Register. The highest workforce risks to the Trust related to recruitment of nursing, medical and AHP staff.	
6)	**Recruitment** MT presented a report regarding recruitment. She highlighted that the vacancy rate had increased in month 1 due to an increase in budgeted establishment. MT outlined that recruitment continued to be one of the key financial recovery initiatives. Generic nurse recruitment campaigns would continue as well as international recruitment for nurses and head-hunters had been engaged for recruitment to hard to fill medical posts. The introduction and impact of IR35 had meant that many agency staff had transferred to work on the bank. A social media campaign had also commenced and all hiring managers were being encouraged to use this to attract staff. DW queried the numbers of urgent care Consultant FTEs shown on the report and confirmed there should be 10 rather than 7. MT advised the data had been taken from the ledger and that the Divisional management teams would need to review their budgets to check these matched the ledger. MT agreed to look into the discrepancies.	**MT**
7)	**Medical Revalidation Annual Report** DMcG was welcomed to the meeting and presented the Medical Revalidation Annual Report. She confirmed that a five year revalidation cycle had been completed with 100% compliance for doctors for 2016-17 and the appraisal quality was high. A new revalidation report published by the GMC had provided recommendations and these were being addressed by the Trust. DMcG advised that new medical appraisers were being trained and the next cycle would be commenced shortly. MT commented that this would be a good success story to be used for recruitment and also encouraging agency staff to join the bank and had met with DMcG regarding taking this forward.	

	The committee approved the report and commended DMcG and the revalidation team for all their hard work on this.	
8)	**Nursing Revalidation Annual Report** DMcG presented the report and confirmed that the first year of nursing revalidation had been completed with 99% of nursing staff revalidated. There had been lessons learned for the 1% where registration had lapsed. The Committee approved the report and thanked DMcG and the revalidation team for their hard work with this.	
9)	**Leading Excellence update** LM provided an update. A needs analysis had been undertaken across senior leaders in the Trust and focus groups had been held for junior leaders. Key training needs had now been identified including business skills at divisional level and junior level. Business Skills workshops were being set up for divisional leads and HoNs/service managers. LM outlined the leading excellence programme and advised that two cohorts would undertake the programme; Cohort 1 would include divisional leadership teams, hospital directors and associate directors, and Cohort 2 would be open to a wider range of staff via competitive application process. Evaluation of the programme would be undertaken by Kingston University. LM advised a "Leading a Service" programme was also being developed for relevant band 6-7 staff across the Trust. The Committee agreed that the programme would be beneficial to leaders across the Trust although there needed to be a clear link to key organisational priorities. LM confirmed this was in place.	
10)	**HR Incident Report – 2016-17** MT presented the HR incident report for 2016-17. She highlighted that a large number of cases had been carried over from 2015-16 into last year, and out of those, a number of Maintaining High Professional Standards (MHPS) medical cases had been concluded. This had resulted in less cases being carried over into 2017-18. MT also confirmed that less matters raised compared to 2015-16 and it was felt this may be partly due to the Speak up Guardian involvement. MT outlined further work to be undertaken to reduce the length of time of suspensions where reasonably practicable and to improve the timescales for case management with the introduction of an electronic casework tool to be implemented.	

	The Chair commented that she had some involvement with cases over the last year and felt that some of these could have been dealt with sooner if handled informally where appropriate or mediation was undertaken. JCC raised that the CQC feedback section of the report appeared to show some improvements were only just starting and was concerned with the timeliness of this with a further CQC inspection due. MT clarified that many of the matters had been addressed and the report would be amended reflect this.	**MT**
11)	**Items for information** **11.1 – workforce report** JCC raised that turnover had increased again across all divisions and further work needed to be undertaken to drill down on why this had occurred. MG/MT agreed to look into and provide an update at the next meeting.	**MG/MT**
12)	**AOB** LH asked whether divisional representatives were required to present anything at the meetings. The Chair clarified that the purpose of having the divisional representatives as part of the membership was so that they were aware of what is discussed at the committee and could cascade relevant matters through their divisions. LM queried whether v/c worked for this meeting. All agreed that due to diary commitments it was the best method to ensure good attendance.	
13)	**The next meeting of the Committee will take place on:** Thursday 28 September 2017, 10.00am – 12.00pm in the Princess Alice Room, EDGH with v/c to Room 3, Education Centre, Conquest	

East Sussex Healthcare NHS
NHS Trust

Minutes of the Quality and Safety Committee Meeting

Wednesday 19 July 2017
St Mary's Boardroom

Present:
Sue Bernhauser, Chair
Adrian Bull, Chief Executive
Jackie Churchward-Cardiff, Non- Executive Director
James Wilkinson, Assistant Medical Director, Quality
Hazel Tonge, Acting Director of Nursing
Lynette Wells, Executive Director, Corporate
Monica Green, Director HR
Ashley Parrott, Associate Director of Governance

In attendance:
Catherine Ashton, Director of Strategy (for Item 4.6)
Hayley Barron, Senior Project Manager, PMO (For Item 4.5)
Lisa Forward, Head of Governance
Sue Curties, Head of Safeguarding (for Item 5.2)
Karen Salt (notes)

1.0 Welcome and Apologies for Absence

Sue Bernhauser welcomed everyone to the Quality and Safety Committee meeting and introductions were made.

Apologies for absence were noted from:

Jonathan Reid, Finance Director
Janet Colvert, Ex-Officio Committee Member
David Walker, Medical Director
David Clayton-Smith, Chair, ESHT
Joe Chadwick-Bell, Chief Operating Officer
Anne Wilson, Director of Infection Prevention and Control

Report from the Chair and Chair's Actions

2.0 Patient Story

Mrs Elizabeth Keating attended the meeting to talk to the Committee about her husband's experience of care in the Trust.

They had decided not to make a formal complaint but wanted to share the experience so that some of the issues could be addressed and improvements embedded in the Trust.

The key issues were as follows:

- Communication between wards and patients/relatives needed to improve

- Repeated taking of history
- The high level of paperwork and data input had replaced one to one care.
- Information taken by nurses not appearing in summary letters
- Inconsistent attitudes to the relatives of patients
- Mrs Keating had spent some time completing a particular form for it to never again be seen or used.
- Daily changes to discharge plans
- Transfers of patients without advising families – this had been distressing
- Lack of acknowledgement that when a patient was confused it made sense to liaise with carers or family members

Mrs Keating felt that nurses needed to remember what it could feel like to be a relative of a patient.

Mrs Keating did note that they had had a much more positive experience recently where an A and E specialist nurse had kept them informed and liaised really well with her and her husband. She also noted that East Dean Ward had a very useful hospital information booklet and felt that this should be replicated across other wards.

Hazel Tonge highlighted that the Trust was working on improvements to the areas noted above but that some areas had progressed further than others.

Action – Hazel Tonge to discuss with Elizabeth Keating how to take forward some of the learning from Mr and Mrs Keating's experience.

Ashley Parrott agreed that there were issues with the summary letters that were challenging to manage and standardise.

Lynette Wells – noted the comment on the lack of consistency between information available from East Dean and Folkington Wards but reported that there was a project to roll the booklet out across other wards.

3.0 **Minutes of the Previous Meeting**

The minutes of the meeting of 24 May 2017 were approved as an accurate record.

3.1 **Matters Arising**

3.2 **Action Log**

QSC 72 – Ashley Parrott reported that enquiries had been made regarding how Trusts managed the risk relating to non-compliant devices but no response had yet been received. Action remained open.

QSC 73 – It was confirmed that Justin Harris would be reporting first to the Patient Safety and Quality Group on 26 July 2017. Action remained open.

QSC 74 – Concerns had been raised with ESHT Chair, David Clayton-Smith. Adrian Bull had facilitated a meeting with Director of Nursing, Alice Webster, and Medical Director, David Walker where a way forward had been agreed. Action closed.

QSC 75 – Ashley Parrott confirmed that the Trust was not an outlier in relation to contacts with the PHSCO. In Q1 2016/17 the Trust had compared well with other Trusts. Q2 of 2016/17 there had been 16 contacts against a range of 15 – 36. It was noted that this needed to be monitored and that future complaints reports should note whether or not the Trust was an outlier. Action closed.

QSC 76 – Adrian Bull confirmed that the Governance Team produced summaries of clinical audits and that Serious Incidents were discussed at the Division IPRs. The follow up of actions arising from the CQC Action Plan was allocated to the Divisions. Action closed.

Compliance and Risk

4.1 **Patient Safety and Quality – Board Assurance Framework**

Lynette Wells presented the Board Assurance Framework noting the following:

2.14 – increased assurance and move from amber to green for mortality metrics.

It was agreed to remove 2.1.4 (Mortality) from the Board Assurance Framework

2.1.8 – was a new risk relating to 7 Day Services. This was a first draft and carried a score of 16. While the risk related to the potential failure to achieve the standards in the time frame it was noted that the impact of that on patient safety needed to be considered.

3.3.1 – The new Patient Transport Service provider was in place and the service was operating effectively.

It was agreed to remove 3.3.1 (Patient Transport) from the Board Assurance Framework.

Action – Lynette Wells to look into issues regarding the visibility of the report on iPads.

Jackie Churchward-Cardiff queried why Risk 1640 'Removal of Doctors in Training Posts' had not been entered on the BAF and registered concern that an opportunity could be lost if action was not taken before the next GMC survey. Monica Green challenged the risk rating reporting that the survey had been an improvement on the previous year's survey and while there were still a number of flags the picture was generally better. It was agreed to amend the risk rating from 'likely/major' (score of 16) to 'possible/major' (score of 12).

Action – Risk 1640 on the High Level Risk Register to be amended to 12.

4.2 **Patient Safety and Quality – High Level Risk Register**

Ashley Parrott presented the report noting that there had been two new additions.

There was a discussion about the Asbestos risk, opened in 2003 and whether the rating was too high given that there was an asbestos register and a management plan in place which aimed to control the risk. It was agreed that the management plan should be tested at the next Estates and Facilities IPR and a report on this risk brought back to the Quality and Safety Committee meeting in September 2017.

Action – Ashley Parrott to seek confirmation that the Asbestos register and management plan are in place and to ensure that the management plan is on the next Estates and Facilities IPR to ensure that actions have been done.

Action - A report on the Asbestos risk to be presented to the next Quality and Safety Committee meeting in September 2017.

Risk 1187 - Opthalmology – Ashley Parrott confirmed that the first stage of process mapping had been done and this aimed to help address current issues.

Risk 1152 – Obsolete Medical Devices in Clinical Use - Jackie Churchward-Cardiff highlighted that this risk had been open since 2014 and appeared to show no progress. There was a query over the definition of the word 'obsolete' and whether this meant that equipment was no longer supported by the manufacturer.

Action – Ashley Parrott to confirm definition of the word 'obsolete' with David Walker, Chair of the Medical Equipment Group and seek expansion of the commentary for Risk 1152.

It was reported that a theatres inventory was being conducted and that there was a significant backlog of replacements with no lifecycle fund or plan. Adrian Bull reported that the aim was to establish a more systematic programme of replacement.

Action – Ashley Parrott to add the lack of inventory and lifecycle plan for medical equipment to the risk register.

Risk 1426 – VTE Risk Assessments – it was noted that this risk had reduced from 25 to 15.

4.3 **Risk Appetite**

Lynette presented the The Good Governance Institute Risk Appetite matrix noting that there had been a positive reaction to it at the Board Seminar. The Quality and Safety Committee was invited to comment on the levels assigned to Quality, Compliance, and Reputation as these were the Domains that linked to the Quality and Safety Committee. The Domains would also be considered by the Finance and Improvement and People and Organisational Development Committees.

It was agreed that overarching comments would be aired at the meeting and specific comments subsequently emailed to Lynette Wells. Feedback from Committee members was positive and noted that the matrix helped to capture the risks and how they needed to be monitored.

It was noted that Quality and Compliance had been split in Appendix 1

Following a discussion members proposed that the levels were set as follows:

Quality – Open/High
Compliance/Regulatory – Cautious/Moderate
Reputation – Open/High

The committee noted and agreed that the risk appetite for these Domains mapped to the ESHT 2020 objectives. Lynette Wells highlighted that items on the risk register could be mapped to the risk appetite and form a decision making tool.

The proposed risk levels were approved subject to the suggested changes above.

Action – Members to send individual comments on the Good Governance Institute Risk Appetite matrix (mapped to ESHT 2020 objectives) to Lynette Wells.

4.4 **CQC Progress Report**

It was noted, with apologies, that the wrong CQC progress report had been circulated and a new copy would be circulated after the meeting. Apologies for this. Important item – assured the Chair the report would come for scrutiny at this committee.

Action – Karen Salt to send latest CQC progress report to all members.

For assurance it was noted that the CQC Progress Report was well scrutinized at the Divisional IPRs and the Quality Improvement Steering Group meetings.

One area needing more pace was End of Life Care. There was a significant amount of work going in to this but more assurance was needed. An Improvement Director had joined to work with the Trust for 2 days per week.

Other key highlights were:

- The first CQC preparation meeting was scheduled for the 27th July.
- Clinicians and General Managers would be invited to present at a progress meeting with the CQC, scheduled for 22 August, to look at the following areas - End of Life Care, A & E and community.
- The date of the next inspection was not yet confirmed and likely to be influenced by the August meeting.
- It was noted that there was a plan in place to address the issues that had arisen at the mock inspection.
- Diagnostics was noted as an area showing red but there was confidence in the leadership of Justin Harris, Radiology Lead who was working towards resolving many of the issues.
- Childrens' transfer into adult services – this work needed more momentum and Sarah Blanchard-Stow, Assistant Director of Midwifery and Nursing, had been asked to lead on this.

4.5 **ESHT 2020 Improvement Programme**

Hayley Barron presented the report and it was agreed to pick up End of Life Care in the Deep Dive at the end of the meeting.

There were three areas of concern:

- Urgent and Emergency Care – having improved from red to amber this remained at amber as the significant improvements had been recent and changes needed time to be embedded.

- Medical model – works on Seaford 1 and 2 at EDGH had commenced at risk and business case for funding for recruitment elements was being developed.
- Red to Green had been rolled out to surgical wards successfully but as this was recent was still showing amber.

7 day services
Of 4 core 'must dos' 1 was rated green, 2 amber and 1 red. This was reflected in the risk register. It was noted that there was an associated risk around the ability to capture data live.

Action – Minutes of the Quality Improvement Steering Group to be seen at each meeting of the Quality and Safety Committee – Karen Salt to add this to the work plan.

4.6 **Improvement Group Exception Report**

Catherine Ashton presented the update noting that the minutes of the Improvement Group would be circulated to QSC members going forward to keep them sighted on what was being discussed. It was noted that the timings of the Groups meant that the minutes submitted were not necessarily the current notes.

The purpose of the group was restated and related to prioritization of improvement initiatives and to ensure that they were aligned with the strategic objectives and those of the Alliance Executive Group (systemwide). The Group was not looking at performance but looked at themes and trends when work was going off track.

In response to a question from Jackie Churchward-Cardiff it was explained that the various work streams were already being monitored through other groups such as the Urgent Care Programme Board. It was noted that the action log for the Group was out of date.

Action – Catherine Ashton to align the Improvement Group meetings with the Quality and Safety Committee meetings to ensure that more up to date minutes and action logs are available.

5.0 **Safety and Quality**

5.1 **Governance Quality Report**

Ashley Parrott presented the Governance Quality Report and noted the following key highlights:

- The Quality Account for 2016/17 had been completed and submitted
- Complaints backlog had reduced – currently at 10 but fluctuating.
- A deep dive for each Division had been conducted with patient representation and Healthwatch present. Each Division had been asked to select 2 trends or themes and report on how they aimed to address the issues.
- Duty of Candour compliance continued to improve.
- The Patient Experience questionnaire was being redesigned and many of the themes noted from the Patient Story had been captured.

Sue Bernhauser (Chair) and Adrian Bull commended the work that had taken place around complaints and reported that the quality of complaint responses had improved significantly.

While there was still work to do on the function of the Group that ratified policies Sue Bernhauser (Chair) commended the work that had been done so far to address out of date policies.

The challenges reported were as follows:

- Completion of Serious Incident actions – this was being fed back to the team and addressed
- Completion of National Audits and NCEPOD.
- Closing the loop – number of actions not followed up – Ashley Parrott confirmed that these were being followed up on a monthly basis with the Divisions concerned to ensure that actions were completed and embedded in practice.

It was noted that the diabetic pathway and the high level of amputations had been through the IPR meetings and culminated in a report, and a Summit (due to take place on 31 July) to address any issues in the diabetic foot pathway.

There was a discussion about the results of the clinical audit of the tool used to assess patients presenting with self-harm. There would be training and a further audit to assess the results of any changes. Ashley Parrott confirmed that the results of audits did go back to the specialties. He further noted that future reports would contain more detail on what was being done to address issues such as poor audits.

5.2 **Safeguarding Annual Report 2016 – 17**

Sue Curties presented the Safeguarding Annual Report which had been shared with the Safeguarding Adults Board, Safeguarding Children's Board and the CCG.
.
The following key points were noted:

- There had been a number of Serious Case Reviews and Domestic Homicide Reviews in the county – one Review had led to learning for ESHT and the introduction of the IDVA role had raised awareness.
- Learning was being shared through training and this was leading to staff feeling more empowered.
- Child protection information systems (CPIS) had allowed better sharing of information about children and would allow A & E staff to check on children.
- Dr Isobel Hodgson and Dr Imad Bowles had been appointed as new Named Doctors.

Action - Sue Curties to ensure that Dr Isobel Hodgson and Dr Imad Bowles are added to the chart in the Annual Safeguarding Report. (page 26)

Hazel Tonge noted that the CQC had commented on inconsistencies in how Mental Capacity Act assessments were conducted on the wards and in A & E. Following increased training (aimed at Matrons) there had been an improvement in the documenting of MCA assessments. Staff were also being encouraged to use the NHS safeguarding app. The picture regarding Mental Health Assessments was not as positive but there had been a

meeting with the provider (Amanda Burke at Sussex Partnership Foundation Trust) and an action plan was in place. A policy was being developed and a training programme, aimed at site managers initially, was under way.

Action – Sue Curties to remove the Confidential watermark prior to submission of the Safeguarding Report to Trust Board.

5.3 **Quality Strategy Review**

Ashley Parrott presented the progress report for the Quality Strategy. This has been shared with the Chief Executive. While the format was agreed to be useful Ashley Parrott was asked to add Red/Green ratings for future iterations of the report.

Action – Ashley Parrott to add Red/Green ratings to the Quality Strategy Review Report template.

5.4 **Quality Section of the Integrated Performance Report Month 2**

The contents of the Quality Section of the IPR for month 2 were noted. The format of the report had changed slightly to make the information easier to read. Hazel Tonge reported that a Never Event was under investigation. Other key points were:

- Mixed Sex Accommodation breached would be tracked going forward.
- Night moves would be followed up by Hazel Tonge and James Wilkinson.
- The trend line for the number of complaints was going down.
- Morbidity and Mortality Policy was being reviewed to reflect new methods of learning from deaths.

5.5 **Quality Improvement Priorities**

Ashley Parrott presented the report in Emma Tate's absence noting a new set of priorities. It was noted that responsibility for the Quality Account had moved from the Governance Team to the Strategy Team to allow them to be sighted on any issues that might cause delay to delivery. A quarterly report would be submitted to the Executive Directors' meeting with milestone reports being submitted to the Quality and Safety Committee.

6.0 **Deep Dive – End of Life Care**

Hazel Tonge presented the Deep Dive for End of Life Care noting that EoLC had been identified as an issue by the CQC. Progress since had been slow but the report aimed to give assurance that the issues affecting delivery were known and being addressed.

The final draft of the End of Life Care policy had been presented at the last Steering Group meeting. It had been noted that there was no mention of community palliative care and paediatric, maternity and Emergency Department EoLC needed to be addressed. The policy was being reviewed and would be presented to the Policy and Documentation Group for ratification before 20 September 2017.

It was noted that the pace of progress needed to improve and in response to a question regarding the slow progress Adrian Bull outlined that there had been some differences in

views of the role of palliative care that had needed to be worked through. There had also been some changes to leadership which had affected progress. The lead had now been passed to Hazel Tonge, current Acting Director of Nursing.

There were still some challenges relating to the team (one consultant and a palliative care nurse short) and there was some dissonance in the relationship between End of Life Care and palliative care. These issues were being worked through with the aim of presenting a strong strategic statement across the system on End of Life Care. Dr Farida Malik was now covering the Conquest site which had been a positive step.

Training had gone well and an electronic training package was being introduced for doctors.

David Walker and David Barclay were working to review the policies (totaling 31 in number) relating to end of life care. It was agreed to add this topic to the agenda of the next meeting.

Action – agenda item End of Life Care Policies to be added to the September meeting

7.0 **Deep Dive for next meeting**

It was agreed that Rachael Stephens be asked to produce a report on Pressure Ulcers for the Deep Dive at the November 2017 meeting.

Action – Hazel Tonge to ask Rachael Stephens to produce a short update report on Pressure Ulcers for the next meeting and to invite Rachael to attend for the discussion.

8.0 **AOB**

There was no other business discussed.

Trust Board Meetings in Public 2018

6th February	0930 - 1230	Hastings
17th April	0930 - 1230	Bexhill
5th June	0930 - 1230	Eastbourne
7th August	0930 - 1230	Eastbourne

To be followed by the AGM

2nd October	0930 - 1230	Hastings
4th December	0930 - 1230	Eastbourne

East Sussex Healthcare NHS Trust Annual Board Planner 2018

Each Meeting

- Monthly staff award
- Quality walk feedback
- Board Committee Feedback
- Board Assurance Framework
- CEO report
- IPR
- Sub-committee minutes
- Use of Trust Seal
- Questions from members of public

- Speak Up Guardian's Report
- ESBT & STP Update

- Business cases over £500k as recommended by FIC/Contracts awarded in excess of £1m

- Leanring from Deaths (Quarterly Report)

Annual Reports

April
- GOSWH

August
- Organ Donation, Fire, WRES, Complaints, Revalidation, R&D

October
- Nursing and Midwifery, Health & Safety, Infection Control, Safeguarding, Equality

February

- Business Planning 2017-19 (CA)
- Annual plan and budget 2018/19

- Project Search Update
- Speak Up Guardian's Report
- Learning From Deaths (Q2)

- Nursing & Midwifery Safe Staffing (from September 2017)

April

- Quality Improvement Priorities 2017/18
- Delivering same sex accommodation annual declaration of compliance
- Delegation of approval of Annual Report and Accounts 2016/7
- Annual Self Certification

- Fit & Proper Declarations to be completed at this meeting by Board (not for agenda)

East Sussex Healthcare NHS Trust Annual Board Planner 2018

June

- Quality Account 2017/8
- Staff Survey Results
- Review of committee structure/work programme

- Learning From Deaths (Q3)

PRIVATE

- Medical HR Cases Update

August

- Committee Annual Reviews of Effectiveness

October

- Clinical Excellence Awards
- Winter preparedness
- Emergency Planning Core Standards
- Mortality Report (requested for September 2017 – should we make this an annual report?)
- Learning From Deaths (Q4)

December

- Capital programme – mid year review
- Annual Business Plan quarter 2
- Review of standing orders, financial instructions and declaration of interests
- Meeting dates for next year

PRIVATE

- Medical HR Cases Update

Board seminars

Monthly standing items

- CEO General Update
- Finance Update
- Performance Update

JANUARY SEMINAR
- Review of IPR and KPIs (Sarah Goldsack)

MARCH OR MAY SEMINAR
- Annual Review of Board Effectiveness
- Annual Critique of Board Papers

JULY SEMINAR
- Review of BAF & Risk Appetite

AGM – Prior to 30th September

- To receive Annual Report and Accounts and Quality Account