EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 6th February 2018, commencing at 09:30 in the Hastings Centre, The Ridge, Hastings TN34 2SA

	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 28th November 2017	A		
4.	Matters arising	B		
5.	Project Search Update	C	Jeanette Williams /Stacey Beard	
6.	Quality Walks Board Feedback		Chair	
7.	Board Committee Feedback	D	Comm Chairs	
8.	Board Assurance Framework	E	DCA	
9.	Chief Executive's Report	F	CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
10.	Integrated Performance Report Month 9 (December) 1. Quality & Safety 2. Access & Responsiveness 3. Sustainability 4. Leadership & Culture	Assurance	G	DN/MD COO HRD	1030 - 1115
11.	Learning From Deaths (Quarter 2)	Assurance	H	MD	

BREAK

12.	Finance and Financial Special Measures Update	Assurance	I	DF	1130 - 1145

STRATEGY

					Time:
13.	ESBT Progress Report	Assurance		DS /CEO	1145 - 1155

GOVERNANCE AND ASSURANCE

					Time:
14.	Sustainability Development Management Plan Update	Assurance	J	Mark Paice / Will Clark	1155 - 1215
15.	Board sub-committee minutes: 15.1 Finance & Investment Committee 15.2 POD Committee 15.3 Quality & Safety Committee	Assurance	K	Comm Chairs	

ITEMS FOR INFORMATION

				Time:
16.	Use of Trust Seal	L	Chair	1215 - 1230
17.	Questions from members of the public (15 minutes maximum)		Chair	
18.	Date of Next Meeting: Tuesday 17th April 2018, Bexhill (TBC)		Chair	

David Clayton-Smith

Chairman

3rd January 2018

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, 28th November 2017 at 09:30 in the St Mary's Boardroom, EDGH.

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

In attendance:
Miss Jan Humber, Joint Staff Committee Chairman
Ms Sarah Blanchard-Stow, Assistant Director of Midwifery and Nursing (for item 095/2017)
Mr Pete Palmer, Assistant Company Secretary (minutes)

093/2017 **Welcome**

1. Chair's Opening Remarks
Mr Clayton-Smith welcomed everyone to the meeting of the Trust Board held in public. He welcomed Mrs Carruth to her first meeting of the Board.

2. Apologies for Absence
Mr Clayton-Smith reported that apologies for absence had been received from:

Mrs Sue Bernhauser, Non-Executive Director
Mr Jonathan Reid, Director of Finance
Mrs Ruth Agg, Speak Up Guardian

3. Monthly Award Winners
Mr Clayton-Smith reported that the monthly award winner for September had been Dave Fox-Dossett, a matron in the Emergency Department at EDGH. October's winners were Janki Patel and Iwona Ward, Lead Pharmacists at ESHT who attended the meeting to collect their awards.

094/2017 **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.

095/2017 **Minutes**

The minutes of the Trust Board meeting held on 26th September 2017 were considered. An amendment to item 081/2017 was noted but they were otherwise agreed as an accurate account of the discussions held. The minutes were signed by the Chairman and would be lodged in the Register of Minutes.

096/2017 **Matters Arising**

It was noted that there were no matters arising from September's meeting.

097/2017 **Quality Walks**

Dr Walker reported that he had recently visited various areas within the Trust and had been delighted with the warmth of the welcome he had received on each occasion. He noted that the Trust's Speech and Language Therapy team had recently won another national award, and had been very positive about their experiences when he visited. He felt that the Quality Walks were very valuable to both staff and members of the Board.

Mr Clayton-Smith noted a theme of concerns about IT equipment within the report and Dr Bull reported that a programme had begun to replace the oldest desktop computers within the Trust. A separate issue existed concerning Systm One tablets for community staff and a programme was being developed to replace these with laptops. Dr Bull agreed to include an update for staff on the steps being taken to resolve IT issues within the next Team Brief, for circulation throughout the organisation.

The Board noted the report on Quality Walks.

098/2017 **Speak Up Guardian's Report**

Dr Bull reported in Mrs Agg's absence, explaining the importance of ensuring that the Speak Up Guardian had regular access to the CEO, Director of HR and to the Board.

He reported that recently released National Speak Up Guardian data had shown the Trust reporting a high level of incidents, demonstrating the confidence of staff in the service provided. The National Speak Up Guardian along with a number of other NHS organisations had contacted Mrs Agg in order to share learning about the successful implementation of the Speak Up Guardian role within the Trust.

Dr Bull noted that sign off processes had been changed for behavioural incidents to ensure that learning would be shared across the organisation. A programme of training and development for staff on how to behave in meetings, particularly performance management and reviews, was being developed, with workshops having been held with staff to develop a charter.

099/2017 **Board Committees' Feedback**

1. Audit Committee

Mr Stevens reported that the Audit Committee had met the previous week and had discussed the challenges that existed around clinical audit in the organisation. He felt that an appropriate process was now in place for review of clinical audits prior to their commencement. Dr Walker noted that an issue remained with audits being started by junior doctors who would then leave the

Trust prior to completion, which was being addressed.

Mr Stevens explained that the Committee had discussed issues raised following an inspection of the local counterfraud team. Mr Clayton-Smith asked if cybersecurity had been reviewed by the Audit Committee and Mrs Wells noted that an audit of cybersecurity had been completed the previous year, which had given limited assurance and that this remained on the agenda of the Committee and cybersecurity had been added to the Board Assurance Framework.

2. Finance and Investment Committee

Mr Nealon reported that the Finance and Investment (F&I) Committee would be meeting the following day. An extensive mid-year review of the Trust's finances had forecast that the Trust's deficit position would increase.Capital was expected to be a major issue during 2018/19 with major pieces of equipment needing to be replaced. Strategies for delivery of replacement equipment were in place.

3. People and Organisational Development Committee

Mrs Kavanagh reported that the People and Organisational Development (POD) Committee had met on 28th September and had received a report from the Guardians of Safe Working Hours. A key issue discussed by the Committee had been that POD agendas were too full and it had been agreed that the Committee would increase the frequency of meetings to bi-monthly during 2018.

Mr Clayton-Smith asked whether the organisation had a retention strategy in place. Miss Green explained that a focus and framework for retention had been developed, but that the strategy had not been finalised. Dr Bull noted that retention was discussed with divisions during IPRs.

4. Quality and Safety Committee

Mrs Churchward-Cardiff reported that the Quality and Safety (Q&S) Committee had met the previous week. They had received reports from infection control demonstrating improved performance during 2017. The Health and Safety Annual report being presented to the Board had been reviewed in detail. She explained that work to ensure that the organisation's plans to improve End of Life Care would need to be carefully monitored to ensure that they were embedded and working as effectively as intended.

The Board noted the Committee Reports.

100/2017 **Board Assurance Framework**

Mrs Wells reported that the gap in control regarding community paediatrics had been removed from the Board Assurance Framework (BAF) while cybersecurity had been added. She explained that a review of scores on the risk register would be undertaken to ensure that they were correct.

Mrs Wells proposed that two red ratings relating to Emergency Department reconfiguration could be moved from red to amber as reconfiguration had been completed. She proposed that risks concerning patient flow, delayed discharges and meeting of constitutional standards should also be moved to amber as there were a large number of controls in place to meet these objectives. Mrs Chadwick-Bell explained the performance had continued to improve throughout the year since January, including performance against 4 hour A&E targets and Referral To Treatment (RTT) targets. Dr Bull noted that

ESHT had maintained a position within the top 30 Trusts in the country for A&E performance for several months, suggesting that the improvements to performance were resilient.

Mrs Wells proposed that the gap in assurance concerning Clinical Leadership should be moved to a green rating, and Dr Walker noted that a report would be presented to the Board in December detailing improvements that had been achieved. The Board supported the amendment to the rating.

Mrs Wells queried whether the amber rating relating to Capital, IT and Estates infrastructure should be increased to a red rating as it was a major concern for the organisation. Dr Bull noted that the Trust had £35million of clinically relevant backlog. He recognised the severity of the risk, explaining that an appropriate management programme was in place and felt that the amber rating was correct. The risk would continue to be reviewed by the Board and F&I Committee. The Board agreed to maintain the amber rating and would continue to review the risk on a regular basis.

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 recommendations to move the red ratings related to Emergency Department reconfiguration, patient flow, delayed discharges and meeting of constitutional standards to amber. They approved the recommendation to move the amber rating for clinical leadership to green.

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

Dr Bull reported that Alan Thorne had joined the Trust as Improvement Director and that Mark Hackett had joined as Financial Improvement Director.

Dr Bull reported that while finances had stabilised, the level of financial improvement being realised was not in line with progress made during the previous year in improving culture, operational performance against statuary targets, and in safety, quality, and governance. He explained the importance of achieving an appropriate balance in ensuring that finance wasn't improved at the expense of safety, while continuing to use public money responsibly.

Cash flow remained a concern and work had been undertaken to better understand debtor and credit positons. The Trust was working with the CCG to resolve cash flow issues and staff had been asked to ensure that any issues with suppliers were raised via DATIX so that they could be swiftly identified and resolved.

Dr Bull reported that Guardians of Safe Working Hours had managed the introduction of the new junior doctors contract well. Exception reporting levels remained low and had helped to identify areas where there were issues that required attention. A senior leadership programme had been introduced, with training being given to senior leaders within the organisation.

Dr Bull explained that a meeting had been held with members of the Bruderhof Darvell Community who had volunteered to renovate a children's play area at the Conquest. This had been completed and he thanked them for the wonderful work that they had done. He noted that a play therapist had been

appointed at Kipling Ward.

QUALITY, SAFETY AND PERFORMANCE

084/2017 **Integrated Performance Report Month 6 (October)**

Access and Responsiveness
Mrs Chadwick-Bell reported that four hour A&E performance had continued to improve, from 82% at the end of 2016 to 94% in November 2017. Delayed Transfers of Care had improved by 7% from the previous year despite an increase in both admissions and attendances. Stranded patients who had stayed in hospital for over six days had been reduced from 520 to 360 during the year, demonstrating improved flow and patient experience. She anticipated a challenging period during and after Christmas, emphasising that the Trust would continue to focus on meeting performance targets.

Mrs Chadwick-Bell advised that work was being undertaken with ambulance services to improve ambulance handovers and that the South East Coast chaired forum would be further examining this issue.

She reported that RTT targets had been met for an 18 week period, but had been missed during both October and November. She hoped that performance would improve in December, noting the importance of balancing performance and financial targets. Cancer targets were being met with the exception of the 62 day standard, although this had improved during the previous two months.

Mrs Chadwick-Bell reported that diagnostic performance continued to be challenging, and hoped that new equipment due to be installed over the forthcoming months would help improve this position. Work was being undertaken to ensure that processes and pathways were correct, and NHS Elect had been asked to provide independent assessment.

Mrs Kavanagh asked whether there were differences in four hour performance between EDGH and Conquest and Mrs Chadwick-Bell reported that performance on both sites during November had been over 94%. Performance fluctuated on a daily basis, but there was generally less than 1% difference between two sites over the course of each month.

Mr Clayton-Smith asked whether there were any specific concerns about winter plans and Mrs Chadwick-Bell reported that she felt that the system wide plans were the best she had ever seen. Staffing remained an issue and the Trust had not been able to recruit to all required hours for primary care streaming. The new Acute Medical Unit at EDGH was due to open in December. Mrs Chadwick-Bell anticipated that the period after Christmas moving into the New Year would be incredibly challenging for the organisation.

Quality & Safety
Ms Carruth reported that four Serious Incidents had taken place in September, with one Never Event reported relating to orthopaedics. The Trust had a robust Root Cause Analysis and investigation process for Never Events and findings would be presented to the Quality and Safety Committee when completed.

An ongoing reduction in falls was being seen and the Trust had signed up to the National Falls Collaborative. A new falls risk assessment tool was being developed and deep dives of 20 falls would be undertaken.

Dr Walker reported that mortality due to sepsis had greatly reduced since the introduction of new guidelines. He explained that SHMI mortality levels had recently increased while RAMI mortality levels had fallen steadily aside from a slight blip in January and February. Work was being undertaken with GPs to encourage them to correctly code episodes and it was hoped that this would lead to a reduction in reported mortality levels. Dr Walker noted that CHKS had temporarily withdrawn RAMI as a measure of mortality as they were altering methods of reporting using this measure. Initial feedback had suggested that the Trust's RAMI would improve under the new reporting measure.

Mr Clayton-Smith asked what learning from the reduction in sepsis could be shared throughout the Trust and Dr Walker explained that the reduction had been a result of improvements to the throughput of patients in A&E alongside a timely national review of sepsis in A&E. Clinicians had been fully engaged with the process.

Mrs Churchward-Cardiff asked whether the increase being seen in night moves for patients was a consequence of improved patient flow in A&E. Ms Carruth explained that concerns had been raised about the validity of this data, and Mrs Chadwick-Bell confirmed that a breakdown of the data had been requested and that this would be discussed by the Q&S Committee.

Leadership & Culture

Miss Green reported that recruitment and retention remained one of the main challenges of the organisation. New consultants had recently started in a number of areas, with more due to start in December and January. 33 newly qualified nurses joined the Trust in October, with 20 more due to start in February. The Trust saw a turnover of 11.3% in October, and retention of staff would be a focus of the organisation in coming months.

The Trust had seen an increase in temporary workforce usage during the last couple of months, mainly via the staff bank and not agency usage. Sickness had been 4.8% in October, with the annual rate remaining unchanged.

Mandatory training and appraisal rates remained relatively static. A Leading Excellence programme and a Leading Service programme had begun, alongside a Matron training programme. 46% of the Trust's staff had already completed a staff survey and Miss Green hoped that 50% would complete a survey by the closing date. Dr Walker noted that two very well attended sessions had been held to help doctors manage the pressure of their roles, with further sessions planned for 2018.

In response to a question from Mr Clayton-Smith, Ms Carruth explained that the Trust was required to publicise fill rates for registered and unregistered nursing staff. Rates of over 100% were seen when there were requirements for special nursing, which were in addition to planned nursing levels. She noted that a robust system was in place for reviewing staffing levels with reviews taking place multiple times a day alongside the use of the electronic rostering system to ensure appropriate levels of cover.

Mr Stevens noted that appraisal compliance had improved slightly, but was concerned about continued shortfalls in appraisal rates. He said that he would like to see more effort being given to ensuring that managers fully understood the importance of appraisals for every member of staff. Dr Bull explained that

appraisal rates were reviewed in every IPR meeting and divisions had been asked to develop improvement plans.

Activity
Mr Clayton-Smith asked whether resources were being reduced where reductions in activity were being seen within the organisation. Dr Bull explained that reducing activity in some areas allowed the Trust to carry out activity internally, rather than outsourcing, which reduced costs.

Mrs Churchward-Cardiff expressed concern about the reducing trend of day case activity reported during the year. Mrs Chadwick-Bell agreed to present more detailed information to the Board to provide assurance about the changes in activity. **JCB**

The Board noted the IPR Report for Month 6.

85/2017 **Mortality Learning From Deaths Policy**
Dr Walker explained that all deaths should be reviewed within three months in order to comply with reporting deadlines. Current issues which were causing delays to reviews were being addressed and reviews that were being carried out were of good quality, with excellent Multidisciplinary team involvement. During the previous quarter only one death had been classed as probably avoidable, which was consistent with equivalent organisations.

Mr Stevens asked what could be done to address the concerns of consultants about the possibility of being sued and the damage to their reputation if they admitted to errors. Ms Carruth explained that there was a need to balance Duty of Candour and transparency with a genuine concern for receiving litigation. She explained that errors were often a result of failing to follow correct processes and that it was important that staff were supported in doing their jobs properly and in being honest when issues arose. Dr Walker noted that coroners commented negatively on M&M reviews which omitted mention of errors that had occurred, emphasising the importance of honesty when mistakes were made.

Dr Bull noted that learning from deaths always took place, although this wasn't always within three months. The new system of public declarations of learning from mortality and avoidable deaths was part of long term national project to increase transparency

86/2017 **Finance and Financial Special Measures Update**
Mr Clayton-Smith noted that a question from Mr Campbell concerning the financial forecasts had not been included in the previous minutes. He apologised for the omission, noting that this had been due to an IT issue. He explained that fantastic improvements in quality and care had been realised within the organisation, but the financial situation remained very challenging.

Dr Bull reported that the Trust had forecast a deficit of £36million prior to STF funding for 2016/17. The Trust had remained on target to meet this total for the first four months of the year, but by month six was £4.7million adverse to plan. Underlying factors for this position included a reduction in elective activities and a new coding system, as well as CIPs not performing as expected. The Trust was aiming to deliver £22million of £28million planned CIPs, and a presentation would be made to NHSI's Financial Special Measures team on December 19th about the deterioration in position.

Work was being undertaken to agree a shared incentive contract with CCGs for the remainder of the year in order to guarantee some aspects of income. An income position had been agreed and the Trust was seeking approval of this from NHSI and NHSE.

Mr Nealon explained that the F&I Committee would be looking for assurance that the Trust had the necessary grip and control to translate ideas into actions. He noted the importance of having an achievable long term financial strategy.

Mrs Kavanagh praised the work that the Trust had done in transforming quality within the organisation, explaining that she was very concerned about the financial situation and asked how realistic the revised forecasts were. Dr Bull explained that the financial challenge facing the organisation needed to be appropriately planned for, noting the importance of ensuring that the Trust's financial plans for 2018/19 were built upon realistic expectations. He anticipated that the organisation would respond to the challenge maturely due to improving engagement and self confidence among staff.

Mr Stevens explained that he would not wish to be part of an organisation where financial priorities were put ahead of patient safety and quality. He noted concerns that divisions were still not fully engaged in the importance of meeting financial targets. Ms Carruth explained that improving the Trust's finances would require time and clinical and financial leadership. Quality Impact Assessments would need to be undertaken to ensure that quality was not affected by any changes and all clinical colleagues would need to be fully engaged in order to make improvements.

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 **Capital Programme Mid-Year Review**

Dr Bull reported that the Trust had allocated £11.7m of capital for 2017/18 and that spending remained on track for the year. Ambulatory areas had been initiated with additional capital from NHSI. A key project had been building the housing for a new CT scanner at EDGH and it was hoped this would be completed prior to Christmas. Minor improvement work continued to be undertaken and issues raised by CQC had either been addressed or continued to be addressed by the Trust.

088/2017 **East Sussex Better Together Progress Report**

Ms Ashton highlighted the progress that had been made by East Sussex Better Together (ESBT) and played a short video showcasing the achievements of ESBT since it had launched in August 2014.

Mrs Chadwick-Bell asked how this information would be shared with staff and Ms Ashton agreed to look at methods of sharing the video within the organisation. Ms Humber noted that the simple and accessible nature of the video meant that it would be very helpful for all groups of staff.

089/2017 **Clinical Strategy**

Ms Ashton noted that the Clinical Strategy had previously been discussed by the Board in Seminar mode. It had also been discussed at the ESBT Clinical Board, with the CCGs and within ESHT. She noted that the strategy would be renewed, refreshed and recommitted to on an annual basis. Additional work

was being undertaken to align the clinical strategy, the long term financial plan and business planning into a future state model.

She explained that she was asking the Board to:

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

Mr Clayton-Smith asked how the Clinical Strategy would evolve and Ms Ashton explained that the five year time frame for the strategy would be a constant rolling timeframe, leading to an iterative process that would be refreshed on an annual basis.

Mrs Churchward-Cardiff noted that it would be helpful to include information within the strategy's principles about how to access services, and asked whether discussing a potential 60% population growth alongside an opportunity to reduce beds were conflicting. Ms Ashton explained that a further piece of work would be undertaken to incorporate information about accessing services. She agreed that a 60% population growth alongside a reduction in beds was a challenging proposal, noting that a reduction in beds for any service could only take place by altering the way in which services were delivered.

Board ratified the Clinical Strategy, noting that it was an iterative strategy that would be developed alongside clinical teams moving forward into 18/19.

090/2017 **Emergency Planning Core Standards and Emergency Preparedness, Resilience & Response (EPRR)**

Mrs Chadwick-Bell explained that the Trust was required to present an annual EPRR statement to the Board. The Trust had undertaken a comprehensive self-assessment on the core standards set by NHSE working closely with CCG.

She explained that the Trust had rated itself as partially compliant and had been close to substantial compliance, with significant progress having been made since the previous year. Appropriate plans were now in place, although training needed to be improved in order to raise awareness of plans. An appointment had been made for a full time position, starting in February, to provide greater capacity for embedding and planning within the organisation.

Mrs Chadwick-Bell noted that a recent major incident had been managed very well and had led to confidence that staff knew about what their roles were in the event of a major incident. Mr Stevens noted that he had been very assured by the Trust's response to the gas cloud incident and was confident that that appropriate processes being introduced would only improve responses further.

Mrs Kavanagh asked when the Board would find out whether the proposed improvements had been embedded and Mrs Chadwick-Bell agreed to provide a six month update to Board. **JCB**

091/2017 **Annual Reports**

1. Infection Control

Ms Carruth thanked the Infection Control team for writing the report, noting that it had been discussed by the Q&S Committee. She reported that during 2016/17 one MRSA bacteraemia case had been reported. Cdiff infections had remained the same as in the previous year and all had been reviewed in order to identify any lapses in care that may have contributed. Two blood stream infections had been reported during the year, both of which were unavoidable.

Changes to the Infection Control team had taken place during the year, and the Trust was hoping to recruit another microbiologist. Dr Walker thanked Dr Anne Wilson for her work as Director of Infection Control (DIPC) for the Trust, noting that she was due to retire. He noted the Ms Carruth would be acting as executive lead for the organisation and a clinical lead would be identified as soon as possible.

The Board received the Infection Control Annual Report

2. Health and Safety Annual Report

Ms Carruth thanked the team who had contributed to report. She explained that she felt that systems and processes that were in place within the organisation were not well reflected by the report. She would be meeting with Ms Kavanagh to discuss how the report could be improved in the future. She noted that there were no areas of concern within the report. Mr Stevens asked if comparative and benchmarking data could be included in the future.

Mr Clayton-Smith asked that an update be presented to the Board in six months to provide assurance about the proposed improvements. **VC**

The Board received the Health and Safety Annual Report

092/2017 **Review of Corporate Documents**

Mrs Wells noted that the proposed changes to Corporate Documents had been discussed in full at the Audit Committee and had been recommended for Board approval.

The Board noted that a review had been undertaken and approved the revisions to the Corporate Documents.

093/2017 **Board Subcommittee Minutes**

The following sub-committee minutes were reviewed and noted:

- Audit Committee minutes of 26th July 2017
- Finance and Investment Committee minutes of 30th August 2017 and 27th September 2017
- People and Organisational Development Committee minutes of 15th June 2017
- Quality and Safety Committee minutes of 19th July 2017

The Minutes were received by the Board

094/2017 **Meeting Dates and Planner for 2018**

Mrs Wells noted that meeting dates for 2017 had been altered to avoid ESBT

meetings, leading to some issues with document flow between Committees and the Board. She hoped that amendments to the schedule for 2018 would improve the flow of information across the organisation.

The Meeting Dates and Planner for 2018 were approved

095/2017 **Questions from Members of the Public**

Parking and Single Siting of Services

Mr Berry reported that that he had recently written to Dr Bull about parking facilities at the Trust and had received a response. He felt that the Trust should look at improving basic facilities such as parking and noted that there were difficulties for patients in having to travel between sites. He asked whether services could be split between the two main sites as they had been in the past.

Dr Bull agreed that parking remained an issue for the Trust, noting the importance of resolving the issue for both the public and for staff. He explained that a number of different options for improving the matter were being reviewed, and that plans would be subject to external scrutiny.

Dr Bull explained that the siting of services was a complex matter with many factors that needed to be considered when decisions were made.

Stillbirths

Mrs Walke commented that she remained very concerned by the number of stillbirths, noting that eight had been reported in 2016. She urged the Trust to review stillbirth trends.

Ms Blanchard-Stow, Associate Director of Midwifery, explained that three stillbirths had been reported in 2017, and that the Trust saw 0.45 stillbirths per 1000 which was below the national average. Additional staff had been employed to look at trends and themes, and every stillbirth was reviewed in detail. She noted that recent proposals around stillbirths by the Secretary of State for Health were already being undertaken by the Trust.

Staff Language Skills

Mrs Walke noted that new staff, particularly nursing staff, were good but some had limited nursing English skills, explaining that the issue had been raised with her on a number of occasions. Ms Carruth noted that the Trust had a diverse workforce, and that the Trust was very careful to ensure that new staff were able to communicate appropriately in whatever role they undertook.

Cancer Pathways

Mrs Walke asked whether tests carried out in Brighton as part of ESHT cancer pathways could hamper cancer waiting times. Mrs Chadwick-Bell explained that the Trust reviewed every breach in order to fully understand why it had occurred. Delays in reporting from other Trusts could cause breaches, but these were tracked and addressed with other organisations.

Clinical Strategy

Mrs Walker noted that the Clinical Strategy said that there had been obvious improvements within the organisation since reconfiguration of services. She explained that she didn't think that this was the case and felt that reconfiguration was the reason for the Trust being placed into Special

Measures. She accepted that the Trust was greatly improved in the last couple of years.

Submitted Questions from the Public
Mr Campbell asked why questions from members of the Public submitted prior to the meeting were not attached to the minutes and Mr Clayton-Smith agreed that this should happen moving forward.

Security Staff
Mr Campbell asked whether A&E staff were happy with the service they received from security staff. Dr Bull noted that following a recent incident where a member of staff had been assaulted in A&E, a security review had been conducted and concluded that there were appropriate security levels. Mrs Chadwick-Bell reported that security teams were very quick to attend when issues were reported.

Trust Roles within ESBT
Mr Campbell noted that the ESBT alliance were implementing integrated roles which would be filled by secondment, asking whether members of staff from ESHT would be seconded to roles. Dr Bull explained that if ESHT staff were seconded then the Trust would ensure that this did not impact on performance. Senior secondments to the CCG had taken place in the past which had proved to be beneficial in improving working relationships and understandings.

Mr Campbell expressed concern that Dr Bull could be seconded to an Alliance leadership role and Dr Bull explained that he had no intention of leaving the role of CEO of ESHT in order to take up another position.

A&E Redevelopment
Mr Cambell asked if the redevelopments of the A&E departments on both sites were on schedule and on budget. Mrs Chadwick-Bell confirmed that work had been completed at the Conquest and a GP had been recruited to provide primary care support. Work at EDGH was due to finish before Christmas and was slightly behind schedule. This had not impacted on the Trust's ability to deliver primary care capacity and a GP was already on site. Budget costs on both sites remained on track.

HSJ Award
Mrs Walke asked about a recent HSJ Award and Dr Bull explained that ESBT had won a national award for the best collaboration between health and local government. He noted that the Trust had also received finalist nominations for Project Search and for the Doctors Assistant Program which unfortunately hadn't won.

096/2017 **Date of Next Meeting**

Tuesday, 6th February 2018, in the Hastings Centre

Signed ……

Position ……..

Date ……

C Campbell, November 27, 2017

ESHT Board Questions – November 28, 2017

1. Can the Board confirm whether A&E staff are satisfied that there is adequate security staff on site to ensure a safe working environment or do they believe that more security staff should be employed? This has been reviewed and the current security arrangements are agreed as satisfactory.

2. The format of the Income and Expenditure Report as at month 6 was amended from previous statements by the exclusion of a year-end outturn forecast. Allowing for the reforecast exercise currently taking place can the Board please advise the current forecast figure and the percentage of probability that is currently applied to the forecast figure? Will be addressed at February's Board meeting.

3. The ESBT Alliance is implementing a number of Integrated Single Leadership roles that are, I believe, scheduled to be filled by secondment from Alliance members. Is it expected that any ESHT senior staff will be seconded to these or other Alliance roles and if so will this have an impact on the Trust's performance? There is only one seconded role – to run the joint Portfolio Office. This will not have an adverse impact on the Trust's performance. Other senior executives have adopted lead roles for the partnership as part of their general duties. Such system leadership would be expected of senior execs. We do need to keep a careful eye on the level of demand made of individuals.

4. Regarding the A&E redevelopment work can the Board advise if the work is on schedule and whether the total cost for the project will exceed the planned project expenditure? This work is on schedule and within target cost.

5. There is a report in the Finance pack headed Cash Flow Report. Can I ask if this title is correct or should it be headed as "Funds Flow Report" as it contains non-cash movement e.g. depreciation? Comment passed to the Director of Finance.

   As part of the budget planning exercise for 2018/2019 will there be an exercise undertaken to assess the assets available to the Trust e.g. staff, premises, sub-contracted services like critical care ambulance services and non-urgent patient transport services and whether or not the available level of assets will meet the demand forecast used for budgeting purposes? Comment passed to the Director of Finance.

6. Would it be possible to amend the basis of car parking charges to 20 minute segments charges at 2p per minute rather than the general time frame envelope charging currently used? Considered but not feasible

7. As the Trust is leading the new communications network, can every set of Board papers please contain a briefing paper on the project covering network design, design approval, planned and actual costs and plan and actual timeframes? Not certain what this relates to

8. Can each set of Board papers include an update on the activities being undertaken by the Improvement Will be a quarterly paper

9. Where patients are unaware of the existence of non-urgent patient transport services could the Reception staff undertake to ask if patients incurred any travel costs in coming for treatment and provide the patients with claim forms for completion? Will be unfeasible to ask every patient but we are raising awareness of patient transport

ESBT Alliance Questions

10. Can the Board offer any clarity on the anticipated method of Trust interaction with ESBT Alliance bodies? Currently through Alliance Executive Group

11. What impact if any will the activities of the ESBT Alliance bodies have on the budgeting process of the Trust for the financial year 2018/19? As a statutory organisation the Trust is responsible for agreeing its budget with commissioners

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 28th November 2018 Trust Board Meeting

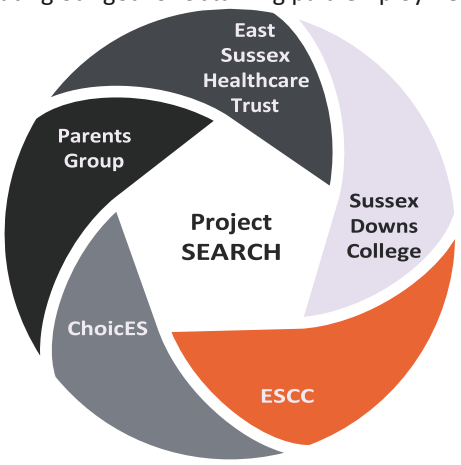
Agenda item	Action	Lead	Progress
084/2017 – IPR Month 6 - Activity	Mrs Chadwick-Bell agreed to present detailed information about the reducing trend of day case activity once this was available.	**JCB**	To be presented when analysis completed
090/2017 - EPRR	Mrs Chadwick-Bell to present an update on progress in implementing Emergency Planning Core Standards and Emergency Preparedness, Resilience & Response (EPRR)	**JCB**	Timetabled for June 2018
091/2017 – 2 – Health & Safety Annual Report	Ms Carruth to present an update on progress with the Health and Safety Annual Report	**VC**	Timetabled for June 2018

What is Project SEARCH?

Project SEARCH is a supported employment initiative for young people with learning difficulties and disabilities. It started in the USA in 1996 and is now being taken forward in Europe and the UK.

Within the UK, Project SEARCH is essentially a joint project between a local authority, a local college or school and a host employer. One of Project SEARCH's most unique attributes is its emphasis on collaboration.

Project SEARCH is driven by partnerships and a network of tutors, job coaches and job developers and business leaders that play an integral role in executing our goal of obtaining paid employment for individuals with disabilities.



What's involved in the programme?

All interns are unpaid members of staff in the host business and so the first part of the programme is spent fully inducting the interns and completing orientation activities.

After induction, the programme runs Monday to Friday, with breaks during academic holidays.

A Typical Day:

10:45 - 12:45 Work
Interns begin initially with 1-2-1 coaching before the Job Coach progresses to observation and skills development support. Utilisation of 'natural supports' from host business staff provides developmental opportunities. Skills are developed over each rotation to reach competitive paid employment working standards and quality benchmarks.

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

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

9:30 - 10:30 Training session
The curriculum is bespoke and aims to support the acquisition of skills and preparation for getting and keeping a job. Interns will gain a Supported Employment qualification.

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

3:45 - 4:30 Back to base room
'Book-ended' support ensures interns can share their individual experiences through peer support sessions, reflect on and evaluate their experiences, work on an individual career plan and apply for work with our Job Developer.

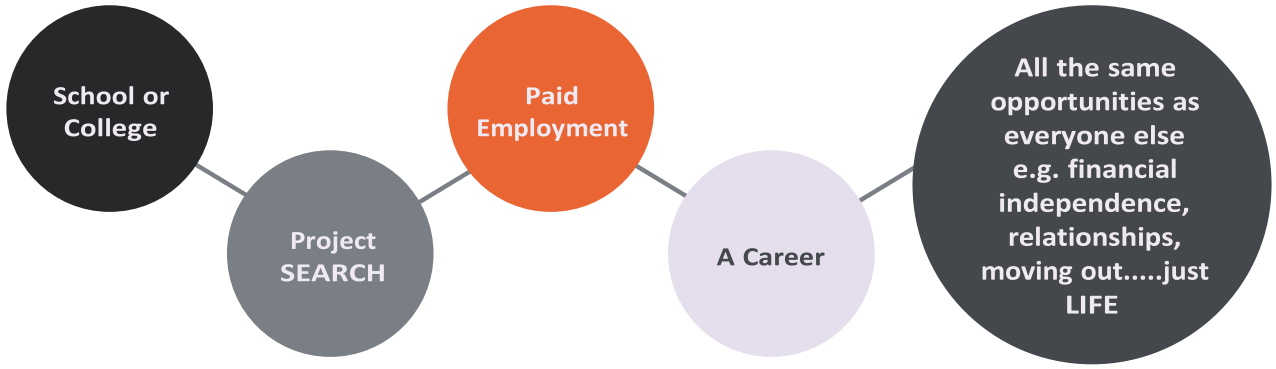
Key info:

- Project SEARCH seeks to work in a collaborative way and immerses the intern within a host employer to enable them to acquire employability and marketable work skills.
- Interns participate in three 10 week rotations to explore a variety of job and career paths.
- The progression goal is into competitive paid employment.
- There is no obligation on the host employer to provide permanent employment.
- Interns can continue to claim DLA/ESA whilst on the programme.

Eligibility Criteria

- Age 18-24
- An Education Healthcare Plan
- Be willing to travel independently
- Wanting to find full time employment

The Project SEARCH Journey



Benefits of Project SEARCH

Benefits to the intern:

- Participate in a variety of internships to explore employment aspirations and interests
- Acquire competitive, transferable and marketable job skills
- Gain increased independence, confidence, and self esteem
- Obtain work based individualised instruction, coaching, support and feedback from job coaches and host business managers and buddy/supervisors
- Develop links to adult support agencies and community networks

Benefits to the host business and potential employers:

- Increased work capacity by carefully selected candidates who are ready for work, who match labour needs and improve performance and retention in some high-turnover or hard-to-fill posts
- Departmental opportunities for staff as mentors/buddies to interns
- On site trained and experienced disability employment specialists who can provide disability awareness training, advice on the Disability Discrimination Act and reasonable adjustments
- Help to develop accessible recruitment practices
- Enhanced business profile through increased local, regional, and national recognition

Contacts

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Find us online

POD Committee Summary 17th January 2018

Meeting information:			
Date of Meeting:	6th February 2018	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 17th January 2018.

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 17th January 2018. 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. HEE National Workforce Strategy

The Committee received a presentation from MG outlining the HEE National Workforce Strategy; the first joint workforce strategy between health and social care. The strategy was aimed to improve the quality of care for patients now and in the future by ensuring that a comprehensive workforce would be in place. The consultation period is up until the end of March 2018 with the final strategy to be published in June/July 2018; the Trust will submit a response.

4. HR Incident Report

The Committee received a presentation from MT outlining the HR Incident Report. A discussion took place around closed cases and it was agreed to look at how investigations were being completed, the preparation as well as reviewing of cases in the future. The Trust's aim was to increase mediation as it was felt that staff would feel more engaged within the process.

5. Review of "Well-Led" - CQC

The Committee received a presentation from LW outlining the Well-Led" CQC document; the Trust would be assessed against 8 key lines of enquiry. Good progress had been made since the previous CQC visit in many areas although challenges remained, which were being addressed.

6. Succession Planning/Talent Management update

The Committee received a presentation from LM outlining the Succession Planning/Talent Management paper. This was part of the "Well Led" domain; the CQC would be looking at the process as well as a succession plan to be in place at Board level. A Talent Management process pilot would be in place by end of March 2018. It was agreed that the Executive team would review and agree critical roles within the Trust.

7. 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.

Approved minutes of the meeting held on 28th September 2017 and 14th December 2017 are attached for the Board's information.

Miranda Kavanagh
Chair of POD Committee

17th January 2018

Board Assurance Framework

Meeting information:	
Date of Meeting: 6th February 2018	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?

Executive Summary:

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

Attached is the updated Board Assurance Framework (BAF) and all updates are shown in red text. This month there are no additions to the BAF and no proposals to remove or change grading of gaps in control or assurance.

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

Quality and Safety Committee – 24 January 2018
Audit Committee – 31 January 2018

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

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

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. Jan-18 Ongoing preparation for inspection. CQC information request completed Dec 2018. CQC first focus groups also taken place.	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 85% trajectory but improving. Number of programmes in place to support improvement including joint PTL tracking with both Brighton and Guys. May-Jul 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 ongoing programmes of work to improve cancer metrics. 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. Jan-18 Achieving cancer metrics with exception of 62 days 77% Lung, colorectal and urology are highest breaching specialities, although urology have improved significantly. Number of actions in place to improve performance detailed in monthly performance report.	end-Mar 18	◄►	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 - 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. Jan-18 New builds at both the DGH and CQ sites, have increased capacity within the emergency departments. At CQ, minors has been relocated to the new unit, along with primary care streaming. At DGH the capacity is used for primary care streaming, but at peak times is also used by ENPs and the ED Drs and speciality teams to avoid using the cubicle space. The Medical Ambulatory unit opened at DGH in December, offering additional space to increase activity and offer improved privacy and dignity. A similar unit is being scoped for CQ, with a view to start building in the spring. The released capacity (old AEC) will be used to further develop the space within the ED. Aim to improve paediatric facilities as well as ambulance handover area, plans are being reviewed currently, allowing timescales to be set.	end-Mar 18	▲ Nov-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 Oct; 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-Mar 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. 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-Jul17 Achievement of key constitutional targets and trajectories remains challenging however, performance is improving . 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. Jan-18 Urgent care and patient flow programme has been re-scoped for 2018, building on the existing work. DToCS have reduced by approx 7%, with NEL LOS reducing by 0.9 days. Benefits can be seen through increased performance of 4 hour standard, which improved from 82.5% in Nov 16 to 94.1% in Nov 17., despite an increase in attendances and admissions. Start of winter has been a challenge, but flow through the department has been sustained at a 10% improvement on the previous year.	end Mar-18	▲ Nov-17	COO	

Strategic Objective 2: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.							
Risk 2.1 Continued - We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.							
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.1.6	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 Jan-18 Audit presented and confirmed that children with mental health difficulties primarily present after 4pm in the afternoon and so the vast majority cannot be assessed until the following day by the mental health nurse. These childrn require a hospital bed until the assessment is undertaken. Initial meeting with CAMHS and another planned Feb.	end Mar-18	◄►	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. Jan-18 There have been difficulties with resources within the PAS team to take this work forward due to other priorities such as eRS. Mitigation continues as above and an implementation plan, with milestones, is being developed by IT/Operations to be monitored through IPR.	end Mar-18	◄►	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. Jan-18 Mandatory Training 88.2% Appraisals 81.3% (Dec data). Targeted interventions continues within areas where compliance remains poor or there has been no perceived changed to compliance despite local service assurance. Review of all Workforce Business metrics in progress to ensure that robust and meaningful data is collated and presented to managers to enable them to take greater ownership of the management of compliance in their own areas, and deliver on trajectory plans Review to begin on full Statutory and Mandatory/Appraisal Training provision to examine and revise content where necessary, and source alternative ways to deliver training	end Mar-18	◄► 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. Jan-18 Leadership Pathway outlining development opportunities for all leaders in the organisation is now in place and will be communicated widely in the next 2 months. Lead in Service programme for ward matrons is currently being developed.	end Mar-18	▲ Nov-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.	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 Jan-18 Work ongoing to develop long term financial model alongside work to provide assurance on the 18/19 financial and operational plans. The new format of leadership briefing will provide the opportunity for Executive Team to brief the organisation on the progress with our plans. Currently meeting the milestones for 18/19 planning which will feed into the longer term IBP	end Mar 18	◄►	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. Jan-18 PID agreed by 7DS steering group. All divisions incorporating 7DS needs into their 2018-19 business planning. Standard 2 New MAU post-take round proforma agreed and incorporated in IPD. Includes ceilings of care and stratification. Work ongoing on recruiting additional AMU consultants. Intermittent weekend additional AMU consultant cover at both acute hospital sites. Standard 5 Guidance for clinical staff on accessing investigations nearly complete. Will be available on intranet and entry points. Standard 6 Work ongoing on changes to GIM rotas to support 24/7 GI bleeding service. Will require changes to consultant job plans Standard 8 Pilot wards (Gastroenterology, Rheumatology) being recruited for electronic recording of patient acuity stratification and daily review delegation (core standard 8). Work ongoing on modifying eSearcher/PAS to incorporate additional stratification /delegation functionality. Project team site visit to Ashford (EKH) to view functionality of Careflow. Careflow to be introduced from 2018-19 Q1, but preparatory work will be undertaken prior to that.	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.	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 – Month 6 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. Jan-18 – In previous months, the level of risk within the financial position has been discussed by the Trust Board, F&I Committee and with NHSI through the Financial Special Measures regime and through monthly IDM meetings. The Trust has reflected in these conversations the risks to delivery of CIP schemes, cost pressures and the recovery of full PBR income from local CCGs in the context of a financially challenged local health economy. At Month 9, and following both extensive dialogue with NHS Improvement and a series of mediation sessions with East Sussex CCGs, the Trust has agreed a revised forecast outturn for the year of £57.4m with a confirmed final income figure for the year from the CCGs of £257.1m. A full briefing on the crystallisation of risk within the position has been reviewed with the Finance and Investment Committee and the Trust has submitted a formal reforecast to NHSI, following completion of the required template. The remaining risk within the position is in respect of managing the financial consequences of winter pressures, agreeing an appropriate valuation basis for the Trust asset base at the end of the financial year, and delivery of the cost improvements agreed through the Trust-wide confirm and challenge process. The financial planning process for 2018/19 is underway, taking account of the lessons from 2017/18 and with the support of the Trust Financial Improvement Director.	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.	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. Jan-18 – At Month 9, the Trust has spent £7.9m of the full capital programme – significantly less than planned at this point in the financial year, reflecting the challenges in delivering capital projects in the context of significant operational pressures. The Capital Review Group is undertaking a full review of the remaining capital expenditure in Q4, and will present a refreshed forecast to the Finance and Investment Committee. Detailed work on the long-term capital plan continues,with a five year plan anticipated before end of Q4 for presentation to the Trust Finance and Investment Committee.	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. Jan-18 Full survey and supporting information provided to ESFRS, a review meeting to be arranged in January. Business case presented at the board seminar in December, resulting amendments to be incorporated. Developing a project to address issues with existing fire compartment walls in the Seaford and Hailsham ward areas.	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 Jan-18 Action plan published Jan-18. Reviewing IT Security Systems and phishing email simulation software in place. Funding approved by Sussex COIN board to implement DNS security across Sussex COIN. Will require a long term sustained programme of work to deliver assurance that threats from cyber-attacks are adequately controlled.	end Mar-18	◄►	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-May 17 Substantive workforce numbers increased from 5684 ftes to 5949 ftes (Apr-Nov). 80 offers made to overseas nurse. Introduction 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. 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; Philippine and Italian nurses recruited. 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. Attending local carers fairs to promote the Trust. Jul-Nov17 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. Monthly events planned and recruitment booklet finalised. Development of new roles. Workforce reviews and planning sessions programed for autumn, linked to business planning. 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 between Dec 2017 and April 18. UK student nurse recruitment event -21 candidates confirmed. Department. Workforce meeting with Nursing to agree future recruitment plans in greater detail. Continued social media activity to drive candidate traffic to Trust website. Targeted activity around ED vacancies. Jan-18 Hard to recruit vacancies identified with Medacs Agency who are assisting the Trust in a targeted approach to sourcing candidates for the key hard to recruit vacancies. Medacs will also be targeted with AHP difficult to recruit vacancies. Overseas nurse recruitment continues with c16 candidates due to arrive Apri-18. Planned attendance at nurse/medical recruitment events for 2018. Out Of Hospital recruitment campaign commenced to support in sourcing a number of posts(c50).Social media, journal articles and local radio are some of the media being used. Support for ED Department in the recruitment of GPs(streaming) Recruitment Incentives to support difficult to recruit posts-1xHisto Consultant and 3 O/Ts to date recruited. Continued activity to attract candidates to join the Trust bank.	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 Jan-18 National staff survey response rate 49% - 3% above the national average and a 4% improvement on the response rate for last year. The results of the survey will be published in late Feb/early Mar18. The results of The Medical engagement score have been published and shared with a great improvement in all areas.	end Mar-18	◄►	HRD	POD SLF

Chief Executive's Report

Meeting information:			
Date of Meeting:	6th February 2018	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

Recent weeks have been dominated by the operational challenges of the festive season, and by stabilisation of the financial position.

The Trust experienced significantly increased demands for urgent care compared to last year but has maintained a significantly improved performance. Many people across the Trust and wider system worked hard and well to maintain standards of care. There was a notable level of commitment and collaboration in all areas. During high pressure periods the values of respect and working together were maintained and contributed to a strong sense of purpose. We must recognise the pressure that many members of staff have been under and the consequent weariness that many are experiencing in the new year. The winter plans had incorporated a reduction in elective/day case activity of some 10%, and this was maintained through the period with only small numbers of cancellations.

The Trust has faced a difficult trading and contracting period. Analysis from KPMG has shown that the underlying performance in 16/17 was £57m deficit. The outturn for 17/18 is likely to show an improved underlying performance of £54m deficit, with a headline deficit of £57m. We have worked closely with NHSI and the financial special measures team on these issues. The principal drivers have been a reduction in in-patient elective care with an increase in day case elective care; some unpredicted in-year costs (eg VAT); a shortfall in delivery of our CIP (although the Trust will deliver circa £23m cost improvements against a target of £28m). The outturn has also been affected by contracting issues. Disputes with the CCGs were mediated by NHSI/NHSE and a fixed income from our host CCGs was determined at some £10m below PBR forecast.

We have seen a significant improvement in our cash position during early January following diligent work to obtain the release of cash funds from both CCG and NHSI. This is further detailed in the financial papers for the Board.

The Trust has received a 'preventing future deaths' report from the Brighton Coroner relating to the death of a patient following major cancer surgery. The Trust's own investigation of the incident is continuing. This inquest followed a very positive meeting with the Coroner for East Sussex during which the Trust's improved approach to systematic investigations and learning from incidents was discussed.

2. Quality and Safety

Quality inspections continue to be carried out on a regular basis and themes are addressed in real time. The Director of Nursing has also introduced weekly clinical huddles for the senior nursing team as part of ensuring clinical visibility.

The Director of Nursing is undertaking a review of progress and assurance on end of life care. The overall management of end of life has improved with systematic identification and notification of patients nearing the end of their life to the site management team and to the chaplaincy team. Training in end of life care is now part of our mandatory regime for all clinicians. We have launched a regular and sensitive approach to getting feedback from families whose relatives have passed away in our care.

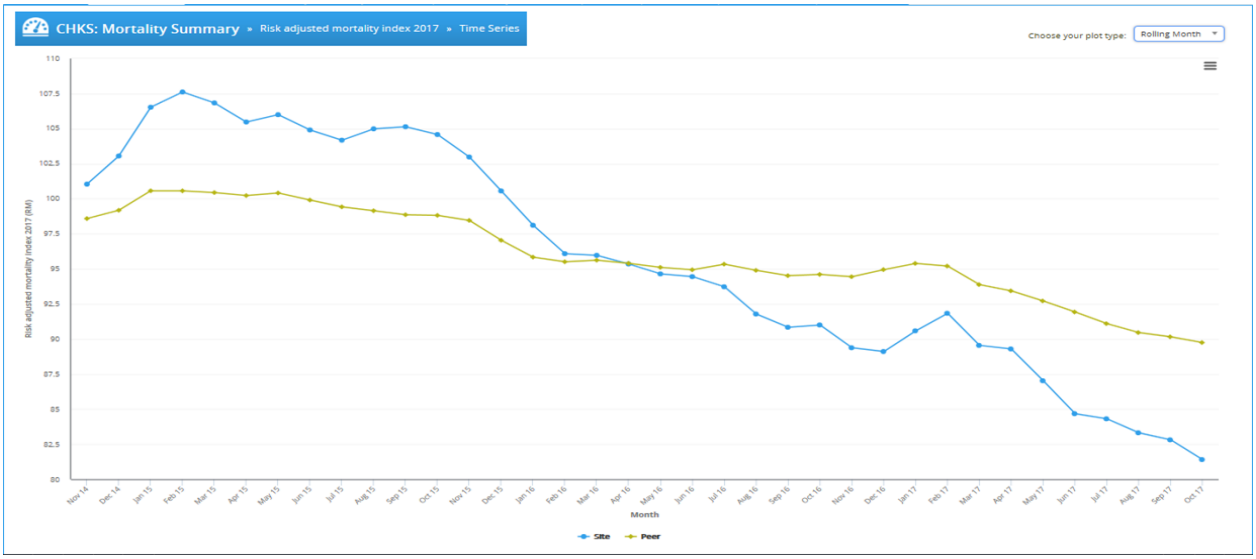
Seasonal influenza cases have been presenting since 5 December with approximately double the number of cases per month so far compared to last year. In response, patient pathways have been revised and the IPC Team has been liaising with Site Teams to agree safest management of infectious patients. A full report on Influenza at ESHT will be prepared at the

end of the season. This has added to the pressure on our hospital and community services over a challenging winter period.

A review of the Committee structure has been completed and terms of reference revised for all core groups.

The Excellence in Care programme (quality measure and safety measure) is developing well and is being extended beyond the pilot wards. A presentation on this was made to the Quality and Safety Committee.

The Trust have been awaiting the new calculation of RAMI by CHKS with some trepidation, as this is the index which previously we felt best reflected our situation. CHKS have been performing a major overhaul of the way RAMI is calculated. The new RAMI has now been published and our position has improved both in absolute terms and relative to our peer comparator group.



The Junior Doctors Forum has raised concerns about the provision of rooms for resting after on call shifts overnight or late evening as many of them live in Brighton. We currently comply with the conditions of the contract (namely to provide free of charge a room for doctors to rest in for the morning following a night shift). Dawn Urquhart is working on a proposal to provide additional facilities for people who are on consecutive night shifts.

3. People, Leadership and Culture

Recruitment

- 20 UK student nurses will join the Trust in February.
- International recruitment is continuing in the Philippines and Indian sub-continent for Nursing, Medical and AHP staff groups, including radiographers. The cohort of Philippino staff who joined radiography are making a welcome contribution to that service.
- 14 International Nurses will join the Trust by April 2018
- Difficult to recruit medical posts have been highlighted to Medacs Head-hunters (Trust Primary Provider) for focused work.
- Return to Practice incentives are being developed to support Nurses back to work.

- Incentives have also been implemented to encourage bank work from existing staff.

Workforce Planning

- A workforce systems review is being undertaken to maximise current workforce management tools. Key areas of focus will be functionality, reporting capability, automation where appropriate and delivery of an enhanced end user experience.
- The roll out of the Safecare module of our electronic rostering system continues on plan and will be completed at Eastbourne and Conquest by March. Electronic rostering for doctors also remains on plan with full rollout by Q2 2018

4 Access and Delivery

November showed a significant improvement in the delivery of the 4 hour standard, achieving 94.1% compared to 82.4% the previous year. The teams have been working together across the Trust and the Local Health and Social Care system to ensure we had robust plans in place to manage the winter period and more specifically the Xmas and New Year surge period.

December saw an early start to the winter pressures but with the system plans we were better able to accommodate the demand between Christmas and New Year. Over this period we saw (compared to last year) an 11% increase in referrals to the Emergency Departments, with some days seeing a 30% increase and a 16% increase in admissions. However our ability to manage our 4 hour pathway through the EDs improved by 10 percentage points compared to the same time last year. We have seen high acuity levels, which has led to greater lengths of stay and the need for patients appropriately to be admitted to hospital. This has added to the increased demand.

Staffing has been challenged, with the senior nursing teams reviewing ward requirements throughout the day to ensure safe staffing levels are in place.

A review of what went well and what could have been improved is being undertaken, and the conclusions will be adopted in the Easter Plan.

5. Strategy, Innovation and Planning

Work is ongoing to ensure that the SIP team, which now includes the PMO, are able to support the divisional and corporate teams on the organisational priorities in terms of development and delivery of quality and financial improvement plans. Business planning is on track.

The longer term strategic plan is focused on analysis of clinical and financial sustainability of individual clinical services. Work is being done with KPMG to model the future state of the organisation based on projected demand and capacity requirements.

6. Communication and engagement

Over this period, we saw a great deal of positive press coverage, especially relating to new ESHT services, innovations and facilities. For example, the new Ambulatory Emergency Care service, mammography equipment, Uro Nav Biopsy scanner, Chemotherapy Treatment Bell and Kipling Courtyard. The Trust's Communications Team has also been working more closely with colleagues across the Sustainability and Transformation Partnership (STP) on joint cross-STP campaigns like the 'Let's Get You Home' that aims to better support patient discharge and the #HelpMyA&E campaign that offers local people information about the alternatives to A&E. During this period there was significant national and local press interest in

NHS winter pressures and demand on hospitals in general. The Communications Team worked closely with the Chief Operating Officer and her team to make sure that the Trust's position was portrayed accurately to the media and stakeholders.

The Trust's new website continued to receive positive feedback following its launch in September, and we are working to improve accessibility and content. The Communication Team are working towards the launch of the internal extranet in the next few months. The Trust's patient engagement work is developing and more local people are signing up to become 'members' of the Trust. This was promoted in the third edition of the #OurMarvellousTeams patient newspaper, which was published in December. Alongside this being offered in outpatients areas across the Trust, the newspaper was sent to Doctor's surgeries and other health and care services. Our social media presence continues to grow and over December we saw much interest in our 12 Days of Christmas recruitment campaign that highlighted the variety of different jobs available at the Trust.

7. Quality Special Measures

We have been advised that our CQC inspection will take place on 6th and 7th March and will encompass a review of services on both of the acute sites.

On 21st and 22nd March the CQC will undertake the "well led" element of the inspection process.

East Sussex Healthcare NHS
NHS Trust

Month 9 – December 2017

TRUST INTEGRATED PERFORMANCE REPORT

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East Sussex Healthcare NHS
NHS Trust

Contents

East Sussex Healthcare NHS
NHS Trust

November 2017

Key Successes

- Improvements in performance in RTT, Diagnostics and A&E.
- All Cancer targets being met with the exception of 62 Days

Key Issues

- A&E Attendances remain high, adding pressure to the 4 hour target.
- Non-elective and emergency admissions continue to increase and this is impacting on flow through the hospital
- Equipment issues have 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

Quality and Safety

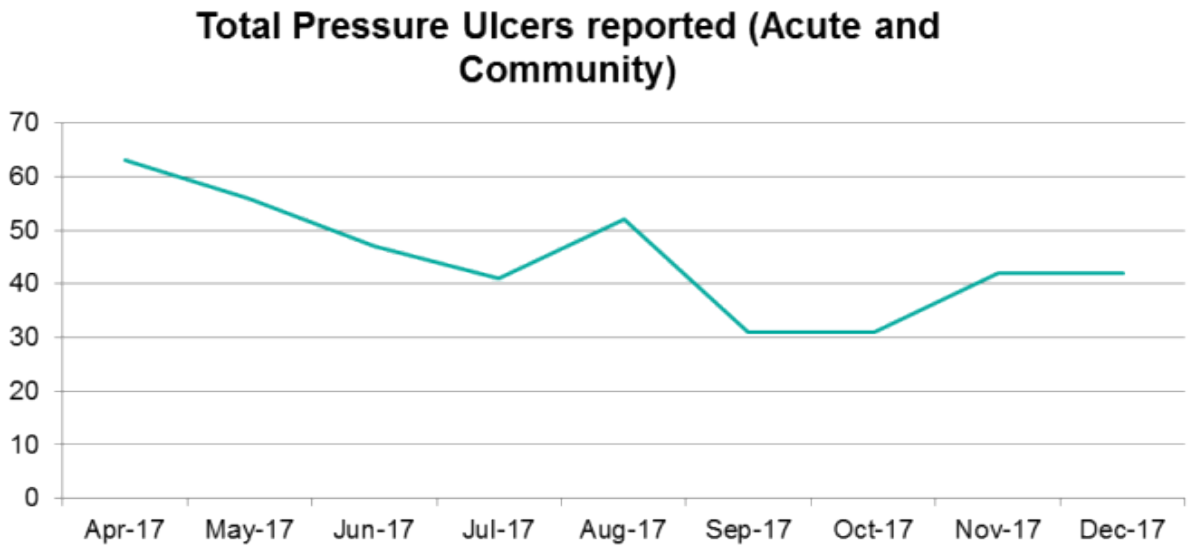
East Sussex Healthcare NHS

Indicator Description	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
	Dec-16	Dec-17	Var	2016/17	2017/18	Var		
Total patient safety incidents reported	1396	1098	-21.3%	12262	9820	-19.9%	1134	
Number of Serious Incidents reported	2	3	1	41	39	-2	5	
Total falls	159	149	-6.3%	1348	1220	-9.5%	142	
Number of no-harm falls	113	114	0.9%	922	900	-2.4%	105	
Number of major/catastrophic falls	0	0	0	1	4	3	1	
All patient falls per 1000 Beddays	6.4	6.3	-0.1	6.1	5.8	-0.28	5.7	
All patient falls with harm per 1000 Beddays	1.8	1.5	-0.4	1.9	1.4	-0.48	1.5	
Falls assessment compliance	85.3%	74.6%	-10.8%	90.1%	89.2%	-0.9%	89.6%	
Total grade 2 to 4 pressure ulcers per 1000 Beddays	2.0	2.4	17.1%	2.1	1.9	-10.1%	2.1	
Pressure ulcer assessment compliance	94.4%	96.4%	2.0%	90.9%	90.2%	-0.6%	91.3%	
Safety Thermometer overall score	93.4%	93.0%	-0.4%	93.8%	92.5%	-1.3%	92.5%	
VTE Assessment compliance	96.2%	95.5%	-0.7%	96.6%	96.3%	-0.3%	96.4%	
% Observations completed on time	83.2%	82.5%	-0.6%	82.3%	83.9%	1.6%	83.8%	
Number of MRSA Cases	0	0	0	0	2	2	0	
Number of Cdiff cases	2	5	3	35	29	-6	3	
Number of MSSA cases	0	1	1	11	8	-3	1	

- The total patient safety incidents reported for December is just above the average for the year to date which is 1097.
- The percentage of no harm/near miss incidents is 81% of all patient safety incidents which is an indicator of a good reporting culture (national figure 73%).
- Patient falls in December increased slightly in numbers and the rate for the year to date is currently 5.7 per 1000 bed days which although a reduction from last year (6.1) it is still above our 5.5 target.
- There were 5 Clostridium Difficile Infections reported in December all of which were from different wards. These are under review to determine if avoidable due to a lapse in care. We are currently at 31 for the year. The limit for 17/18 is 41.

PRESSURE ULCERS

East Sussex Healthcare NHS
NHS Trust



A total of 42 ESHT acquired pressure ulcers reported in December which is a reduction from October 17 data. There were no category 3 or 4 pressure ulcers in the acute and 24 category 2. There has been 1 category 3 and 1 category 4 reported in the community and the review of these is underway to determine if avoidable.
Our current rate, in December, for pressure ulcers in the Acute and Community Hospitals is 1.8 per 1000 bed days, the average for the year is 1.4 per 1000 bed days. Work is underway to clarify if any lapses or avoidable harm.

Serious Incidents (SI) reported in December

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
	Dec-16	Dec-17	Var	2016/17	2017/18	Var		
Total patient safety incidents reported	1396	1098	-21.3%	12262	9820	-19.9%	1134	
Number of Serious Incidents reported	2	3	1	41	39	-2	5	
Never Events	0	0	0	1	4	3	0	

During December there were 3 Serious Incidents reported:

- Two patient falls resulting in fractures on Hailsham 3 and Benson Ward.
- One complication from Gynaecology Surgery resulting in significant blood loss and altered plan of care.

All of these incidents are under investigation and immediate action was taken for the Gynaecology event to ensure safety.

Never Event update:

- Misplaced gastric Tube – Report approved and all actions completed
- Wrong tooth removed – Reported approved and one action remaining
- Incorrect size hip prosthesis – Report complete and submitted to CCG
- Incorrect ophthalmic lens inserted - Report complete and submitted to CCG – immediate actions taken and in place.

As of the end of December there were 26 open Serious Incidents in the system. 13 are with the CCG awaiting review and the remainder are all in the investigation stage but within the timescales. Duty of Candour compliance for all moderate and above harm incidents remains at 91% informed verbally, 92% followed up in writing and 90% findings shared with patient or family upon completed investigation. There are still Amber (moderate harm) investigations outstanding that are within the Divisions (37 in total) which require completion to ensure learning identified and shared with patient/family. This is being worked through by the ADN's.

PATIENT EXPERIENCE

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
	Dec-16	Dec-17	Var	2016/17	2017/18	Var		
Inpatient FFT response rate	24.3%	38.7%	14.3%	18.0%	39.8%	21.8%	37.4%	
Inpatient FFT score	97.4%	96.7%	-0.7%	97.3%	97.0%	-0.3%	97.0%	
A&E FFT response rate	8.0%	7.3%	-0.8%	7.8%	9.3%	1.5%	8.8%	
A&E FFT score	88.0%	93.4%	5.4%	87.5%	89.2%	1.7%	88.3%	
Outpatient FFT Score	93.3%	97.0%	3.7%	95.6%	95.9%	0.3%	95.9%	
Maternity FFT response rate	19.5%	36.3%	16.8%	31.7%	33.3%	1.6%	34.2%	
Maternity FFT score	100.0%	100.0%	0.0%	94.3%	98.3%	4.0%	97.7%	

Patient Experience feedback continues to be an important quality measure in terms of score and response rate. The inpatient response rate has reduced for the second month in a row which is a shame as in August we were within the top 8 nationally. A table is sent out on a monthly basis to the departments showing their results Support is offered and provided for departments on improving the response numbers are low. A small sample of comments (positive and negative) in December include;

Positive:

- Thank you to the nurse 'Rachel' who held my hand & made me laugh - Endoscopy
- Always felt supported and listened to (Midwifery Unit, Eastbourne)
- Doctors very good Nothing too much trouble for nursing staff – Jevington
- Very caring in the little time that given - staff rushed of their feet
- Very friendly, kind nothing too much trouble the care I received was amazing – Hailsham 4.
- So very friendly and kind, really felt so safe. Wonderful. Thank you – Jubilee Eye Suite

Negative:

- better signage, didn't know when I had got to A&E
- Endoscopy - lots of waiting around which was a little unnerving - but understand reasons why
- Organisation with medication, better communication with patients

The overall experience questions shows the trust scoring highly on respect, privacy and dignity and cleanliness but low on providing information about care or condition and feeling involved in decision making.

ESHT currently remains on 4 stars (185 ratings) for Eastbourne and 4.5 Stars (197 ratings) for the Conquest on the NHS Choices website.

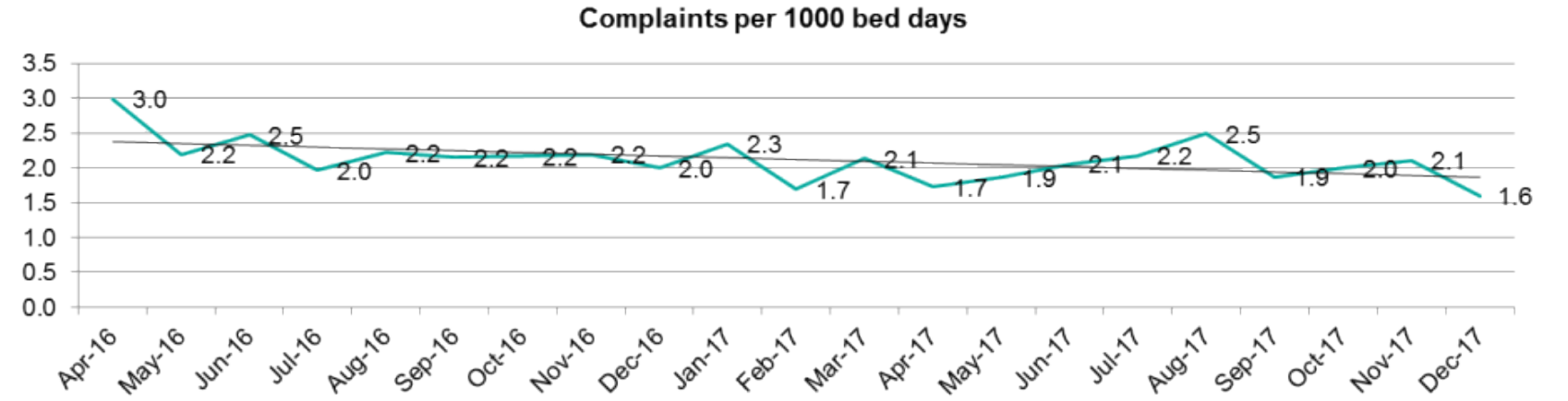
MIXED SEX ACCOMMODATION

East Sussex Healthcare NHS
NHS Trust

The board should be aware that due to recent changes in reporting/definitions as advised by NHSI/E, the Trust may report some incidences of mixed sex accommodation going forward. This will take effect from Feb 2018. A working group for Kent Surrey & Sussex has just agreed to standardise the process and cease all local agreements and the trust is expected to comply. To be clear, the Trust is not making any changes operationally and will continue to monitor this using the nightly snapshot census as well as the new "real time" process. A detailed paper will go to the Patient Experience Group and this group will also monitor progress going forward and any complaints from patients. Patient safety and prompt treatment must remain the priority and in difficult circumstances this may occasionally mean that patients are allocated to a bed in a rapid assessment area that is not in a single sex area. If this happens staff will always endeavour to move the patient as soon as an appropriate bed is available. The Trust remains committed to preserving the privacy and dignity of all our patients and this will continue to have focus and oversight by the COO and the DoN.

Complaints

East Sussex Healthcare NHS
NHS Trust



38 new complaints were received in December and at the end of the month there were no overdue complaints (69 in April 2017). The average per month year to date is 48. Complaints by bed days within each Division from April 2017 up to and including December 2017 are as follows:

- Medicine – 1.0 per 1000 bed days (14 complaints per month)
- DAS – 2.3 per 1000 bed days (15 complaints per month)
- Out of Hospital – 1.2 per 1000 bed days (2 complaints per month)
- Women, Children and sexual Health – 4.3 per 1000 bed days (7 complaints per month)
- Urgent Care - Average 7 reported per month.

The main themes in December were complaints about overall care provided, incorrect diagnosis, patient fall whilst in care and problems/complications following surgery.

No new cases were referred to the PHSO during December. The position for 2017/18 remains as 1 fully upheld and 2 partially upheld.

More detailed reports are discussed at the Patient Experience & Engagement Steering Group reporting to the Patient Safety and Quality Committee.

Nursing and Midwifery Workforce

- The nursing & midwifery establishment review process is nearing completion with DoN assurance & challenge meetings with each division to agree the recommended ward establishments for presentation and consideration by FISC,POD & the Trust Board.

- Winter pressures continue to negatively impact ward staffing levels on a daily basis. It has been particularly challenging to achieve and maintain planned registered nurse staffing levels on a shift by shift basis. The Temporary Workforce Service (TWS) is unable to fill the requested number of registered nurses and staff moves between wards have increased to balance risk and optimise safety. It has not always been possible to open escalation areas due to staffing.

- Staff morale has been impacted by winter pressures, staffing gaps and staff moves.

- “Safe Care” is now in all relevant wards at Eastbourne and Conquest acute sites. However, whilst the implementation has been achieved to timescale the system is not yet fully embedded as a way of working.

- A range of measures regarding recruitment, retention and rostering continue with collaborative working between clinical, managerial and HR colleagues.

- The governance and reporting framework for Safer Staffing is being reviewed, revised and strengthened over Q4. Health roster compliance sessions within each division are being revised and will have DoN input and include a senior review session as well as ward level reviews.

Safer Staffing

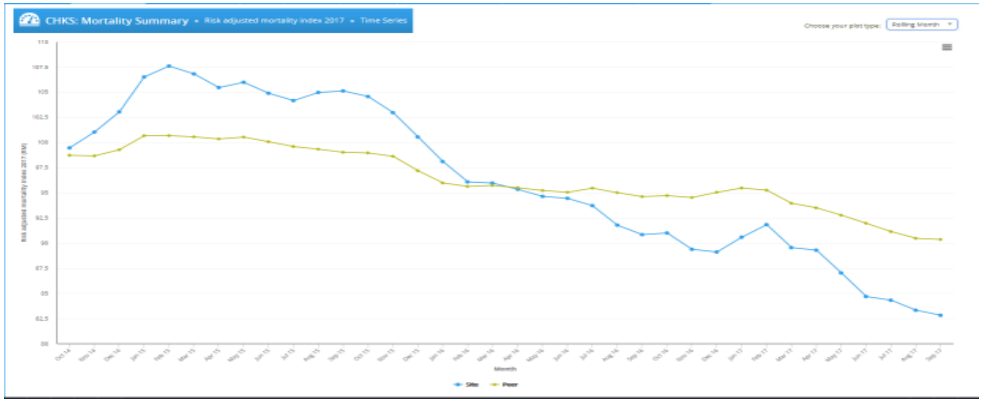
		Day		Night	
Site Code	Site Name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
RXC03	BEXHILL HOSPITAL	92.8%	104.6%	97.3%	114.5%
RXC01	CONQUEST HOSPITAL	88.9%	113.7%	88.5%	121.2%
RXC02	EASTBOURNE DISTRICT GENERAL HOSPITAL	88.8%	115.6%	91.4%	130.2%

- The Safer Staffing return generally shows RN levels below planned in a number of areas and higher than planned use of HCA staff. Analysis shows two main drivers for higher use of HCA staff;
  - Some wards are not rostering to their template for RNs and are planning to have a HCA fill the shift at roster publication. This is due to the typically higher fill rate achieved for HCA staff by the Temporary Workforce Service (TWS). This practice has been challenged through the nurse establishment review process as it negatively impacts on skill mix.
  - Winter has seen an increase in non elective conversion rate and the patients admitted have been ‘sicker’ and assessed as needing more nursing care. This is driving an increase in the need for specials and cohort HCA staff to meet clinical need.
- Nurse staffing has been a limiting factor, on occasion, for patient admission and movement throughout the hospital alongside winter pressure. Staff moves between wards to maintain at least 2 RNs per shift have increased and are impacting staff morale.
- Daily reporting on TWS fill rate is now in place and will be supplemented by a daily report of actual staffing against planned from Safecare.
- Divisional actions to optimise staffing over the winter and optimise rosters will be led by the Associate Directors of Nursing in each division.
- The DoN has written a paper outlining some key short term actions to support this work including challenge sessions to ensure effective rostering, use of ”specials” for at risk patients and review of what staff can request additional staff.
- More detailed reporting will be going to the People and Organisational Development (POD) Committee including breakdown of fill rates and impact.

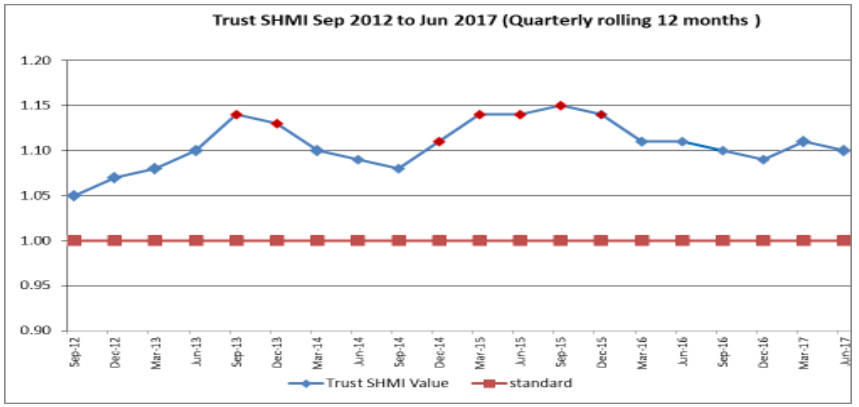
Mortality Metrics

East Sussex Healthcare NHS
NHS Trust

RAMI 17 (Rolling 12 months)



SHMI (Rolling 12 months)



SHMI for the period July 2016 to June 2017 is the latest published and is 1.10. The Trust remains within the EXPECTED range.

RAMI 17 October 2016 to September 2017 (rolling 12 months) is 83 compared to 91 for the same period last year (October 2015 to September 2016). September 2016 to August 2017 was 83 (RAMI 17).

RAMI 17 shows an September position of 74 against a peer value of 86. The August position was 67 against a peer value of 81.

Crude mortality shows October 2016 to September 2017 at 1.83% compared to October 2015 to September 2016 at 1.85% (a 0.85% reduction)

The percentage of deaths reviewed within 3 months was 68% in August 2017, compared to 56% in July 2017.

SHMI (NHS Digital) Top 5 diagnostic groups by Volume Jul 16 to Jun 17	Observed deaths	Expected deaths	SHMI
Pneumonia (except that caused by tuberculosis or sexually transmitted dis	422	417.61	1.01
Septicaemia (except in labour), Shock.	236	221.43	1.07
Acute cerebrovascular disease.	173	145.63	1.19
Congestive heart failure; nonhypertensive.	102	90.24	1.13
Urinary tract infections.	101	92.18	1.10

Septicaemia CCS Group

Access & Delivery

ACCESS AND DELIVERY

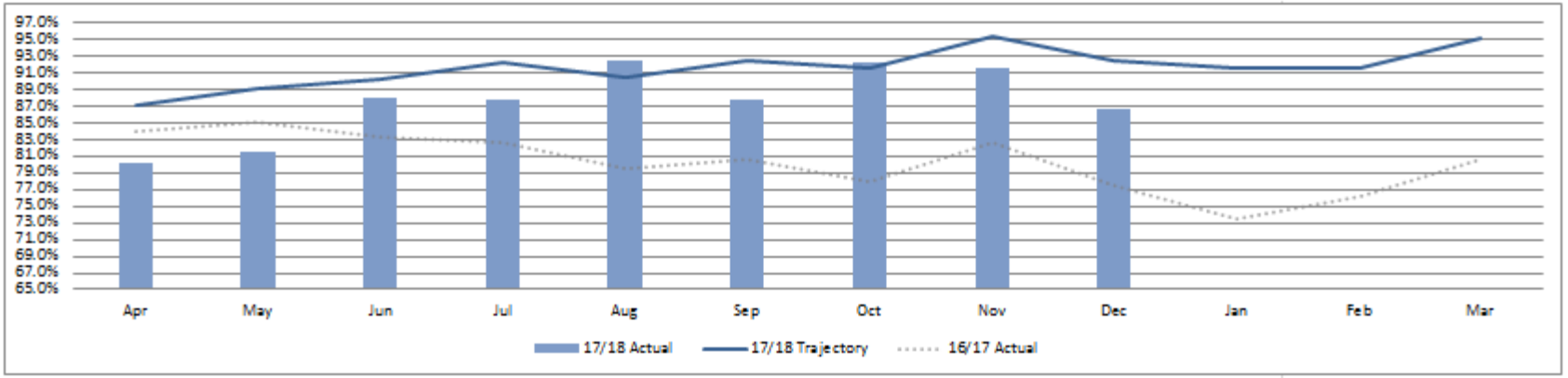
East Sussex Healthcare NHS
NHS Trust

URGENT CARE

Indicator Description	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
	Dec-16	Dec-17	Var	2016/17	2017/18	Var		
Four hour standard	77.6%	86.7%	9.1%	81.4%	87.8%	6.4%	85.4%	
12 Hour DTAs	0	0	0	3	0	-3	0	
Unplanned re-attendance to Emergency Department	3.0%	2.7%	-0.3%	3.0%	2.8%	-0.3%	2.8%	
% Patients waiting less than 15 minutes for assessment in ED	90.1%	83.0%	-7.1%	91.3%	83.2%	-8.1%	83.4%	
% Patients waiting less than 60 minutes for treatment in ED	41.6%	46.4%	4.8%	40.0%	44.8%	4.8%	44.9%	
% Patients waiting less than 120 minutes for treatment in ED	69.2%	76.0%	6.7%	67.3%	74.3%	7.1%	74.0%	
% Patients that left without being seen in ED	1.8%	1.9%	0.1%	1.6%	1.7%	0.1%	1.6%	
% Patients admitted from ED (Conversion rate)	28.2%	30.4%	2.2%	25.0%	28.1%	3.1%	28.0%	
Number of ambulatory care admissions with zero length of stay	555	738	183	4923	6952	2029	704	
% of ambulatory care admissions with zero length of stay	37.6%	45.8%	8.2%	38.0%	45.4%	7.4%	43.5%	
Emergency Re-Admissions within 30 days	9.1%	8.2%	-1.0%	9.1%	9.9%	0.8%	9.8%	
Emergency Department attendances	9136	10065	10.2%	84373	90170	6.9%	9695	
Ambulance conveyances	3331	3527	5.9%	27818	29072	4.5%	3195	
Admissions via A&E	28.2%	30.4%	2.2%	25.0%	28.1%	3.1%	28.0%	

The Trusts' 4 hour performance was 86.7% (77.6% Dec 16).
-EDGH – 87.6%
-Conquest – 85.9%
•January type 1 performance as at 22/1/18 is 85%
•Minors performance for December is 99.5%
•Attendances in December increased by 10.2% on the previous year (1065 vs 9136)
•Ambulance conveyances increased by 5.9%.
•Performance over the festive period improved by 11.2% compared to the previous year and the 3 dates where performance did not improve on last year correlated with significant peaks in activity 26 Dec and 30 Dec and 31 Dec.

A&E Monthly Performance (4Hr Wait)–Type 1 Only



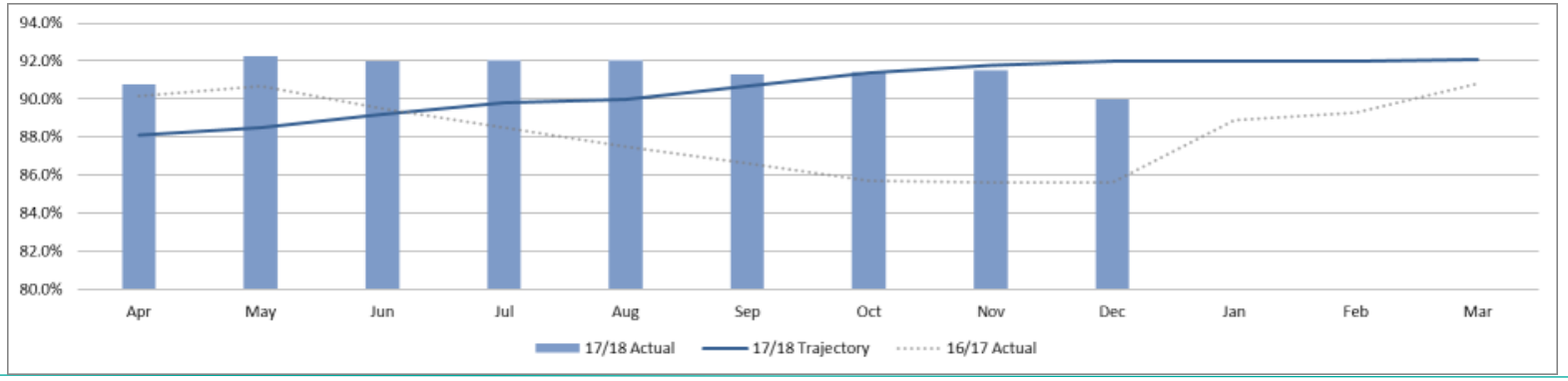
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18 Trajectory	87.1%	89.0%	90.1%	92.2%	90.5%	92.4%	91.5%	95.2%	92.3%	91.5%	91.5%	95.1%
17/18 Actual	80.1%	81.4%	88.0%	87.7%	92.5%	87.8%	92.1%	91.4%	86.7%			
16/17 Actual	83.9%	85.1%	83.2%	82.5%	79.5%	80.5%	78.0%	82.5%	77.5%	73.4%	76.1%	80.7%

- **A&E performance in December was 86.7%. Performance despite being a 9.2% improvement on the previous year was disappointing. The Winter mitigating actions were put in place fro the 27 December 2017 and although some of these action could have been put in place to improve the December position we believe this would have had a detrimental impact on how the peak Christmas period was managed. The acuity of patients through December was significantly higher with many respiratory type illness's presenting.**
- **Attendances remain on the increase across both sites and were up 10.2% on December 2016, and 6.9% year on year.**
- **Stranded patients is a direct correlation to the 4 hour clinical standard, the trust has seen significant improvement in the those patient staying in excess of 6 days and particularly those staying over 21 days.**
- **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.**
- **Minors performance for December was 99.5% which demonstrates a consistent improvement. The trust is also committed to reducing breaches in the non-admitted patients.**

East Sussex Healthcare NHS
NHS Trust

RTT

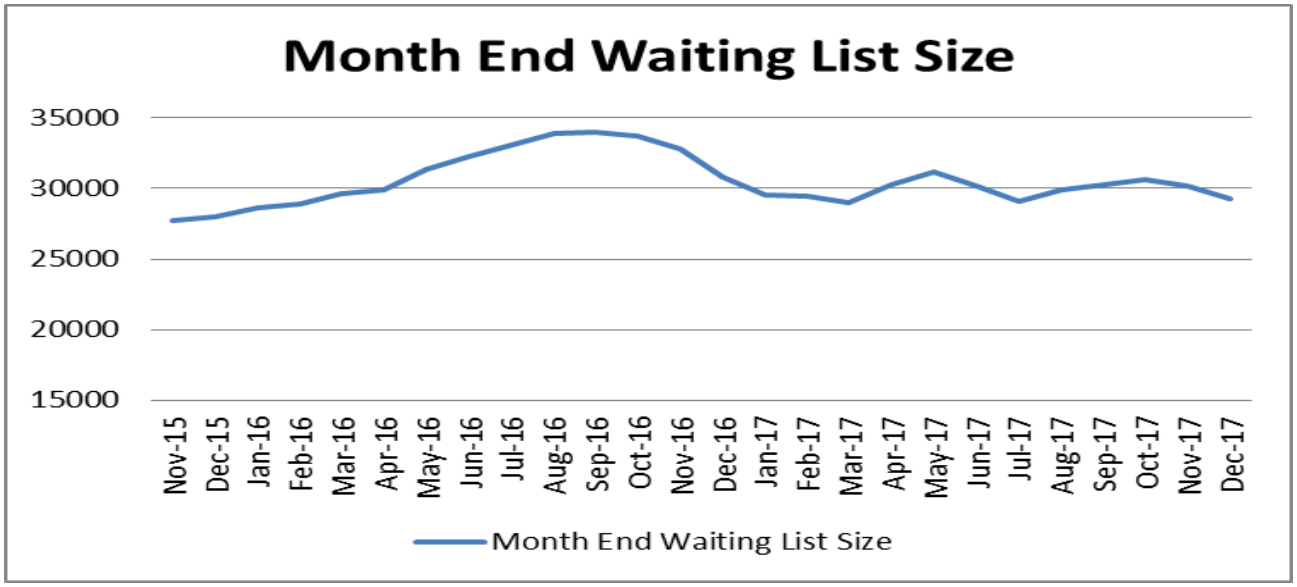
Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Dec-16	Dec-17	Var	2016/17	2017/18	Var		
RTT Incomplete standard	92.0%	85.6%	90.0%	4.4%	87.7%	91.5%	3.8%	91.1%	
RTT Backlog (Number of patients waiting over 18 weeks)	M	4425	2929	-1496	4425	2929	-1496	2806	
RTT 52 week waiters	0	0	1	1	0	2	2	0	
RTT 35 week waiters	M	348	165	-52.6%	348	165	-52.6%	231	



The Trust performance for the December was 90%. This reflects the reduction in available capacity during December 2017.

- **focusing on out-patient and theatre productivity to better manage demand and capacity without additional costs.**
- **Review of access policy and principles applied**
- **Additional colorectal consultants increase capacity**
- **Agreed outsourcing for electives**
- **Focus on MSK pathways**

RTT

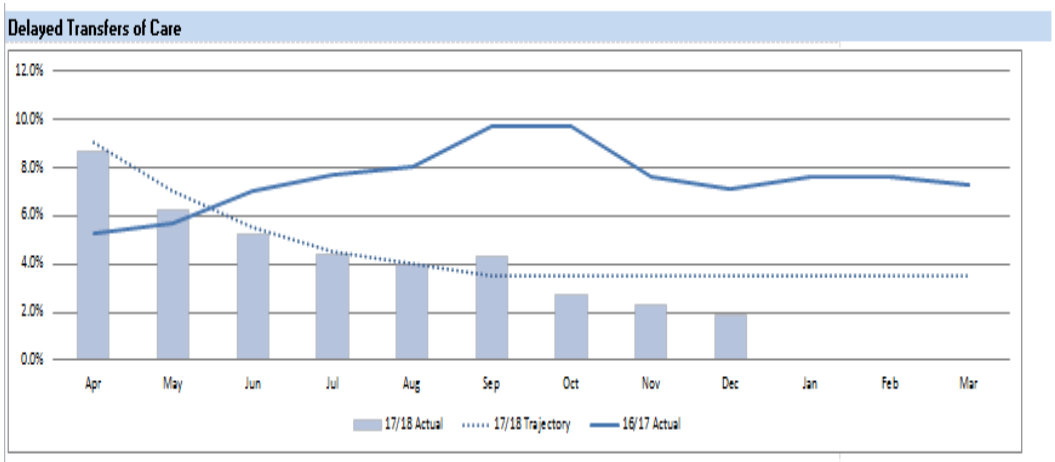


- **The waiting list has remained relatively static at around 30,000. There was a marginal increase in September due to reduced activity levels throughout the trust in August and September.**
- **As anticipated this has reduced during October, November and December.**

East Sussex Healthcare NHS
NHS Trust

CANCELLATIONS AND DTC

Indicator Description	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
	Dec-16	Dec-17	Var	2016/17	2017/18	Var		
Delayed transfer of care national standard	7.1%	1.9%	-5.2%	7.5%	4.4%	-3.2%	5.1%	
Cancellations								
Urgent operations cancelled for a second time	1	0	-1	5	1	-4	0	
Proportion of last minute cancellations not rebooked within 28 days	0.0%			1.4%	0.5%	-0.9%	99.3%	
Outpatient appointment cancellations <6 weeks	67	43	-35.8%	340	404	18.8%	43	
Outpatient appointment cancellations >6 weeks	1247	1377	10.4%	11496	12202	6.1%	1325	



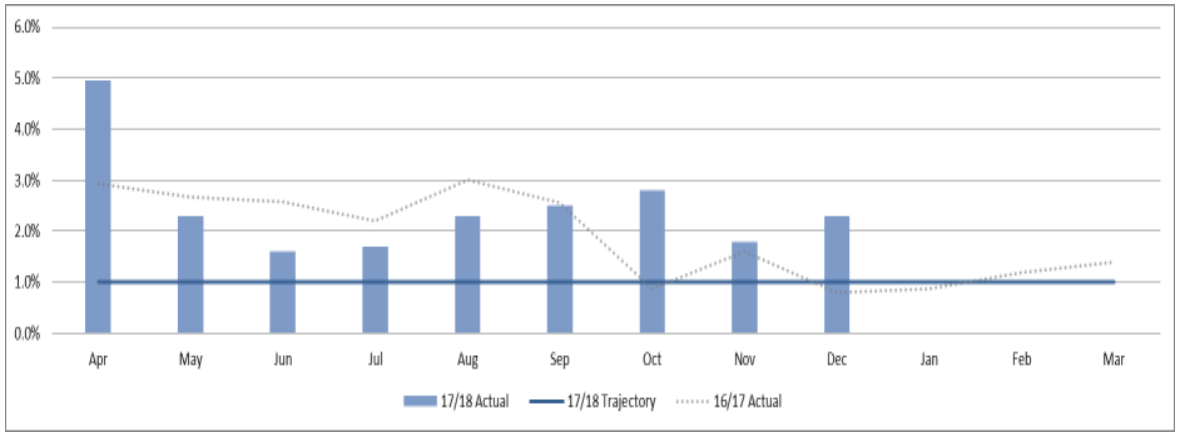
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18 Trajectory	9.0%	7.0%	5.5%	4.5%	4.0%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
17/18 Actual	8.6%	6.3%	5.2%	4.4%	4.0%	4.3%	2.7%	2.3%	1.9%			
16/17 Actual	5.3%	5.7%	7.0%	7.7%	8.0%	9.7%	9.7%	7.6%	7.1%	7.6%	7.6%	7.3%

- **DTC continued to reduce in December. This is the third consecutive month that the Trust has achieved the national target of being under 3.5%. This has been as a result of continued closer working with social care. Whilst non elective bed days increased in December (from the previous month) they remain down against the same period last year (3.9%). With Emergency spells increasing by 13.4% on the previous year. Stranded patients has also been maintained despite the increase in activity and the challenging Christmas period.**

Diagnostics

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Dec-16	Dec-17	Var	2016/17	2017/18	Var		
Diagnostic standard (% patients waiting more than 6 weeks)	1.0%	0.8%	2.3%	1.5%	2.2%	2.5%	0.3%	2.2%	



Diagnostics remains a challenge for the organisation. Performance in December was 2.3%
Key areas for improvement are radiology, endoscopy and urology.
Actions –
New scanners procured. First one functional from January. Mobile vans being used in the meantime.
Additional theatre capacity required for endoscopy, discussions underway with Surgery to support this
Review of productivity opportunities and booking principles across all diagnostics

The breaches were:

	Breaches
Audiology	1
Cystoscopy	12
Endoscopy	29
Physiological Measu	7
Sleep Studies	1
Radiology	60

East Sussex Healthcare NHS
NHS Trust

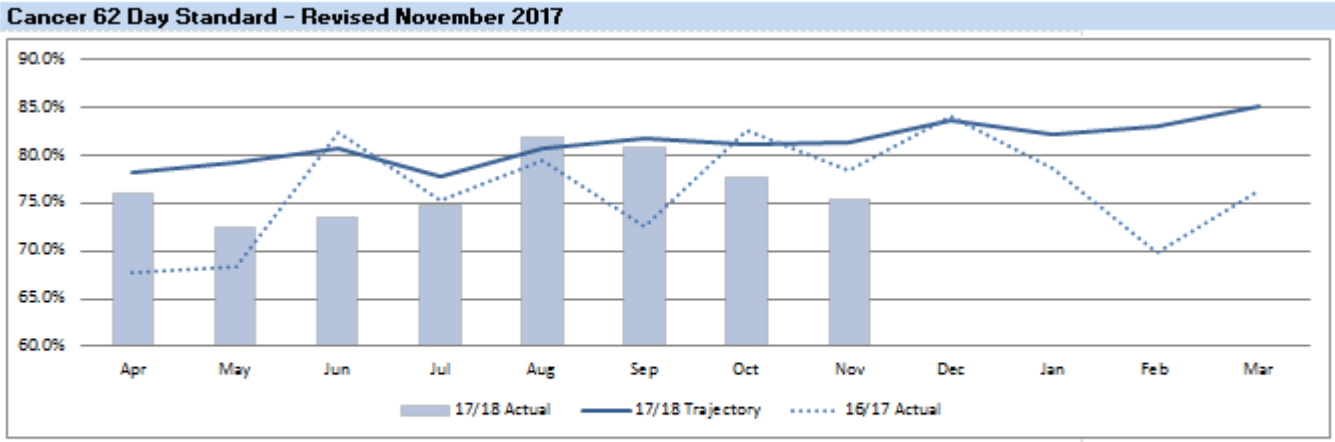
CANCER STANDARDS

Indicator Description	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
	Nov-16	Nov-17	Var	2016/17	2017/18	Var		
Cancer 2WW Standard	98.7%	97.4%	-1.3%	97.1%	95.9%	-1.2%	96.4%	
Cancer 62 day urgent referral standard	78.3%	75.4%	-3.0%	76.8%	76.5%	-0.4%	76.1%	
Cancer 2WW Standard (breast symptoms)	98.2%	95.0%	-3.2%	96.7%	95.9%	-0.9%	96.4%	
Cancer 31 day standard	99.5%	98.3%	-1.2%	98.7%	97.5%	-1.3%	97.8%	
Cancer 31 day subsequent drug treatment	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Cancer 31 day subsequent surgery	100.0%	100.0%	0.0%	99.1%	98.1%	-1.0%	97.4%	
Cancer 62 day screening standard	100.0%	62.5%	-37.5%	89.2%	74.7%	-14.5%	78.4%	

- **The cancer data is reported a month in arrears.**
- **For December the trust met all of the cancer standards with the exception of the 62 Day urgent referral standard and the 62 Day screening (represents 1 breach).**
- **2WW referrals have increased in December by 3.3% on the previous year.**

Cancer 62 Days

East Sussex Healthcare NHS Trust



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18 Trajectory	78.2%	79.2%	80.6%	77.8%	80.6%	81.7%	81.0%	81.2%	83.6%	82.1%	83.0%	85.0%
17/18 Actual	76.0%	72.4%	73.4%	74.7%	81.9%	80.8%	77.6%	75.4%				
16/17 Actual	67.6%	68.3%	82.3%	75.3%	79.5%	72.6%	82.5%	78.3%	84.1%	78.6%	69.9%	76.3%

Lung, colorectal and urology are the highest breaching specialities, although urology have improved significantly

Actions to deliver in December:

- **Newly established Operational Cancer Board chaired by COO**
- **Radiology review in progress with NHS Elect.**
- **Additional colorectal capacity**
- **Increased clinical engagement**
- **Detailed review of breaches with COO and at MDMs with consultants weekly, new breach report to be shared weekly**
- **A new reporting system is being developed to provide staff with a live view/dashboard**
- **Pathway review with NHS Elect – urology**
- **Focus on pathway timed radiology**
- **Guys and NHSI to implement 'supertracker' for lung pathway**

East Sussex Healthcare NHS
NHS Trust

Cancer Standards – 62 days

Site	Seen/Treated			On Target			Breaches			Compliance			Target
	Conq.	EDGH	All	Conq.	EDGH	All	Conq.	EDGH	All	Conq.	EDGH	All	
Breast Cancer	7.0	10.5	**17.5**	6.0	9.5	**15.5**	1.0	1.0	**2.0**	85.7 %	90.5 %	**88.6 %**	85 %
Colorectal	8.0	1.0	9.0	3.0	0.0	3.0	5.0	1.0	6.0	37.5 %	0.0 %	33.3 %	85 %
Gynaecology	3.0	3.0	6.0	3.0	1.5	4.5	0.0	1.5	1.5	100 %	50.0 %	75.0 %	85 %
Haematology	4.0	5.0	9.0	2.0	4.0	6.0	2.0	1.0	3.0	50.0 %	80.0 %	66.7 %	85 %
Head & Neck	1.5	1.5	3.0	1.0	1.0	2.0	0.5	0.5	1.0	66.7 %	66.7 %	66.7 %	85 %
Lung	8.5	9.5	18.0	5.5	6.0	11.5	3.0	3.5	6.5	64.7 %	63.2 %	63.9 %	85 %
Other	1.0	2.0	3.0	1.0	1.0	2.0	0.0	1.0	1.0	100 %	50.0 %	66.7 %	85 %
Skin	5.5	26.0	**31.5**	5.5	25.0	**30.5**	0.0	1.0	**1.0**	100 %	96.2 %	**96.8 %**	85 %
Upper GI	5.0	4.0	9.0	4.0	0.0	4.0	1.0	4.0	5.0	80.0 %	0.0 %	44.4 %	85 %
Urology	10.5	25.5	36.0	9.5	18.5	28.0	1.0	7.0	8.0	90.5 %	72.5 %	77.8 %	85 %
Total	54.0	88.0	142.0	40.5	66.5	107.0	13.5	21.5	35.0	75.0 %	75.6 %	75.4 %	85 %

Breach reasons:

Complex Pathway -	18	
Elective Capacity -	3	
OP Capacity -	1	
Administrative Delay -		7
Other -	13	

Leadership & Culture

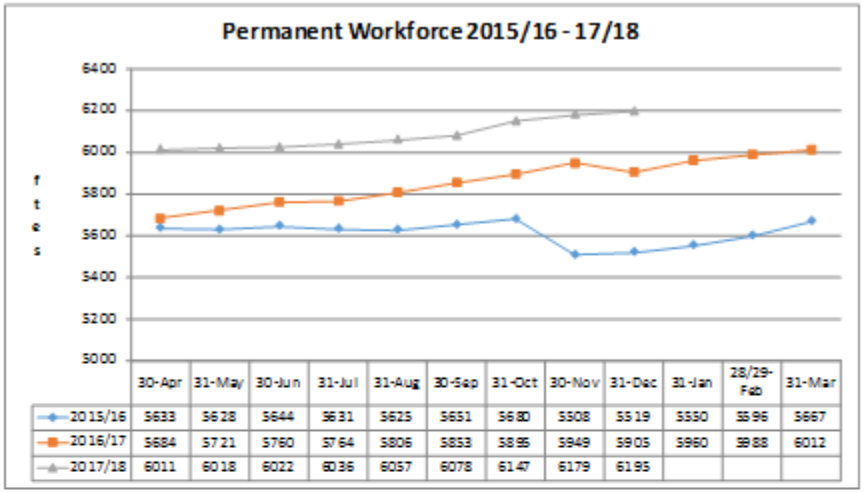
LEADERSHIP & CULTURE

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Dec-16	Dec-17	Var	2016/17	2017/18	Var		
Trust turnover rate	10.0%	9.7%	11.3%	1.5%	9.9%	11.2%	1.3%	10.9%	
Temporary costs and overtime as a % of total paybill	10.0%	14.9%	13.6%	-1.2%	15.7%	14.4%	-1.3%	14.4%	
Proportion of staff with up to date annual appraisal	85.0%	78.5%	81.4%	3.0%	84.7%	81.5%	-3.2%	80.9%	

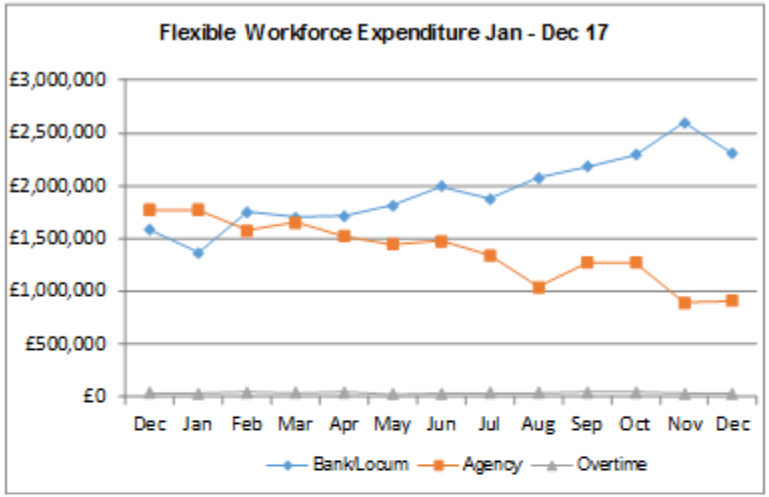
Commentary

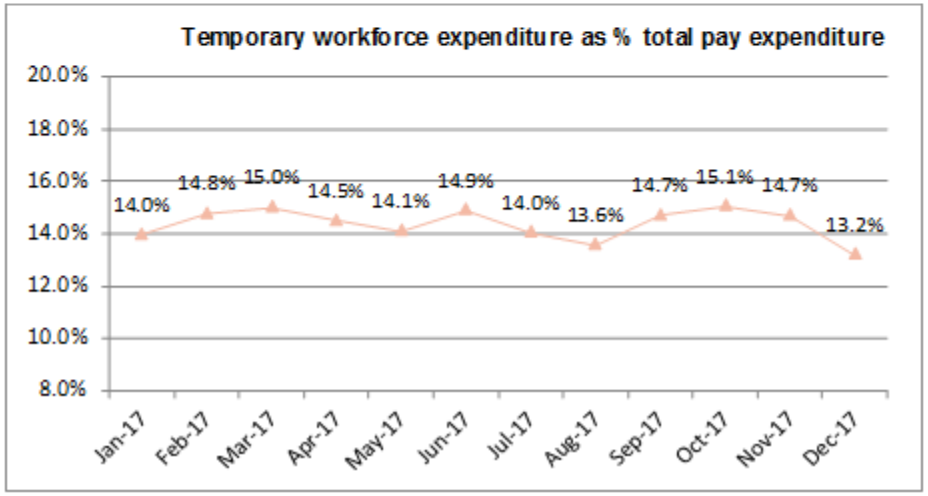
- Actual workforce usage of staff in November was 6,846.7 full time equivalents (ftes), 26.5 ftes below the budgeted establishment.

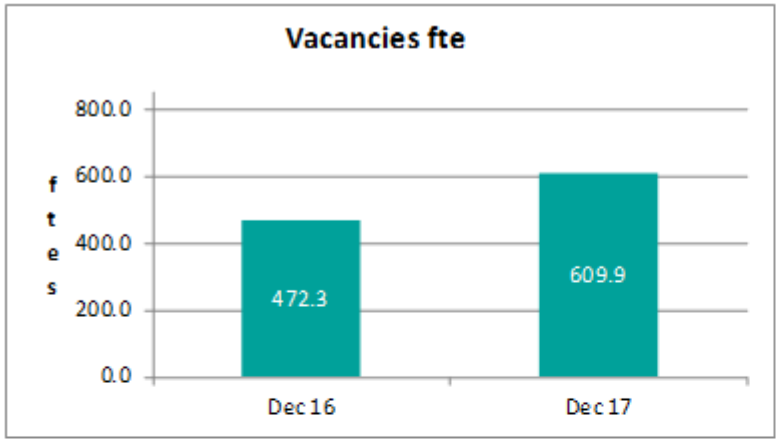
- Temporary staff expenditure was £3,244K in December (13.2% of total pay expenditure). This comprised £2,305K bank expenditure, £907K agency expenditure and £31K overtime. This is a reduction of £274K overall compared to November.
- There were 609.9 fte vacancies (a vacancy factor of 9.0%), this is 12.1 ftes lower than in November.
- Annual turnover was unchanged at 11.3%, which represents 648.5 fte leavers in the last year.
- Monthly sickness was 5.3%, an increase of 0.3% from November. The annual sickness rate was 4.4%, an increase of 0.1%.
- The overall mandatory training rate decreased by 0.4% to 88.2%. Compliance was slightly down in all subjects except for Moving & Handling, Mental Capacity Act and Deprivation of Liberties training where compliance slightly increased.
- Appraisal compliance decreased by 0.1% to 81.3%

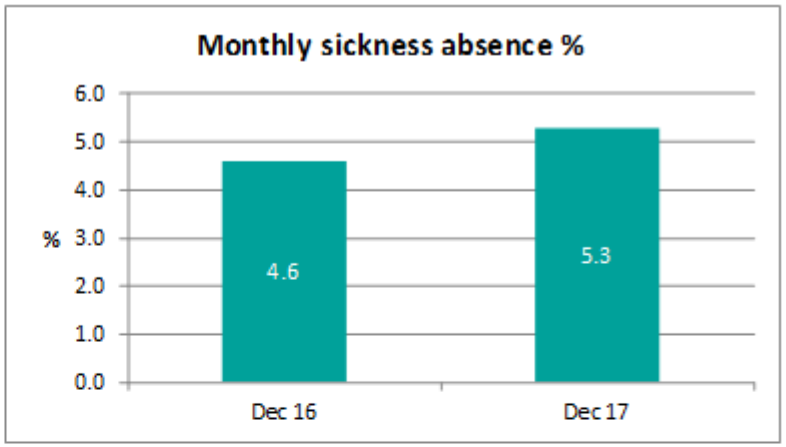


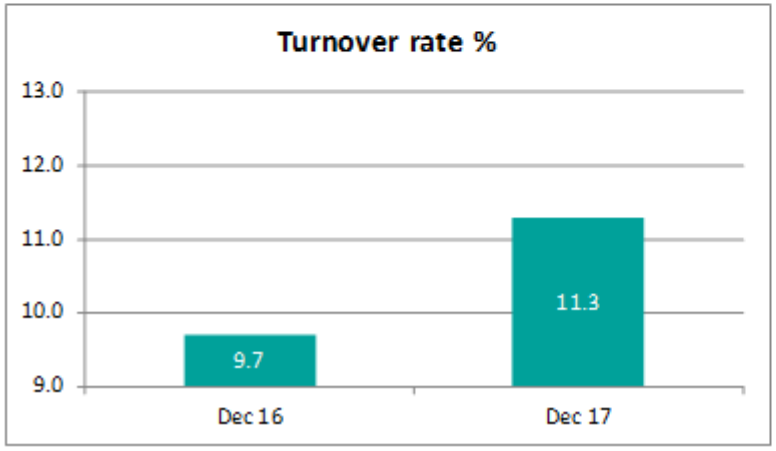
	30-Apr	31-May	30-Jun	31-Jul	31-Aug	30-Sep	31-Oct	30-Nov	31-Dec	31-Jan	28/29-Feb	31-Mar
2015/16	5633	5628	5644	5631	5625	5651	5680	5508	5519	5550	5596	5667
2016/17	5684	5721	5760	5764	5806	5853	5895	5949	5905	5960	5988	6012
2017/18	6011	6018	6022	6036	6057	6078	6147	6179	6195			

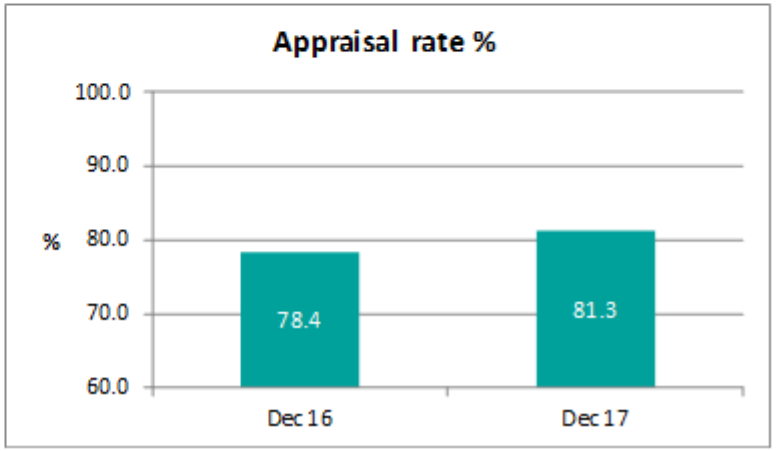




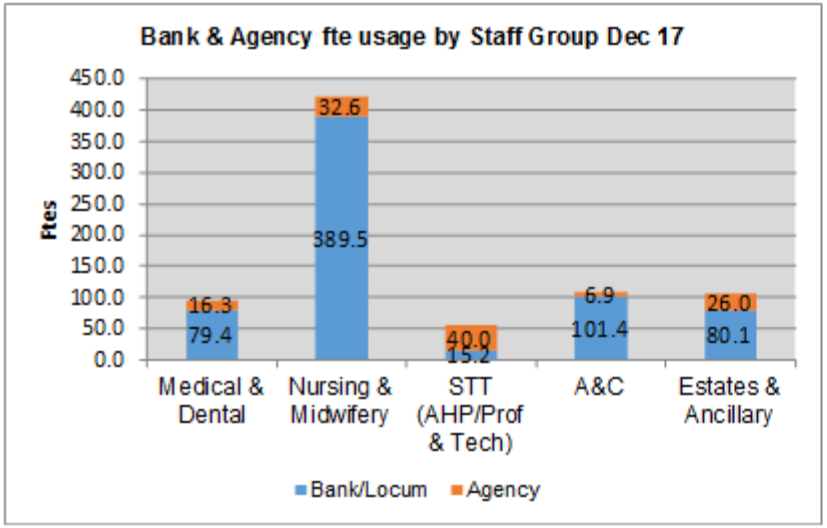

Vacancies fte
800.0
600.0
400.0
200.0
0.0
ftes
472.3
609.9
Dec 16
Dec 17

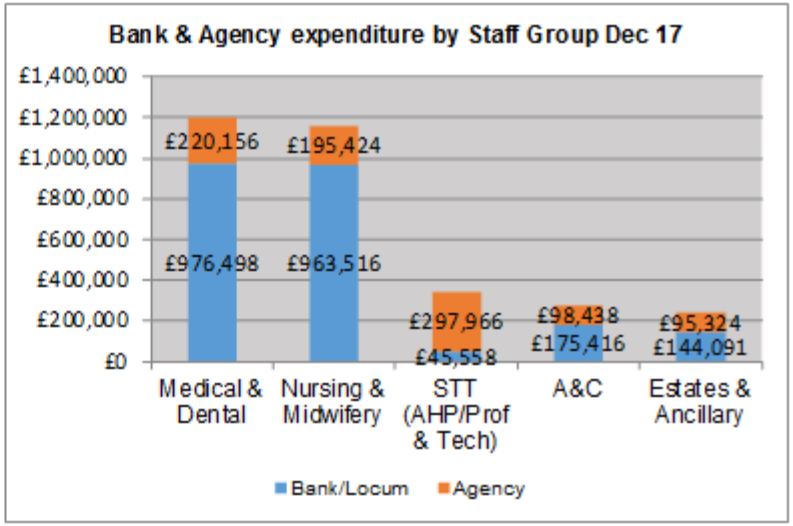

Monthly sickness absence %
6.0
5.0
4.0
3.0
2.0
1.0
0.0
%
4.6
5.3
Dec 16
Dec 17


Turnover rate %
13.0
12.0
11.0
10.0
9.0
9.7
11.3
Dec 16
Dec 17


Appraisal rate %
100.0
90.0
80.0
70.0
60.0
%
78.4
81.3
Dec 16
Dec 17

3. Recruitment



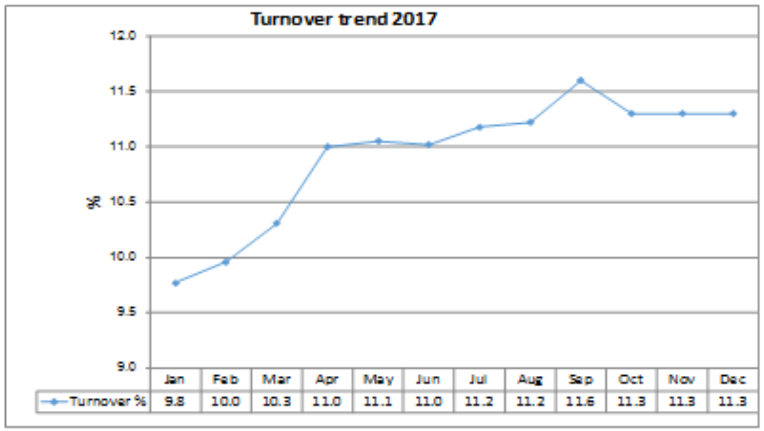


Temporary workforce expenditure has decreased this month by £274k:

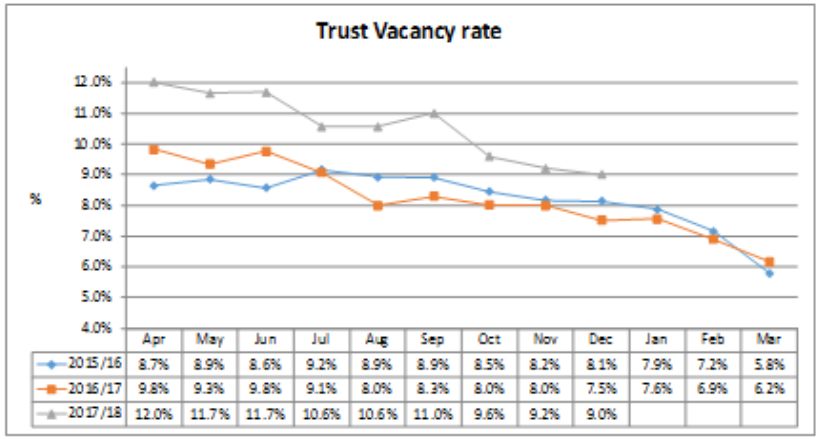
- Bank costs reduced by -£291K
- Agency costs increased by +£18K
- Overtime reduced by -£1K

Much of the variation is due to accounting adjustments with accruals and year to date bank payments being made in November, so December expenditure is more representative of monthly spend. Medical locum spend in Urology was adjusted this month which significantly reduced bank expenditure.

There have been some winter pressures in Gastroenterology and Trauma & Orthopaedics and slightly higher use of agency in Radiology.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Turnover %	9.8	10.0	10.3	11.0	11.1	11.0	11.2	11.2	11.6	11.3	11.3	11.3



	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%	7.6%	6.9%	6.2%
2017/18	12.0%	11.7%	11.7%	10.6%	10.6%	11.0%	9.6%	9.2%	9.0%			

The Trust vacancy rate has decreased by 0.2% to 9% (a reduction of 12.1 fte vacancies). Within this, the medical vacancy rate has reduced by a further 0.6% to 7.2% (44.6 fte vacancies). For registered nursing & midwives, the vacancy rate has slightly increased by 0.2% to 9.6% (204.5 fte vacancies), whilst for unregistered nurses, it has decreased by another 0.1% to 12.0% (120.8 fte vacancies).

As part of the Financial Recovery Plan, vacancy reviews are ongoing.

This month, the Trust successfully appointed a Respiratory Consultant and an additional Speciality Dr in A&E. The Medacs agency are being used as the primary source for hard to fill medical posts and there is an ongoing recruitment campaign for overseas medical and dental staff.

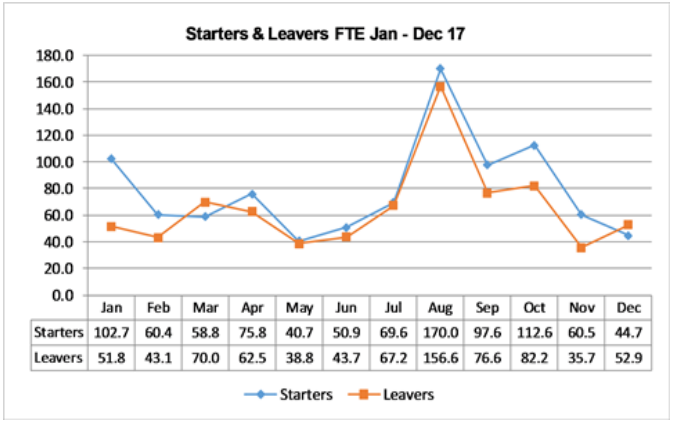
5 Philippine nurses arrived in December. Another 16 nurses are planned to arrive in the first quarter of 2018 whilst further Skype interviews have been conducted with a further 11 offers made.

Recruitment activity has been scoped for Out of Hospital Care to support 3 new business cases and a nurse recruitment agency has been engaged. The Trust will also be attending recruitment events at Surrey University in January, with other events planned throughout 2018. These events are focussed on recruiting experienced UK nurses.

The introduction of generic nurse recruitment, with planned selection and assessment events, has reduced the time spent away from operational duties for nursing colleagues. Time taken to hire is being monitored as a key performance indicator. The baseline, in July, was 65.4 days with a target of 50 days. Currently the run rate is averaging 58.3 days.

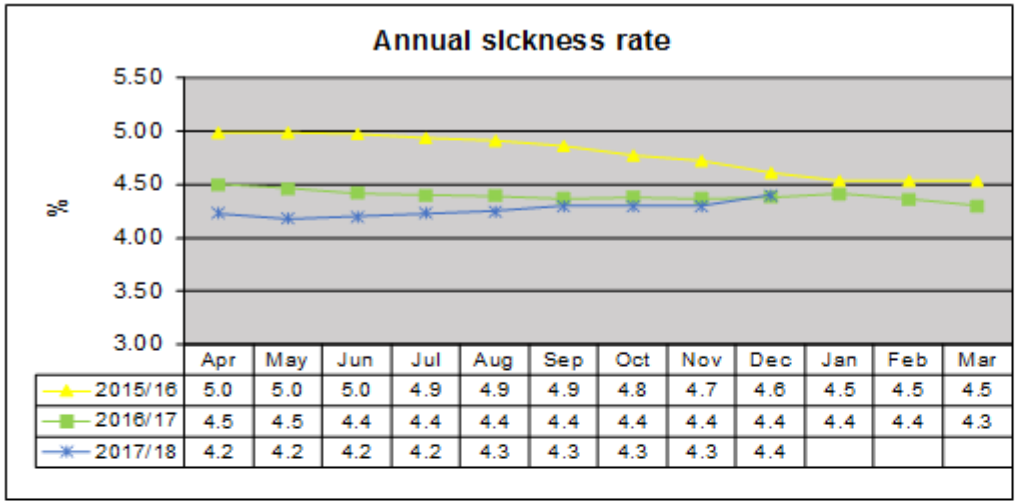
The promotion of the Trust brand has seen an increase in traffic to the Trust website (1,947 applications in November 2017, compared to 1,038 in November 2016). At the same time, the "12 days of Christmas" recruitment campaign, run in conjunction with the Communications department, has seen a major increase in traffic to the Trust Twitter and Facebook sites.

Turnover has remained unchanged at 11.3%. This represents 648.5 fte leavers in the last 12 months. The turnover rate for Medical & Dental staff (excluding junior doctors rotation) has increased this month, by 0.6% to 10%. The rate for Registered Nurses & Midwives has slightly increased by 0.2% to 10.4% but the rate for Additional Clinical Services staff (mostly unqualified nurses and therapy helpers) has decreased by 0.7% to 13.8%.

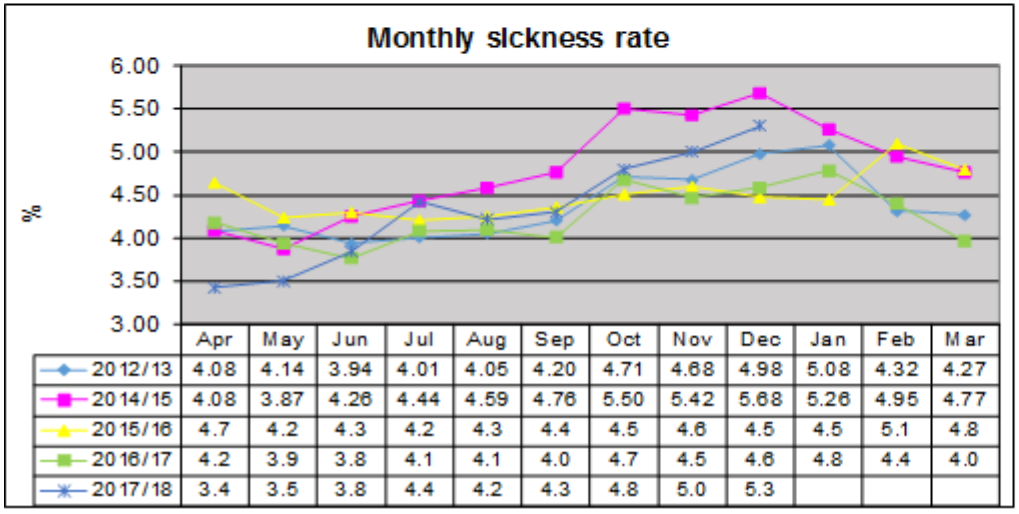


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Starters	102.7	60.4	58.8	75.8	40.7	50.9	69.6	170.0	97.6	112.6	60.5	44.7
Leavers	51.8	43.1	70.0	62.5	38.8	43.7	67.2	156.6	76.6	82.2	35.7	52.9

East Sussex Healthcare NHS
NHS Trust



	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	4.3	4.3	4.4			



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	4.08	4.14	3.94	4.01	4.05	4.20	4.71	4.68	4.98	5.08	4.32	4.27
2014/15	4.08	3.87	4.26	4.44	4.59	4.76	5.50	5.42	5.68	5.26	4.95	4.77
2015/16	4.7	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	4.8	5.0	5.3			

Monthly sickness has increased by 0.3% to 5.3% in December and the annual sickness rate has increased by 0.1% to 4.4% however this is the same as at this point last year Dec '16.

Whilst the increase in sickness is expected during the Winter months, the peak for cold, cough and flu has impacted earlier this year. Last year in Dec, only 9.9% of total sickness was due to colds, coughs, flu whereas this Dec '17 it was 13.5%. Previously the peak was seen in January '17at 16.1%

The staff group with the highest monthly sickness rate is Estates & Ancillary staff at 7.8% (increase of +0.6% since the previous month), Additional Clinical Services staff sickness was 5.7%, though this represents a reduction of 1.2%.

7. Mandatory Training

Mandatory training course	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Induction %	95.0	95.0	94.3	91.9	93.5	92.5
Fire %	85.5	85.9	85.5	85.8	86.0	85.8
Moving & Handling %	90.2	90.2	89.7	89.1	89.3	89.4
Infection Control %	89.0	89.6	89.3	88.8	88.8	88.7
Info Gov %	85.8	85.3	85.7	85.0	85.8	84.6
Health & Safety %	89.6	88.8	88.1	87.9	88.7	87.9
Mental Capacity Act %	96.5	96.0	95.8	94.8	94.8	95.1
Depriv of Liberties %	98.0	97.6	97.5	95.5	95.5	95.8
Safeguard Vuln Adults	90.3	90.1	88.9	88.0	87.8	87.4
Safeguard Child Level 2	87.4	86.4	86.1	85.9	86.0	85.7

Clinical Unit Mandatory Training & Appraisals

Clinical Unit	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Health & Safety	Mental Capacity Act training	Depriv of Liberties training	Safeguard Vulnerable Adults	Safeguard Children Level 2	Safeguard Children Level 3	Appraisal compliance
Urgent Care	85.0%	89.0%	87.9%	90.0%	82.0%	91.5%	93.0%	84.8%	83.6%	88.3%	88.1%	88.1%
Medicine Division	84.8%	88.0%	90.3%	85.9%	84.1%	87.1%	92.8%	91.1%	86.1%	84.8%	n/a	83.5%
Out of Hospital Care Division	85.9%	89.2%	97.9%	92.3%	80.5%	86.2%	97.2%	99.5%	85.6%	83.0%	n/a	74.7%
Diagnostics Anaesthetics & Surgery	82.4%	87.7%	89.7%	84.3%	84.0%	87.6%	96.2%	96.9%	89.1%	86.8%	n/a	84.5%
Womens Childrens & Sexual Health Division	85.4%	89.6%	86.8%	87.1%	84.8%	87.5%	94.2%	93.6%	89.9%	88.5%	86.1%	85.1%
Estates & Facilites	89.5%	89.5%	98.4%	96.6%	84.9%	86.6%	n/a	n/a	n/a	n/a	n/a	82.1%
Corporate	90.9%	93.9%	95.0%	92.2%	90.6%	91.1%	95.9%	96.0%	87.2%	82.9%	86.4%	82.1%
TRUST	85.8%	89.4%	92.5%	88.7%	84.6%	87.9%	95.1%	95.8%	87.4%	85.7%	86.3%	81.3%

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

Winter operational pressures on the Trust have impacted upon attendance, for example on the 1 Day Mandatory Clinical Update Day (192 places booked with 47 DNAs).

Monthly Mandatory Training and DNA reports have been distributed to divisions to follow up on non-compliance.

The Trust appraisal rate is slightly down by 0.1% to 81.3%. 1,237 staff are overdue an appraisal

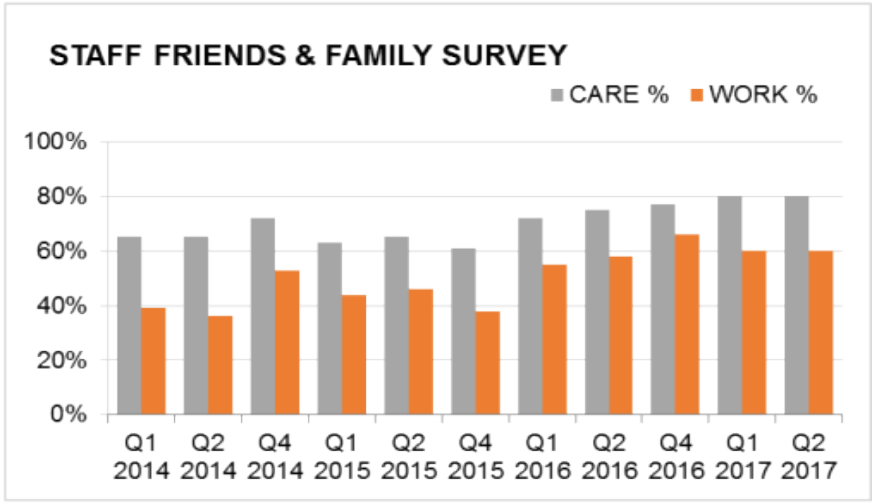
WELLBEING & ENGAGEMENT

HEALTH & WELLBEING

- Flu vaccination target of 70% for front-line staff achieved
- Over 800 staff have signed up to Health checks in the hospital & the community
- March 2017 Health & Well-being events planned to raise awareness of support (physical & psychological)
- Next Schwartz rounds will take place in February 2018

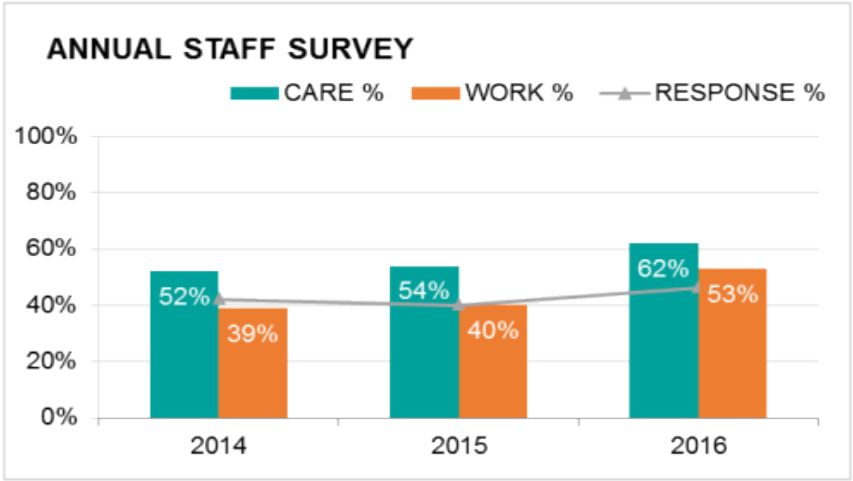
STAFF ENGAGEMENT

- Awaiting the final results of the National staff survey to be published on 6th March 2018
- Planned engagement/feedback as part of the Retention Strategy



SFFT PERIOD	CARE %	WORK %	RESPONSE %
Q1 2014	65%	39%	9%
Q2 2014	65%	36%	15%
Q4 2014	72%	53%	8%
Q1 2015	63%	44%	23%
Q2 2015	65%	46%	11%
Q4 2015	61%	38%	8%
Q1 2016	72%	55%	17%
Q2 2016	75%	58%	13%
Q4 2016	77%	66%	15%
Q1 2017	80%	60%	18%
Q2 2017	80%	60%	22%

STAFF SURVEY	CARE %	WORK %	RESPONSE %
2014	52%	39%	42%
2015	54%	40%	40%
2016	62%	53%	46%



Finance

FINANCE

FINANCE REPORT – December 2017

Jonathan Reid, Director of Finance – January 2018

Financial Summary – December 2017

Key metrics	Plan YTD	Actual YTD	Variance YTD	Plan Out-turn	Forecast Out-turn	Variance Out-turn
Agreed control total (exc STF) (£'m)	(29.1)	(40.7)	(11.5)	(36.4)	(57.4)	(21.0)
Agreed control total (inc STF) (£'m)	(22.7)	(39.4)	(16.7)	(26.5)	(56.1)	(29.6)
Re-scoped CIPs	19.0	14.4	(4.6)	28.7	27.3	(1.5)
Cash balance (£'m)	2.1	5.1	3.0	2.1	2.1	0.0

Better Payments practice code	Month Volume	Month Value	YTD Volume	YTD Value
Trade invoices	24.1%	22.9%	14.6%	24.5%
NHS invoices	19.5%	21.1%	32.2%	86.7%

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

Key Issue	Summary
Financial Summary	• December represented a challenging month both financially and operationally for the Trust. • Income is £0.9m lower than last month, due to a credit note relating to services provided last financial year. • Activity reductions seen between November and December appear significantly higher than was seen across the same period last year. • Pay costs were £0.6m higher than in M8, however £744k apprenticeship levy was included in M9 for the first time. • Non pay costs were also up against previous months. • The impact of the recent income mediations is not included in the above figures.
Efficiencies	• YTD the Trust is reporting £4m adverse variance. • The forecast delivery is £27.3m against the £28.7m plan £1.5m away from plan, this includes the additional improvements of £4.6m identified in December.
Balance Sheet	• Receivables and Payables remain high, cash remains under pressure.
Cash Flow	• Cashflow remains extremely challenging resulting in significant creditor pressure.
Capital Programme	• The overall capital programme has a 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.

Income & Expenditure – December 2017

I&E Summary (£'m)	In Month			YTD			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
NHS Patient Income	26.8	25.5	(1.3)	238.8	236.6	(2.2)	318.4	309.8	(8.6)
Tariff-Excluded Drugs & Devices	2.8	2.6	(0.2)	25.1	25.8	0.6	33.5	34.3	0.8
Private Patient / ICR	0.3	0.1	(0.3)	3.0	2.0	(0.9)	4.0	3.0	(0.9)
Other Non Clinical Income	2.8	2.6	(0.1)	25.9	27.3	1.4	34.2	35.9	1.7
Total Income	**32.7**	**30.8**	**(1.9)**	**292.8**	**291.7**	**(1.1)**	**390.0**	**383.0**	**(7.0)**
Pay - Substantive	(22.2)	(21.3)	0.9	(201.2)	(182.6)	18.7	(267.7)	(243.2)	24.5
Pay - Bank	(0.5)	(2.3)	(1.8)	(4.6)	(18.8)	(14.3)	(6.0)	(25.2)	(19.2)
Pay - Agency	(0.1)	(0.9)	(0.8)	(0.9)	(11.2)	(10.2)	(1.2)	(14.5)	(13.3)
Total Pay	**(22.7)**	**(24.5)**	**(1.8)**	**(206.7)**	**(212.6)**	**(5.8)**	**(274.8)**	**(282.8)**	**(8.0)**
Drugs	(3.3)	(3.4)	(0.1)	(30.1)	(32.1)	(2.0)	(40.2)	(42.6)	(2.5)
Supplies and services - Clinical	(2.5)	(3.1)	(0.7)	(24.7)	(26.6)	(2.0)	(31.9)	(34.9)	(3.0)
Supplies and services - General	(0.3)	(0.4)	(0.0)	(3.1)	(3.2)	(0.1)	(4.0)	(4.3)	(0.2)
Purchase of healthcare (non NHS bodies)	(0.3)	(0.4)	(0.1)	(2.9)	(3.8)	(0.9)	(3.8)	(5.3)	(1.4)
Consultancy costs	(0.0)	(0.1)	(0.1)	(0.2)	(0.5)	(0.2)	(0.3)	(0.7)	(0.4)
Clinical Negligence	(1.2)	(1.2)	-	(11.0)	(11.0)	(0.0)	(14.6)	(14.6)	(0.0)
Premises	(1.3)	(1.2)	0.1	(10.4)	(10.3)	0.1	(14.0)	(13.9)	0.1
Depreciation	(1.1)	(1.1)	0.0	(9.6)	(9.5)	0.1	(12.8)	(11.7)	1.1
Other	(1.8)	(2.0)	(0.2)	(17.1)	(17.4)	(0.3)	(21.8)	(21.9)	(0.1)
Total Non Pay	**(11.9)**	**(13.0)**	**(1.1)**	**(109.1)**	**(114.4)**	**(5.3)**	**(143.4)**	**(150.0)**	**(6.6)**
Total Operating Costs	**(34.6)**	**(37.4)**	**(2.8)**	**(315.8)**	**(326.9)**	**(11.1)**	**(418.3)**	**(432.8)**	**(14.6)**
Surplus/-Deficit from Operations	**(1.9)**	**(6.6)**	**(4.7)**	**(23.0)**	**(35.2)**	**(12.2)**	**(28.2)**	**(49.8)**	**(21.6)**
Financing Costs: Interest, PDC, Etc	(0.7)	(0.4)	0.3	(6.2)	(5.6)	0.6	(8.2)	(7.6)	0.6
Total Non Operating Costs	**(0.7)**	**(0.4)**	**0.3**	**(6.2)**	**(5.6)**	**0.6**	**(8.2)**	**(7.6)**	**0.6**
Total Costs	**(35.3)**	**(37.8)**	**(2.5)**	**(322.0)**	**(332.5)**	**(10.5)**	**(426.5)**	**(440.4)**	**(13.9)**
Net Surplus/-Deficit	**(2.6)**	**(7.0)**	**(4.4)**	**(29.1)**	**(40.8)**	**(11.6)**	**(36.4)**	**(57.4)**	**(21.0)**
Donated Asset/Impairment Adjustment	-	0.0	0.0	-	0.1	0.1	-	-	-
Operational Surplus/-Deficit	**(2.6)**	**(7.0)**	**(4.4)**	**(29.1)**	**(40.7)**	**(11.5)**	**(36.4)**	**(57.4)**	**(21.0)**
Sustainability & Transformation Fund	1.0	-	(1.0)	6.4	1.3	(5.2)	9.9	1.3	**(8.6)**
Net Surplus/-Deficit	**(1.6)**	**(7.0)**	**(5.4)**	**(22.7)**	**(39.4)**	**(16.7)**	**(26.5)**	**(56.1)**	**(29.6)**

Highlights

- Contract income forecast reflects the negative impact of mediation and under delivery of CIP on elective activity.
- Pay is overspent in month (£1.8m) £0.7m is driven by CIPs not delivering the anticipated benefits in month. In addition to continued agency and waiting list spend, and £0.7m apprenticeship levy.
- YTD Non pay overspends are predominantly in drugs and Medica (radiology reporting) costs.
- Reporting away from plan drives no STF delivery in from M3 onwards so this is showing £8.6m under plan by year end.

Divisional Performance (1) – December 2017

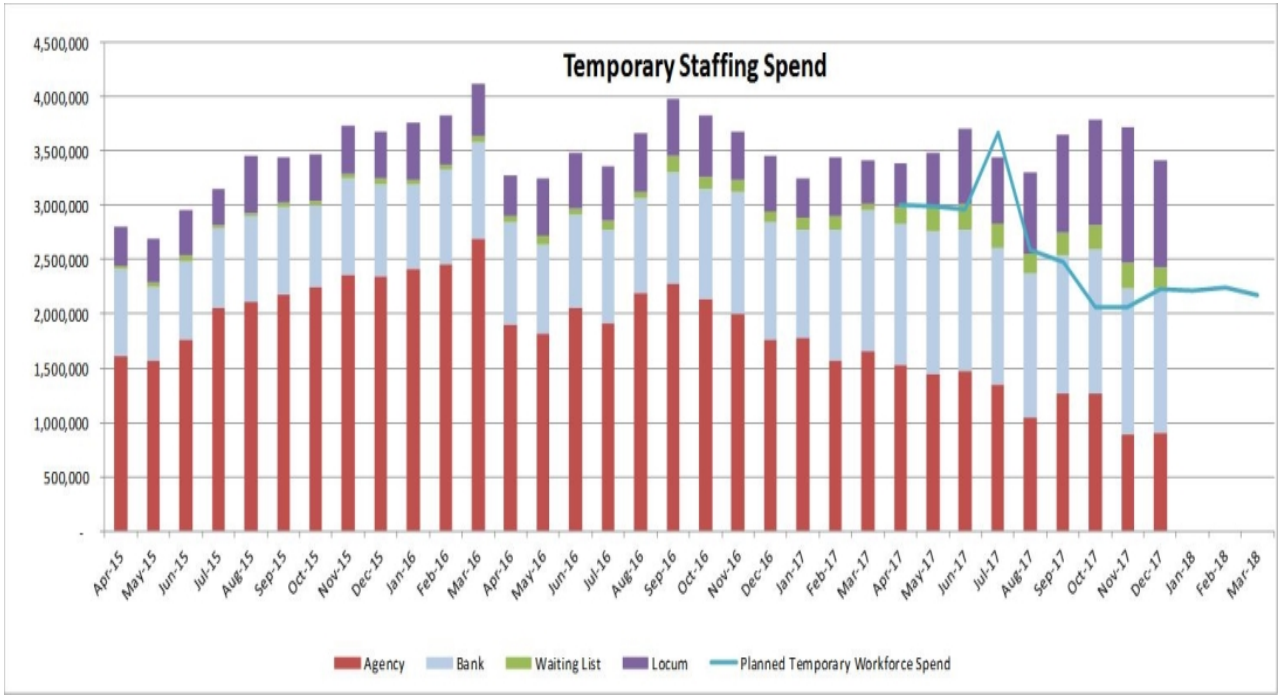
Divisional Summary (£'m)	In Month			YTD			Forecast			Notes
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	
Urgent Care:										YTD Contract Income has increased by 10% compared to Plan £. Pay overspend £1m- Medical £0.6m, Nursing £0.4m. Non pay overspend £0.2m-
Contract Income	1.7	1.9	0.1	15.9	17.6	1.6	21.0	24.1	3.1	
Other Income	0.1	0.0	(0.1)	0.3	0.2	(0.2)	0.6	0.3	(0.3)	
Pay	(1.0)	(1.0)	(0.0)	(8.4)	(9.4)	(1.0)	(11.2)	(12.8)	(1.6)	
Non Pay	(0.0)	(0.1)	(0.1)	(0.4)	(0.6)	(0.2)	(0.5)	(0.8)	(0.3)	
Total	**0.9**	**0.8**	**(0.1)**	**7.4**	**7.7**	**0.3**	**9.8**	**10.7**	**0.9**	
Medicine:										YTD Contract Income has increased by 2% compared to Plan £. Pay overspend £1.2m- Medical £0.4m, Nursing £0.7m CIP £0.3M with partial offset in Professional & Technical -£0.2m. Non pay overspend £0.9m- Cardiology0.3m -(Pacemakers, Stents, Cathetars, Equipment). Endoscopy £0.4m (Leasehire & HSDU Consumables). CIP (CSR £0.1m)
Contract Income	7.4	7.6	0.2	66.2	67.8	1.6	88.2	90.3	2.1	
Other Income	0.1	(0.1)	(0.2)	2.2	2.3	0.1	2.5	2.8	0.3	
Pay	(4.6)	(5.0)	(0.4)	(43.1)	(44.3)	(1.2)	(57.0)	(60.0)	(3.0)	
Non Pay	(0.7)	(0.8)	(0.2)	(6.4)	(7.2)	(0.9)	(8.4)	(9.6)	(1.3)	
Total	**2.2**	**1.6**	**(0.6)**	**18.9**	**18.5**	**(0.4)**	**25.2**	**23.4**	**(1.8)**	
DAS:										Under delivery of CIP YTD of £3.9m and forecast CIP of £4.8m variance. Spend of £1.5m on waiting list payments, and continued agency usage to cover vacancies, however elective activity is down. Radiology non pay continues to overspend. Michelham private patient unit is £0.4m overspent YTD.
Contract Income	9.4	7.8	(1.6)	84.2	76.6	(7.6)	112.1	102.9	(9.2)	
Other Income	0.5	0.4	(0.1)	4.2	3.7	(0.5)	5.6	5.0	(0.5)	
Pay	(7.2)	(7.3)	(0.1)	(65.3)	(66.4)	(1.0)	(87.0)	(88.7)	(1.6)	
Non Pay	(2.4)	(2.8)	(0.4)	(22.9)	(24.8)	(1.8)	(29.9)	(33.4)	(3.5)	
Total	**0.2**	**(1.9)**	**(2.1)**	**0.0**	**(10.9)**	**(11.0)**	**0.7**	**(14.1)**	**(14.8)**	
WAC										Divisional income up due to £5k payment from ESCC to Sexual Health which will be offset in non pay expenditure Pay - Health Visitor recruitment £15k Womens Health £45k agency use to cover sickness Non pay Audiology Hearing aids up £40k
Contract Income	3.9	3.3	(0.5)	34.8	34.8	(0.0)	46.3	46.2	(0.1)	
Other Income	0.0	0.1	0.0	0.3	0.5	0.2	0.3	0.6	0.3	
Pay	(2.5)	(2.6)	(0.2)	(22.3)	(23.2)	(0.9)	(29.6)	(30.8)	(1.3)	
Non Pay	(0.3)	(0.4)	(0.1)	(2.4)	(2.7)	(0.3)	(3.2)	(3.5)	(0.4)	
Total	**1.2**	**0.4**	**(0.8)**	**10.3**	**9.4**	**(1.0)**	**13.8**	**12.4**	**(1.4)**	

Divisional Performance (2) – December 2017

Divisional Summary (£'m)	In Month			YTD			Forecast			Notes
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	
Out of Hospital:										OOH is £0.4m overspent itm due to; Drugs £0.2m, which is due partly to activity and partly to reassigning costs. Therapies overspent by £0.4m, of which £44k relates to the hire of a portacabin, £15k to Orthotics footwear, and the rest is due to the allocation of the FRP target which impacts itm by £0.3m and the FOT by £0.7m.
Contract Income	3.3	3.4	0.2	29.7	29.0	(0.7)	39.4	39.3	(0.2)	
Other Income	0.5	0.4	(0.0)	4.2	3.7	(0.5)	5.5	4.9	(0.7)	
Pay	(2.8)	(2.9)	(0.2)	(26.4)	(26.0)	0.4	(34.7)	(35.0)	(0.3)	
Non Pay	(1.0)	(1.4)	(0.4)	(10.6)	(10.7)	(0.0)	(13.6)	(14.2)	(0.5)	
Total	**(0.1)**	**(0.5)**	**(0.4)**	**(3.2)**	**(4.0)**	**(0.7)**	**(3.4)**	**(5.0)**	**(1.7)**	
Estates & Facilities:										E&F is £0.2k ytd overspent, due to the additional FY CIP allocation of £0.9m with Facilities overspends (Hotel Servs, Waste & Postage) & income underachieving (DoP 16/17 old year credit to SCT, Laundry, Car Parking & Accommodation) offset by NHSPS & Estates pay vacancies. FOT reflects opportunites with HMRC rebate relating to Carbon ERR & Council tax rebate.
Contract Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Other Income	0.8	0.7	(0.0)	6.7	6.1	(0.6)	8.9	8.2	(0.7)	
Pay	(1.3)	(1.4)	(0.1)	(12.5)	(12.4)	0.0	(16.4)	(16.6)	(0.2)	
Non Pay	(1.4)	(1.2)	0.1	(12.3)	(11.9)	0.3	(16.2)	(16.0)	0.3	
Total	**(1.9)**	**(1.9)**	**0.0**	**(18.1)**	**(18.3)**	**(0.2)**	**(23.7)**	**(24.3)**	**(0.6)**	
Corporate Services:										Corporate is reporting the additional £2m CIP target allocated and the Apprenticeship Levy of £744 ytd (£1.1m). Pay vacancies across Corporate offset by increased agency usage & FSM associated costs. Backdated HMRC tax & Technical savings
Contract Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Other Income	1.2	1.4	0.2	11.2	11.6	0.4	14.8	15.1	0.3	
Pay	(2.9)	(4.1)	(1.2)	(28.7)	(30.5)	(1.9)	(37.4)	(40.9)	(3.5)	
Non Pay	(2.0)	(2.5)	(0.4)	(20.4)	(21.7)	(1.3)	(26.5)	(29.3)	(2.8)	
Total	**(3.7)**	**(5.1)**	**(1.4)**	**(37.9)**	**(40.6)**	**(2.7)**	**(49.1)**	**(55.0)**	**(6.0)**	
Other:										Contract income (other) reflects the impact of mediation and not meeting the criteria to receiev STF funding (£5.2m variance YTD and £8.6m FOT). An adjustment has been made in the forecast to reduce pay and non pay spend pending actions being undertaken by divisions to reduce expenditure in their forecasts as part of the confirm and Challenge sessions. The forecast also assumes benefit of capital charges as part of Techhnical adjustments
Contract Income (TEDDs)	2.8	2.6	(0.2)	25.1	25.8	0.6	33.5	34.3	0.8	
Contract Income (Other)	2.1	1.4	(0.7)	14.5	12.2	(2.3)	21.4	8.3	(13.1)	
Other Income	(0.1)	(0.3)	(0.2)	(0.1)	1.4	1.5	(0.1)	2.0	2.0	
Pay	(0.4)	(0.1)	0.4	(0.1)	(0.3)	(0.2)	(1.6)	1.9	3.5	
Non Pay TEDDs)	(2.8)	(2.6)	0.2	(25.1)	(25.8)	(0.6)	(33.5)	(34.3)	(0.8)	
Non Pay (Other)	(2.0)	(1.5)	0.5	(14.7)	(14.4)	0.2	(19.8)	(16.4)	3.4	
Total	**(0.4)**	**(0.4)**	**(0.0)**	**(0.2)**	**(1.2)**	**(0.9)**	**(0.0)**	**(4.2)**	**(4.2)**	

Workforce Pay Costs – December 2017

Staff Category £'m	FTE Plan	FTE Actual	In Month			YTD		
			Plan	Actual	Variance	Plan	Actual	Variance
Nursing	3,136	3,147	9.5	9.6	(0.1)	86.7	85.4	1.4
Medical	656	671	5.4	5.8	(0.4)	48.4	51.7	(3.3)
Administrative & Clerical	1,258	1,261	2.8	2.9	(0.1)	26.0	25.8	0.2
Prof & Tech	524	522	1.7	1.8	(0.2)	15.0	16.1	(1.1)
Professions Allied to Medicine	515	447	1.7	1.5	0.2	15.4	13.2	2.2
Ancillary	718	688	1.4	1.4	(0.0)	12.8	12.8	(0.0)
Senior Manager (Other)	123	101	0.7	0.6	0.1	6.6	5.7	0.9
Executive	8	10	0.1	0.1	0.0	1.1	1.1	(0.0)
Other Employees	(4)	-	0.1	0.8	(0.7)	0.4	0.9	(0.5)
Vacancy Factor	(60)	-	(0.7)	0.0	(0.7)	(5.6)	0.0	(5.6)
Grand Total	**6,873**	**6,847**	**22.7**	**24.5**	**(1.8)**	**206.7**	**212.6**	(5.8)



Highlights

- Nursing spend is £1.4m underspent YTD, due to underspends predominately in ESBT, Health visiting and corporate, (some of these are also included in the vacancy factor line.) However, ward based nursing is £1.7m overspent
- YTD Medical staff £3.3m overspend is predominately driven by the use of high cost temporary staff, although medical pay is showing an improving trend as a result of the shift from agency to locums.
- A&C and Senior manager's underspends are predominately in corporate.
- Prof & Tech overspends are in part offset by the vacancy factor.
- The £5.6m vacancy factor line includes CIP targets that were allocated to divisions
- Overall temporary staffing costs April-Dec 2017 of £32m, which is in line with spend April-Dec 2016.
- Agency spend is within the NHSi ceiling, and has reduced by 38% compared to the same period the previous year, offset by increases on Wli, locum and bank.

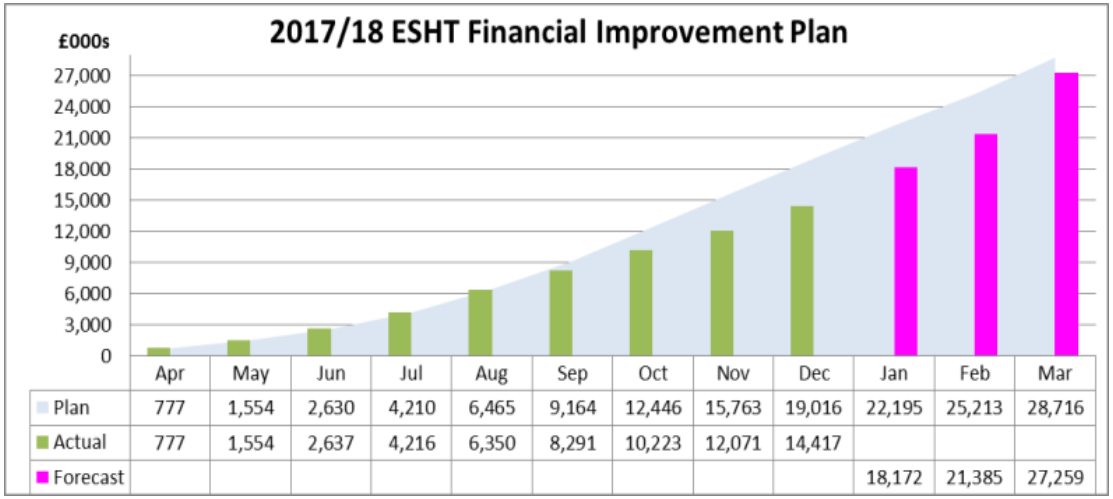
Cost Improvement Plan – December 2017

Division	YTD Plan £000	YTD Actual £000	YTD Variance £000
Corporate	1,200	65	(1,135)
Estates & Facilities	803	595	(208)
DAS	6,576	2,704	(3,872)
Medicine	3,842	2,945	(898)
Urgent Care	1,291	1,508	216
WAC	1,243	1,681	438
Out of Hospital	1,609	1,385	(224)
Trustwide	1,841	3,534	1,693
Total	18,406	14,417	(3,990)

Headlines

- The Trust is behind the revised CIP plan by £4m YTD.
- The focus has moved away from Workstreams to a Divisional focus with confirm and challenge sessions happening weekly with the management teams.
- The largest variance is in DAS £3.9m, in Data Quality and Elective Pathways.
- Workforce are exploring further ideas that could deliver in year savings, these still need to be quantified.
- The forecast delivery is £27.3m, this is £1.5m behind the £28.7m plan.
- The additional in year improvements that were identified in December are now reflected in these numbers.

Division	Full Year Plan £000	Full Year Forecast £000	Full Year Variance £000
Corporate	2,844	201	(2,643)
Estates & Facilities	1,736	947	(789)
DAS	9,046	4,238	(4,808)
Medicine	7,043	5,061	(1,982)
Urgent Care	2,113	1,981	(132)
WAC	3,551	2,885	(666)
Out of Hospital	3,128	1,914	(1,213)
Trustwide	(744)	10,033	10,777
Total	28,716	27,259	(1,456)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	777	1,554	2,630	4,210	6,465	9,164	12,446	15,763	19,016	22,195	25,213	28,716
Actual	777	1,554	2,637	4,216	6,350	8,291	10,223	12,071	14,417			
Forecast										18,172	21,385	27,259

Activity & Contract Income – December 2017

Income (£'m)	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Inpatients - Electives	4.6	3.7	(0.9)	43.0	38.0	(4.9)
Inpatients - Emergency	7.5	8.1	0.6	66.1	71.3	5.2
Excess Bed Days	0.5	0.2	(0.3)	4.9	3.3	(1.6)
Outpatients	3.6	2.9	(0.7)	34.0	31.2	(2.9)
Other Acute based Activity	2.7	2.5	(0.1)	23.9	24.2	0.2
Direct Access	0.8	0.6	(0.2)	7.4	7.3	(0.1)
Block Contract	4.2	4.0	(0.3)	39.3	35.7	(3.7)
Fines & Penalties	0.0	0.0	0.0	0.0	0.0	0.0
Other	3.3	2.3	(1.0)	21.7	22.1	0.4
CQUIN	0.5	0.5	(0.0)	4.9	4.9	(0.1)
Subtotal	27.8	24.9	(2.9)	245.2	237.9	(7.3)
Exclusions	2.8	2.7	(0.1)	25.2	25.8	0.6
TOTAL	**30.6**	**27.6**	**(3.0)**	**270.4**	**263.6**	**(6.8)**

Activity	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Inpatients - Electives	4,324	3,463	-861	39,963	34,989	-4,974
Inpatients - Emergency	3,573	3,911	338	31,698	33,948	2,250
Excess Bed Days	2,282	971	-1,311	20,240	13,688	-6,552
Outpatients	30,021	26,292	-3,729	277,431	274,309	-3,122
Other Acute based Activity	12,203	11,609	-594	108,653	110,004	1,351
Direct Access	284,226	233,464	-50,762	2,626,644	2,657,920	31,276
Other	9,094	8,854	-240	82,846	87,457	4,611

Income Headlines

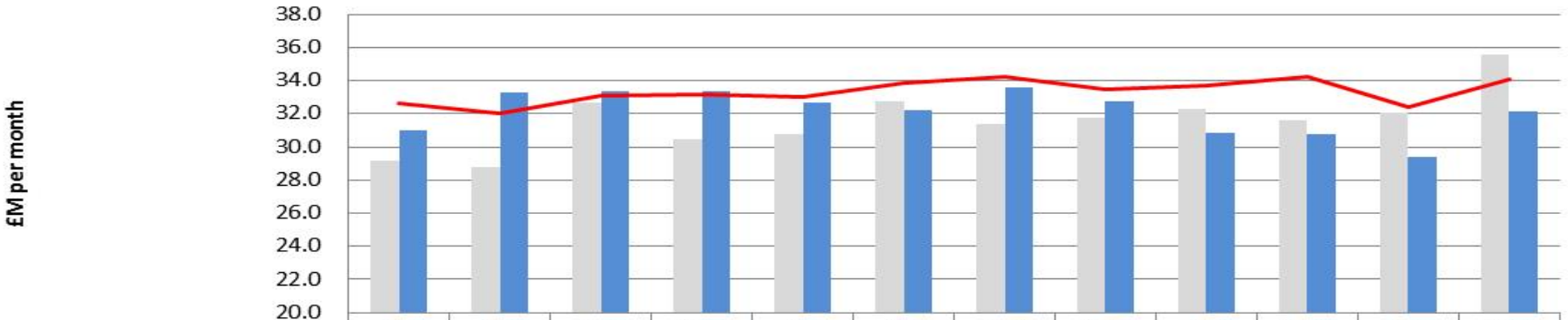
- Excluding STP funding, the Trust is below plan in month and YTD.
- The plan for December factored in a reduction for bank holidays however the Trust has seen a much greater reduction and this is significantly greater than the reductions seen in previous years.
- In financial terms underperformance in elective and daycase is offset by higher levels of non-elective.
- Non-Elective is higher than expected although there is a significant reduction in excess bed days in month.
- A&E activity continues above plan (YTD 3%) however the Trust is seeing significantly high levels of the high acuity HRGs (vs plan) and this generates a 20% positive variance in income.
- Outpatient income is about 21.8% below plan in month and about 10% below plan YTD.

Activity Headlines

- Daycase activity has decreased compared to the last three months and has significantly underperformed in December.
- Elective activity is below plan in December, with the lowest activity per day all year of 26
- Non-elective activity is above plan in month 9. This continues a trend, going back to March 2017, of increasing non-elective activity. The level of excess bed days reduced in December - this is a welcome reduction, following work to discharge patients.
- Outpatients activity is below plan in month 9. Activity per working day was low in month, reflecting the decreased level of activity

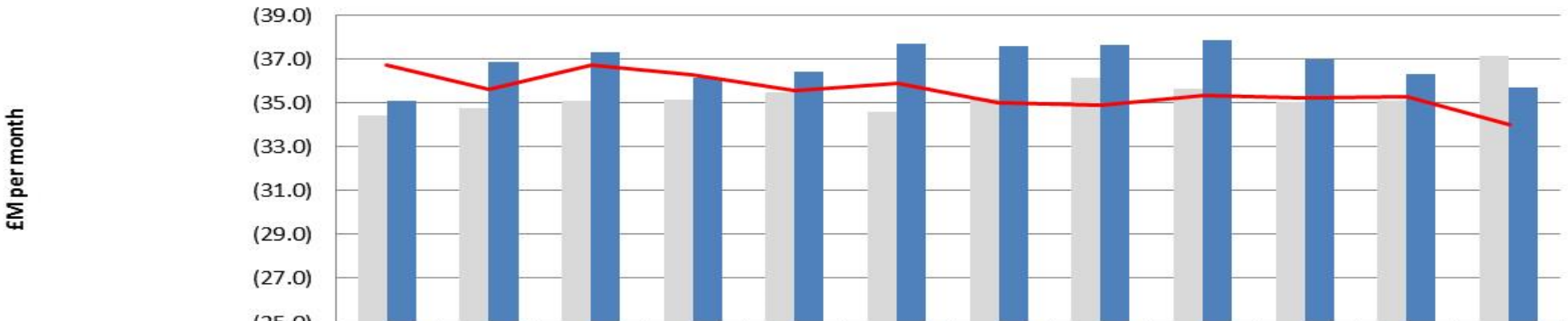
Trends – December 2017

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	35.6
Run Rate 2017/18 Income	31.0	33.3	33.4	33.3	32.7	32.2	33.6	32.7	30.8	30.8	29.4	32.1
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 & Non Pay Run Rate



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
2016/17 Run Rate	(34.4)	(34.7)	(35.1)	(35.1)	(35.5)	(34.6)	(35.2)	(36.1)	(35.6)	(35.0)	(35.1)	(37.1)
Run Rate 2017/18 Spend	(35.1)	(36.8)	(37.3)	(36.2)	(36.4)	(37.7)	(37.6)	(37.6)	(37.8)	(36.9)	(36.3)	(35.7)
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)

- Divisional run rate graphs are shown

Financial Risks & Mitigating Actions – December 2017

Risks	Mitigations
The Trust has a £28.7m savings requirement, currently forecast adverse variance is £1.5m. There is a risk this could increase.	The Trust has made some changes to programme management and governance, including strengthening Executive oversight and introducing confirm and challenge sessions to monitor divisional performance.
In addition to CIP slippage other areas of overspend have contributed to the forecast variance of £21.0m, YTD CIP delivery is £14m this is forecast to rise to £27m by the year end.	A new Financial Improvement Director has been appointed to the Trust
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. Four-eyes insight have recently started working with the Trust
The costs of escalation and other attributable items may not be contained within the funding envelope, including the costs of Winter.	Work continues to manages these budgets; the level of winter funding received is significantly above plan..
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.
The Trust is on a fixed income agreement with it's two main commissioners, there is a risk that for operational reasons the Trust may have to undertake additional activity that is not paid for.	The Trust is now operating on a fixed cost envelope and attempting to manage it's cost accordingly.
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.
Although improving cash remains extremely constrained and there is a risk that key suppliers will refuse to deal with the Trust	Additional funding (£8m) has been received in January and further improvements linked to the revised forecast are anticipated.

Sustainability and Strategy

SUSTAINABILITY

Strategy, Innovation and Planning

Work is ongoing to ensure that the SIP team which now includes the PMO are able to support the divisional and corporate teams on the organisational priorities in terms of development and delivery of quality and financial improvement plans

Support continues for the divisional and corporate teams to develop their business plans and an update on progress will be provided to the Board.

The longer term strategic plan is focused on analysis of clinical and financial sustainability of services and how we can develop strategic plans that will drive improvement in the areas we identify require improvement.

Activity

ACTIVITY

Activity Headlines

The Christmas period was particularly challenging for the trust with 11% more attendances than the same period last year and 5% more arrivals by ambulance. Admissions were up by 16% yet the trust only cancelled 2 operations due to bed capacity during that time and maintained a four hour clinical standard of 86.7% for December as a whole.

Elective inpatient and day case activity remains lower than previous years and down against the agreed plan

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Dec-16	Dec-17	Var	2016/17	2017/18	Var		
Emergency Department attendances	M	9136	10065	10.2%	84373	90170	6.9%	9695	
Ambulance conveyances	M	3331	3527	5.9%	27818	29072	4.5%	3195	
Admissions via A&E	M	28.2%	30.4%	2.2%	25.0%	28.1%	3.1%	28.0%	
Primary Referrals	M	7675	6503	-15.3%	81082	75304	-7.1%	8584	
Consultant to Consultant referrals	M	1333	1672	25.4%	13713	15641	14.1%	1700	
2WW Referrals	M	1345	1300	-3.3%	14759	14798	0.3%	1649	
Elective spells	M	619	507	-18.1%	6001	5470	-8.8%	623	
Day Cases	M	3753	3383	-9.9%	35776	35162	-1.7%	3960	
Elective Beddays	M	1899	1375	-27.6%	17364	14768	-15.0%	1703	
Total Non-Elective Spells	M	3966	4409	11.2%	34419	37376	8.6%	4056	
Number of Emergency spells	M	3363	3815	13.4%	28767	31833	10.7%	3442	
Number of Maternity spells (ante and post partem)	M	329	320	-2.7%	3031	2986	-1.5%	331	
Number of other non-elective spells (Births/Transfers from other hospitals)	M	274	274	0.0%	2621	2557	-2.4%	282	
Non-Elective beddays	M	23304	22388	-3.9%	204287	195136	-4.5%	22137	
LOS									
Elective Average Length of Stay	M	3.1	2.7	-0.4	2.9	2.7	-0.2	2.7	
Non-Elective Average Length of Stay	M	6.1	5.1	-1.0	5.9	5.3	-0.6	5.5	
Inpatient Average Length of Stay at intermediate care units	M	33.5	26.6	-6.9	29.4	28.4	-0.9	30.1	
Outpatients									
First outpatient attendances	M	10642	8588	-2054	106660	96379	-10281	10128	
Follow-up outpatient attendances	M	21861	20723	-1138	231002	239043	8041	24513	
First outpatient DNA rate	M	9.6%	8.9%	-0.7%	9.1%	8.5%	-0.7%	8.5%	
New to follow up ratio	M	2.1	2.4	0.4	2.2	2.5	0.3	2.4	

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Dec-16	Dec-17	Var	2016/17	2017/18	Var		
Community Nursing									
Community nursing referrals	M	3984	3671	-313	35962	36635	673	4176	
Community nursing total contacts	M	33012	32994	-18	306344	316809	10465	35439	
Community Nursing face-to-face contacts	M	18929	18679	-250	173554	178731	5177	19892	
Community nursing ALOS	M	21.4	5.1	-16	23.7	13.7	-10.0	15	

The Christmas period was particularly challenging for the trust with 11% more attendances than the same period last year and 5% more arrivals by ambulance. Admissions were up by 24% yet the trust only cancelled 2 operations due to bed capacity during that time and maintained a four hour clinical standard of 86.7% for December as a whole.

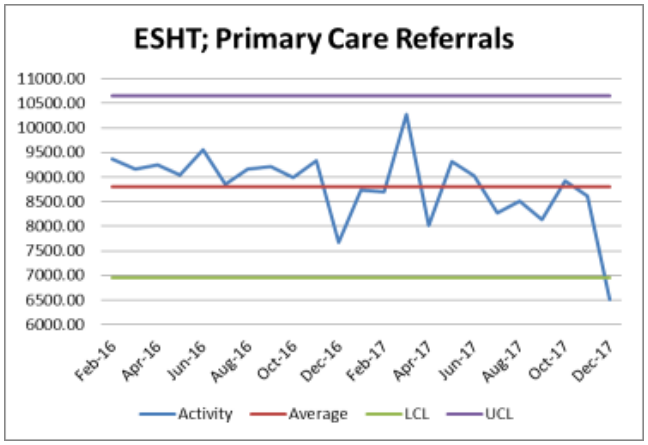
Elective inpatient and day case activity remains lower than previous years and down against the agreed plan.

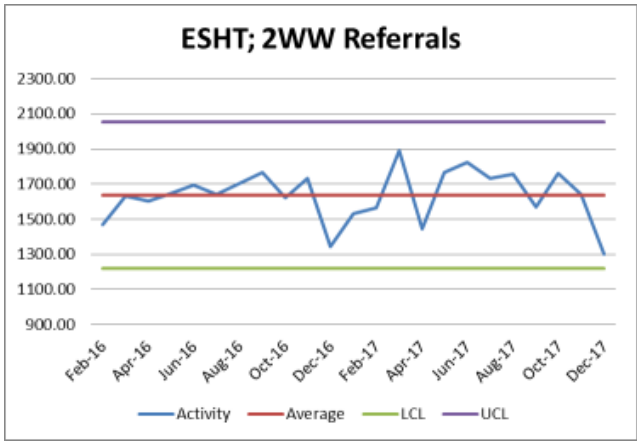
Activity to date is shown in the table below against last year's outturn and against the plan year to date.

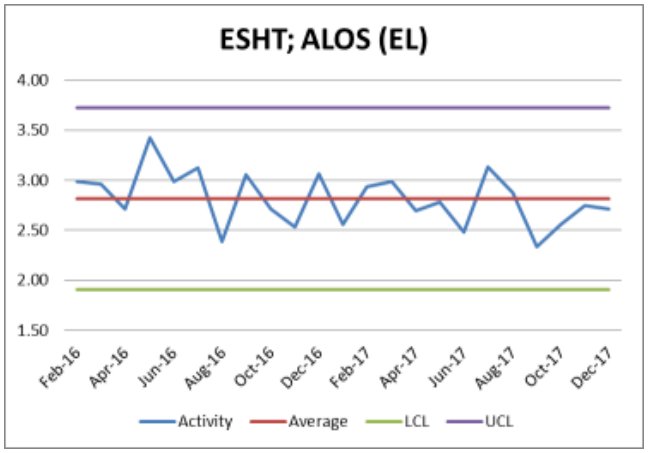
	Actual 17/18	Actual 16/17	Plan 17/18	Variance to last year	Variance to plan
Daycase	35,162	35,776	38,584	-1.7%	-8.9%
Inpatient	5,490	6,013	6,429	-8.7%	-14.6%
Elective (Total DC/IP)	40,652	41,789	45,013	-2.7%	-9.7%
Non Elective	34,943	31,959	32,323	9.3%	8.1%
First OP	88,617	97,342	97,376	-9.0%	-9.0%
Follow Up OP	219,816	211,413	214,939	4.0%	2.3%

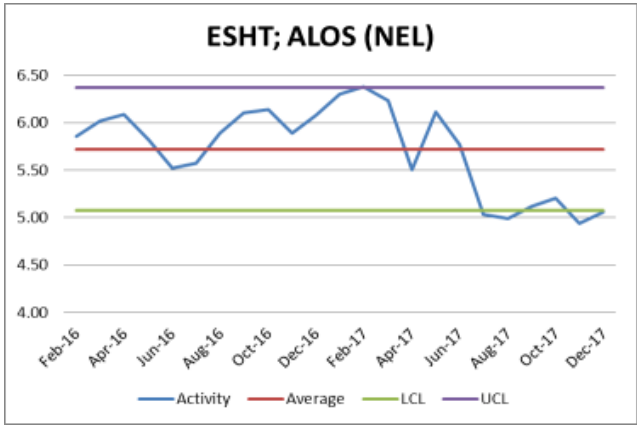
excludes well babies and neonatals

East Sussex Healthcare NHS
NHS Trust









Primary care referrals reduced during December as expected for seasonal trends.

The referrals for two week waits also dropped in December but the overall trend remains up against the average. 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 November. This would indicate a higher than expected number of patients discharged with low lengths of stay which is in line with the increase in 0 LOS.


WHAT
MATTERS
TO YOU
MATTERS
TO US
ALL

Mortality Report – Learning from Deaths 1st April 2016 to 30th September 2017

Meeting information:			
Date of Meeting:	6th February 2018	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. The mortality database has been updated to reflect the new review process and now includes a record of all plaudits and care concerns raised by family or carers of the deceased.
This report details the deaths recorded and reviewed from April 2016 – September 2017.
The importance of reviewing deaths within the 3 month timescale is critical to ensure the reporting is accurate and provides a useful overview of the number of deaths that were actually or potentially avoidable. This is the only risk remaining with the learning from deaths process changes. Consultants have been reminded (again) of the importance of timely review and accuracy of grading the avoidability of deaths.

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

N/A

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/September 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.

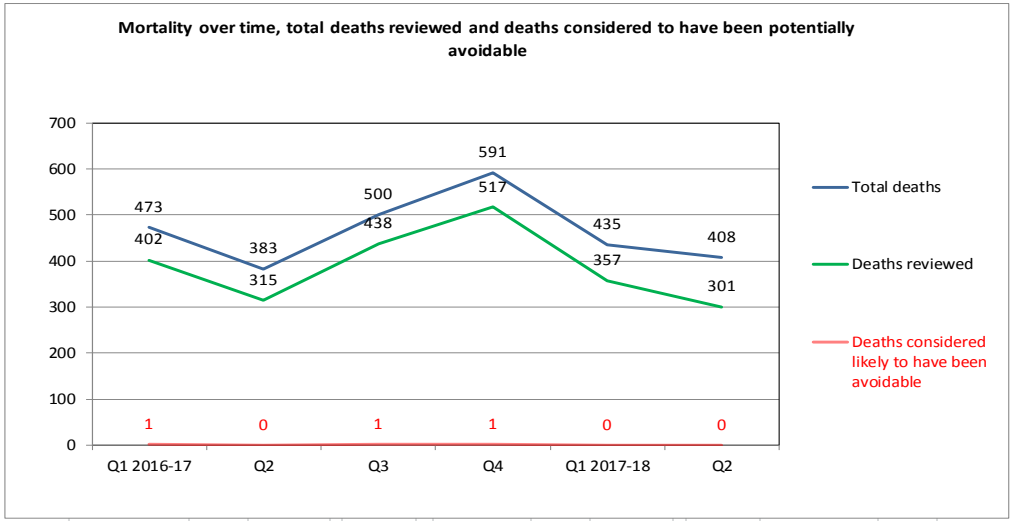
Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 08/01/2018)

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	Q2

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
150	131	108	101	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
408	435	301	357	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
843	1947	658	1672	0	3



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)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-

Data shown above is as at 08/01/2018 and does not include patients with identified learning disabilities.
Family/carer concerns expressed to the Trust Bereavement team are now recorded on the mortality database. There were 2 care concerns raised relating to Q2 deaths, neither of which were taken forward as a formal complaint.
Complaints - Of the complaints relating to 'bereavement' which were partially or fully upheld during Q2, none had reviews on the Mortality database which concluded poor or very poor care.
Serious incidents - There were no severity 5 serious incidents (cause of death was significantly contributed to by a lapse in care or service delivery) raised in Q2.
As at 08/01/2018 there were 185 April 2017 - September 2017 deaths still outstanding for review on the Mortality database.

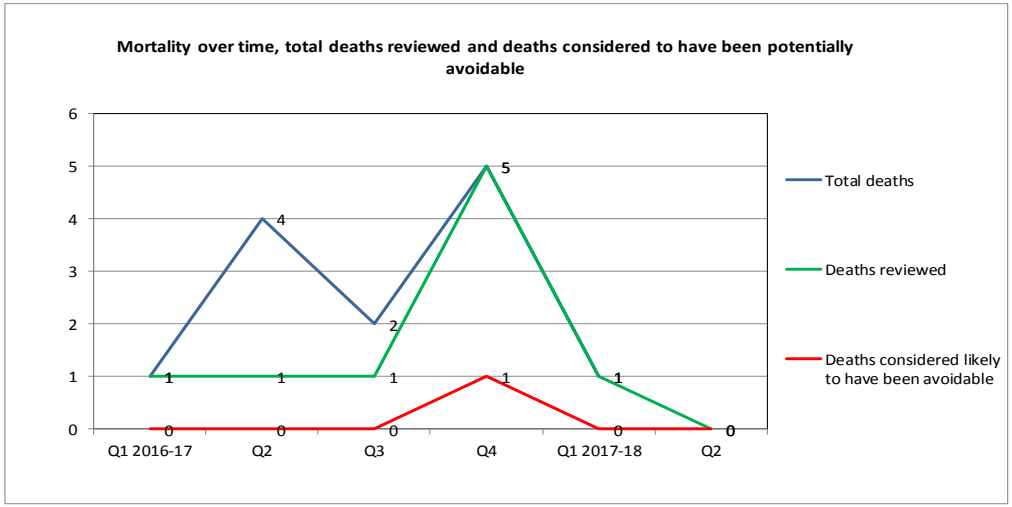
Summary of total number of learning disability deaths and total number reviewed (Data as at 08/01/2018)

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	Q2

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
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	1	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1	12	1	8	0	1



In March 2016 the Mortality database was updated, allowing the Learning disability team to enter review comments for Learning disability deaths.
The 2016/17 Learning disability deaths were reviewed by the Trust Learning disability team prior to the national requirement of reviewing deaths using the new national LeDeR (learning disability mortality review) methodology.
The LeDeR programme is now in place and the Learning disability deaths are being reviewed against the new criteria.

Finance and Financial Special Measures Update – Quarter 3 2017/18

Meeting information:			
Date of Meeting:	6th February 2018	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? Risk to delivery of the financial position, and associated operational risks, are on the risk register

Executive Summary:

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

Through the Finance and Investment Committee, and at Board Seminar, the Board has been reviewing the refreshed forecast for financial performance in 2017/18. The revised forecast has now been shared with NHS Improvement, following review at the December and January Financial Special Measures review meetings, and through the Finance and Investment Committee meetings of 17 & 31 January. This paper is presented to request formal adoption by the Board.

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

Details of financial performance are reviewed at monthly Finance and Investment Committee meetings.

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

The Board is asked to approve the refreshed forecast for 2017/18. The Board is also asked to note the required improvement actions in train for the remaining months of the financial year.

FINANCIAL PERFORMANCE 2017/18 – QUARTER 3 UPDATE

Introduction

The Trust set an ambitious financial plan for 2017/18, aiming to significantly reduce the underlying deficit and to deliver the NHS Improvement control total. During the financial year, a number of factors have driven non-delivery of the financial plan, and this paper sets out the results of the reforecast undertaken at Month 9. The Trust has been in discussion with NHS Improvement since month 6, and the Board has reviewed the risks to the forecast at Board Seminar and through the Finance and Investment Committee. The requirement for a reforecast has been reported in Trust Board papers. The Trust has also been in mediation with its lead Clinical Commissioners over a number of key items and the results of this mediation were confirmed in January 2018.

The Trust has now shared the value of the reforecast with NHS Improvement through the Financial Special Measures review meetings in December 2017 and January 2018. The Trust planned to deliver a £36.4m deficit, before Sustainability and Transformation Funding (STF), and is now forecasting a £57.4m deficit, before STF funding. As the Trust has not met its control total, it is not eligible for STF funding for Quarters 2-4, with a value of £8.6m. Quarter 1 was received and the reported deficit will therefore be £56.1m, against a financial plan of £26.5m, a movement of £29.6m. This represents a significant deviation from plan, driven by non-delivery of efficiency savings, reduced elective work, additional cost pressures, and the results of mediation – each of which are discussed below – and the Trust is working hard to ensure that the financial planning process for 2018/19 is robust and leads to an improvement in the financial position of the organisation.

Review work undertaken by KPMG has indicated that the 'exit deficit' for 2016/17 was £57.8m, after adjusting for non-recurrent items. The forecast 'exit deficit' for 2017/18 is £53.5m, after adjusting for non-recurrent items. This represents a marginal improvement in the underlying financial position for the Trust, alongside a significant improvement in operational performance and key indicators of quality and safety. The Trust must deliver a step-change in financial performance in 2018/19, whilst maintaining the strong momentum on quality and safety delivered in 2017/18.

Key Drivers of the 2017/18 Reforecast

There are four key drivers of the 2017/18 reforecast. These are shown below, with further detail provided. Each month, the components of the financial position are reviewed in detail by the Finance and Investment Committee, with further information provided to the Trust Board:

	£m
2017/18 Financial Plan (excluding STF)	**(36.4)**
Non-Delivery of Cost Improvement Programme	(6.1)
Reduced Elective Activity	(4.8)
Cost Pressures	(4.8)
Mediation Outcomes	(9.8)
Quarter 4 Improvements	4.6
Month 9 Reforecast (excluding STF)	**(57.4)**

Non-Delivery of Cost Improvement Programme: The Trust set an ambitious CIP target of £28.4m for the financial year. The programme has not been delivered in the way that the Trust planned, with a number of benefits arising from changes in payment rules including the implementation of HRG4+. However, colleagues from across the organisation have collectively delivered £22.3m of efficiency savings, leaving a shortfall of £6.1m. The good progress on delivery should be commended, but the Trust needs to strengthen delivery arrangements into 2018/19 to ensure full delivery of future

programmes. Actions are in train, with the support of the Financial Improvement Director, to secure this.

Reduced Elective Activity: The Trust has made significant improvement in delivery against the RTT performance standards, but remains an inconsistent performer for some key specialties eg. 62 day cancer standard. For a number of key services, however, the level of elective and planned care activity (including outpatients), the Trust delivered less activity than planned, and less than funded through the cost base. Whilst overall income was above plan, elective and planned care activity is forecast at £4.8m below planned levels, without an associated reduction in cost. Detailed work is in train through the 2018/19 planning process to ensure that activity assumptions are robust, and are supported by detailed 'production plans' mapping activity levels to resources, including both workforce and funding.

Cost Pressures: The Trust has seen additional cost pressures in year arising from a number of key areas. These include additional costs for drugs and items of clinical support equipment, where the Trust has seen a number of key prices rises despite the strong support of the procurement team, and a number of additional costs associated with temporary workforce and programme support teams. The improvement plan for Quarter 4 is aimed at mitigating and reducing these cost pressures to ensure delivery of the revised forecast.

Mediation Outcomes: The financial position for the East Sussex local health economy is challenging, with significant cost pressures facing the local Clinical Commissioners. A number of mediation cases were brought to regulators by the Trust and the Clinical Commissioners, with the aim of resolving some historical disputes and providing a robust baseline for future financial and strategic planning within the framework of East Sussex Better Together. The outcome of these mediation cases has reduced the Trust income by £9.8m, with £4.3m of this reduction reflecting a non-recurrent payment for a single contract. The Trust and partners within East Sussex Better Together are committed to building on the excellent working between Alliance members.

Quarter 4 Improvements: The Trust is planning £4.6m of improvements to the financial position over the period December to March (described as Quarter 4 improvements). £0.9m of this was delivered in Month 9, and the Trust is forecasting delivery of these improvements over the remainder of the financial year. These measures combine a continued focus on the control of expenditure with a full review of the Trust's balance sheet and contract balances, and the detailed components of the improvements are reviewed on a monthly basis by the Finance and Investment Committee. There remains an element of risk within this programme, and the Board will continue to be updated on progress on delivery on a monthly basis.

Finalising the 2017/18 Forecast

There are a number of key variables which impact on the 2017/18 reported position, and a summary of the range of outcomes is provided below. The STF funding is applied in all cases, as the Trust has earned and received Quarter 1 payment – this is shown separately as it does not count against NHS Financial Performance targets.

	Best Case £m	Mid Case £m	Worst Case £m
Month 9 Reforecast excluding STF	(57.4)	(57.4)	(57.4)
Q 1 STF Funding	1.3	1.3	1.3
Month 9 Reforecast including STF	**(56.1)**	**(56.1)**	**(56.1)**
Risk to the Quarter 4 Improvements	0.0	(1.0)	(2.5)
Receipt of Winter Funding	1.0	1.0	1.0
Receipt of 0.5% CQUIN (£1.2m)	n/a	n/a	n/a
Month 9 Range of Reported Position	**(55.1)**	**(56.1)**	**(57.6)**

Delivery of the quarter 4 improvements and finalisation of the national funding arrangements for winter and system CQUIN are the key drivers of any potential upsides and downsides in the year end forecast at Month 9. The quarter 4 improvements contain a number of components which are under detailed review by the Finance and Investment Committee, and therefore remain at risk. In addition, the level of operational pressure in January 2018 may have driven a number of additional cost pressures – although the Trust is protected from any variation in elective income through the fixed income value put in place by NHSI and NHSE. The quarter 4 plan also assumes that the accounting treatment for the apprenticeship levy (£0.9m) can be maintained or the financial risk mitigated.

However, the Trust has also not yet accounted for the full amount of additional winter funding announced under the 2017 Budget, as it remains in discussion with system colleagues around the conditions associated with the allocation of this funding – the financial arrangements are complex and as a result, a final determination is pending. The Trust is assuming that it will not receive the £1.2m system CQUIN which, for other providers, has been returned to deliver a strengthened financial position, on the basis that the Trust's fixed income value is inclusive of this amount.

Delivering the 2017/18 reforecast will require financial diligence and focus through to the year end. The weekly 'confirm and challenge' sessions with the clinical units continue to identify those areas where potential improvements can be secured, or risks mitigated, and this is co-ordinated through the weekly Financial Improvement Oversight Group, which reports to the FISC and the Executive Team directly. The Finance and Investment Committee will continue to see monthly detailed reports on the progress in delivering the forecast.

Strengthening Financial Delivery for 2018/19

There are a number of key lessons for the Trust arising from the 2017/18 financial performance. The Trust set a very ambitious plan at a time of significant operational pressure, and whilst working within an ambitious programme of change across East Sussex Better Together. Delivery of significant improvements in quality and safety, alongside improved performance, must sit alongside improved financial performance, and the Trust is working to ensure the financial architecture for 2018/19 is strengthened and that future financial plans are delivered in full.

Contract Management and Service Funding: The Trust, working with the Clinical Commissioners, has strengthened the joint governance arrangements over contract agreement and management. Early agreement on a robust contract for 2018/19, with all parties clearly aligned on the assumptions and expectations over the contract process is anticipated and the contract negotiation process for 2018/18 is being led through a monthly review process overseen by the Trust Chief Executive and the CCG Chief Officer. NHS Improvement and NHS England are supporting the East Sussex Better Together local health economy to develop a robust plan for 2018/19 which is underpinned by strong contracts, and allows for a focus on cost reduction and system financial plans, rather than contract disputes.

Cost Improvement Programme Development and Delivery: Working with the Financial Improvement Director, the governance structure has been strengthened. Governance for Financial Improvement continues to sit within the Financial Improvement and Sustainability Committee, chaired by the Chief Executive. The FISC now meets monthly. The operation of the FISC is now supported by a Financial Improvement Oversight Group, which is chaired by the Director of Finance, and co-ordinates all aspects of financial performance including cost improvement, contract delivery, income and expenditure and cash/creditor management.

Planning and implementation for the overall cost improvement programme has moved from a series of centrally-developed workstreams towards a divisionally-led approach, where Clinical Units and corporate teams are being given the information and support to deliver improved financial performance. This is being implemented through regular 'Confirm and Challenge' sessions which involve the Financial Improvement Director and the leadership team for the Clinical Unit. A weekly Quality Impact Assessment session, supported by the Medical Director and Chief Nurse, is in place to ensure that new schemes are fully assessed for any potential impact on quality at an early stage, and any ongoing monitoring or follow-up requirement around quality is tracked and escalated as appropriate.

The Trust performance management and governance arrangements, however, remain unchanged, with the monthly Integrated Performance Reviews remaining the key meeting where the Clinical Leadership Teams and the Executive Team hold each other to account for delivery and review progress against each of the key areas of quality, safety, performance, workforce and finance.

Financial Planning and Budgeting: The Trust continues to receive strong support from the NHSI Financial Special Measures team, and from the NHSI Regional Team, providing challenge on delivery, as well as practical advice and guidance on accessing cash and capital, and ensuring alignment with national priorities and programmes. The Trust continues to meet with the FSM team on a monthly basis, and from early 2018, the Regional and FSM meetings will be aligned under a single Executive Lead, which will allow for a fully integrated discussion on all aspects of Trust performance and the contextualisation of financial delivery.

The Trust is developing a detailed financial plan for 2018/19, and has started discussions within the Finance and Investment Committee, and at Board Seminar, and with NHSI around the planned deficit, the efficiency ask and the system financial pressures for the coming year. Agreeing the right financial plan will require a balance of ambition and achievability – the Trust needs to continue to reduce the underlying financial position and to move towards financial balance.

Alongside the detailed work on 2018/19 planning, the Trust is developing a robust roadmap to sustainability – a clinical strategy that is based in robust financial analysis – to describe the overarching programme of change required over the next three years to bring the Trust back into financial balance. This includes a detailed analysis of the underlying or structural factors which are driving the deficit, as well an analytical understanding of the areas of efficiency or productivity opportunity which can be addressing in a rolling programme of financial and clinical improvement.

Conclusion and Next Steps

In 2017/18, the Trust will not achieve its financial plan. The strong progress which has been made in quality, safety and operational performance needs to be matched by an improvement in financial delivery. The Trust has made some progress in strengthening the control environment, and in building financial capacity within the organisation, but significant improvement remains necessary. However, the improved performance on the other key domains demonstrates that the organisation can and will improve over time, with the development of the right plan, and the shared commitment of all colleague to delivery. Getting the right plan in place for 2018/19 will be critical, and the Board will continue to

play a key part in shaping and agreeing the plan for next year. Lessons have been learned within the organisation on the key drivers of the movement in the 2017/18 financial position.

The route map to financial, as well as clinical sustainability, is an important element of this process – if the Trust can describe how, and where, it will improve efficiency over the next three years without adversely impacting on quality, this will help colleagues, inside and outside the organisation, to confidently develop and deliver robust cost improvement plans which lead to improved financial performance. This work on sustainability will continue into June 2018, and will come through the Board for development and agreement.

The final quarter of 2017/18 will be an important three months for the organisation, and for the local health economy. The planned improvements to the 2017/18 position must be delivered – and this will be tracked by the Finance and Investment Committee – and a robust plan for 2018/19 must be finalised and agreed by the Board. This plan must be aligned to the contract with Commissioners – and in turn the Trust's plans must sit within the context of the East Sussex Better Together system financial plan. The scrutiny and support of the Board will be key to ensuring that the Trust and the East Sussex system enter 2018/19 with the right financial plan, and the arrangements in place to ensure delivery of the plan.

Jonathan Reid
Director of Finance
East Sussex Healthcare NHS Trust

Sustainability Development Management Plan Update

Meeting information:			
Date of Meeting:	6th February 2018	Agenda Item:	14
Meeting:	IPR	Reporting Officer:	Mark Paice/Will Clark

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

Has this paper considered: (Please tick)

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

Other stakeholders please state: ……

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

Executive Summary:

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

This strategy has been written in response to the NHS Sustainable Development Unit's NHS Carbon Reduction Strategy (2009) and Sustainable, Resilient, Healthy People & Places – A Sustainable Development Strategy for the NHS, Public Health and Social Care System (2014), which require NHS organisations to put in place Board-approved Sustainable Development Management Plans and reduce carbon dioxide (CO2) emissions resulting from their operations. It establishes a set of principles and targeted interventions aimed at addressing one of our Trust's core strategic objectives, which is to be a strong sustainable business, grounded in our communities and led by excellent staff.

The Climate Change Act 2008 sets legally binding targets for the UK to reduce its CO2 emissions by 80% by 2050 and all public sector organisations in the UK have a responsibility to put in place plans to meet this target. The NHS is one of the largest employers in the world and is the largest public sector contributor to climate change in Europe. Consequently it has the potential to make a significant contribution to tackling climate change in the UK.

Since the adoption of our original SDMP we have made considerable progress in terms of reducing our measured carbon footprint. Through the work we are currently undertaking to engage a partner through an Energy Performance Contract.

One of the key steps identified within the strategy is to appoint a new executive lead for sustainability to champion the aims and objectives set out and to ensure that sustainability considerations are visible at board level.

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

Estates and Facilities IPR

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

It is recommended that :

- The updated SDMP Strategy is approved by the board
- The board support an annual performance update to coincide with the annual report.

Sustainable Development Management Plan

East Sussex Healthcare NHS Trust

Updated January 2018

CONTENTS

CARE WITHOUT CARBON

This Sustainable Development Management Plan has been developed by Sussex Community NHS Trust's sustainability team using its Care Without Carbon model to sustainable healthcare.

Welcome

Welcome to the East Sussex Healthcare NHS Trust (ESHT) Sustainable Development Management Plan (SDMP). This plan has been developed in response to A Sustainable Development Strategy for the NHS, Public Health and Social Care Systems (2014), which reinforces the urgent need for all NHS organisations to take action to reduce their environmental impact and embed sustainability into their strategies, cultures and communities. As a Trust, we are fully committed to becoming a more sustainable healthcare provider and we invite you to join our journey and help us achieve our vision.

The following document establishes a set of principles and targeted interventions that directly support the delivery of our strategic objectives, in particular our objective to **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**.

Reflecting our mission to deliver better health outcomes and an excellent experience for everyone we provide with healthcare services, our top priority is to provide high quality health and care services and help drive transformation and rise to the challenges of the future. This SDMP is central to the way we do this.

Through this SDMP we have set clear commitments to decarbonise our operations and promote healthy, low carbon lifestyles. It will achieve this by working across seven key areas between now and 2020:

> Buildings – reducing the environmental impact of our estate

> Journeys – minimising the health and environmental impact of travel

> Procurement – creating an ethical and resource efficient supply chain

> Culture – informing, empowering and motivating people to achieve sustainable healthcare

> Wellbeing – enhancing the wellbeing of our workforce

> Adaptation – ensuring our infrastructure and operations are resilient to climate change

> Governance – embedding sustainability in our corporate governance processes and procedures.

By taking action in this way, we expect to achieve significant CO_2 and cost savings between 2017 and 2020:

> Cumulative savings of £2.7 million

> Reduction of over 13,600 tonnes CO_2

This is in addition to a raft of health and wellbeing benefits.

The case for sustainable healthcare

This plan has been written in response to the NHS Sustainable Development Unit's NHS Carbon Reduction Strategy (2009) and A Sustainable Development Strategy for the NHS, Public Health and Social Care Systems (2014), which requires all NHS organisations to put in place Board-approved SDMPs and reduce carbon dioxide (CO_2) emissions resulting from their operations. It establishes a set of principles and targeted interventions aimed at addressing one of our Trust's core strategic objectives, which is to 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.

What do we mean by sustainable development?

Sustainable development (or *sustainability*) is about meeting the needs of today without compromising the needs of tomorrow. In the health and care system, this means working within the available environmental and social resources to protect and improve health now and for future generations. In practice this requires us to reduce our carbon footprint, minimise waste and pollution, make the best use of scarce resources and build resilience to a changing climate whilst taking care of our staff and nurturing community strengths and assets.

Why is sustainable development important for the NHS?

The case for sustainability in healthcare is clear. There is sound evidence that taking action to become more sustainable can achieve cost reductions and immediate health gains. More importantly, it ensures the development of a health system that is sustainable in the long term – reducing inappropriate demand, reducing waste and incentivising more effective use of services and products.

A Sustainable Development Strategy for the Health, Public Health and Social Care System (2014) identifies the need to enable the positive impacts of the NHS while at the same time reducing its negative impacts. This is illustrated in the diagram on the following page (Figure 1).

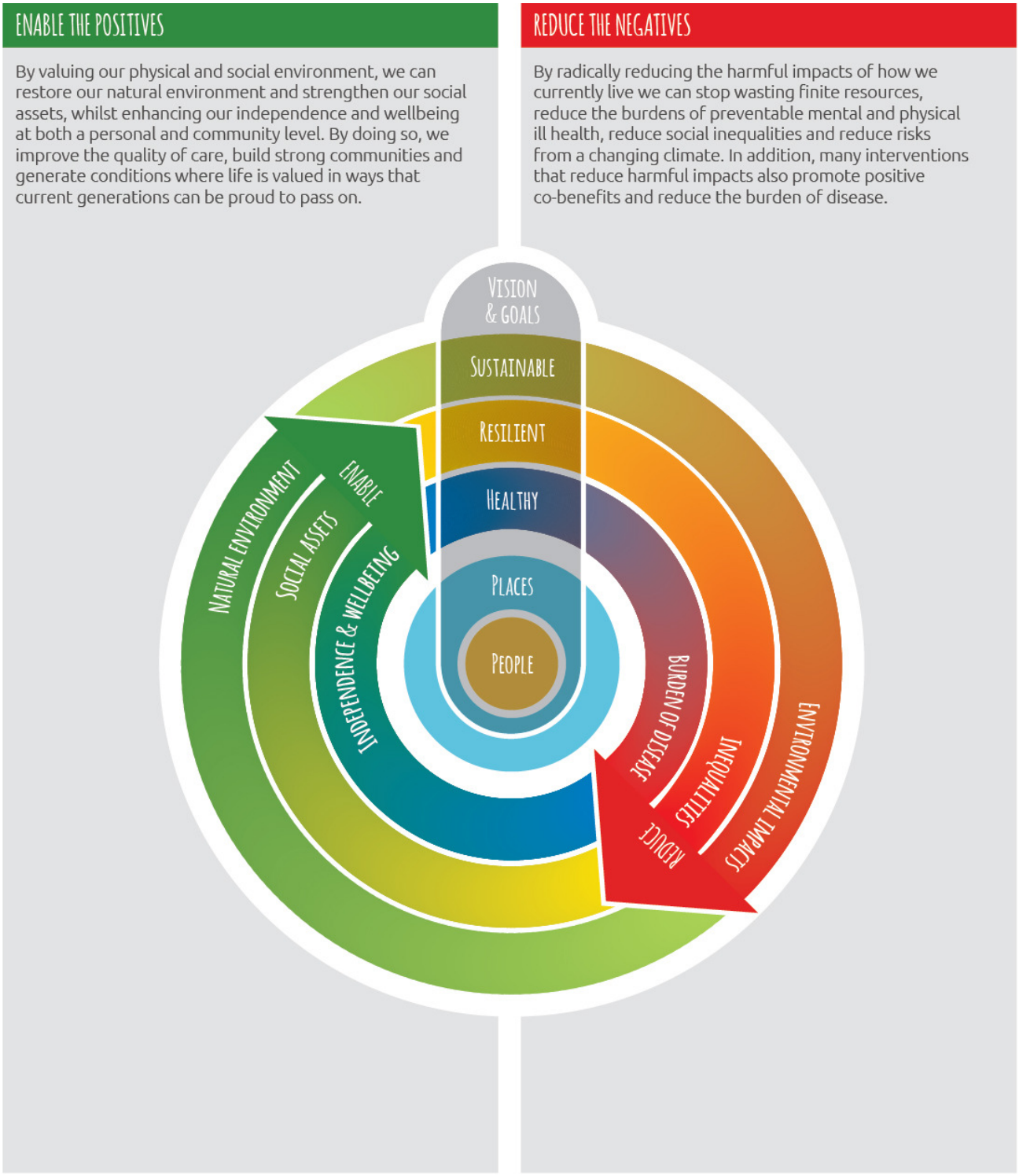


Figure 1: **The sustainable healthcare model, adapted from A Sustainable Development Strategy for the Health, Public Health and Social Care System (2014)**

THE KEY DRIVERS FOR THIS SDMP ARE AS FOLLOWS:

Reducing carbon dioxide emissions is the law in the UK

The Climate Change Act 2008 sets legally binding targets for the UK to reduce its CO_2 emissions by 80% by 2050 and all public sector organisations in the UK have a responsibility to put in place plans to meet this target. The NHS is one of the largest employers in the world and is the largest public sector contributor to climate change in Europe. Consequently it has the potential to make a significant contribution to tackling climate change in the UK.

There is a strong business case for taking action to become more sustainable

The business of caring for patients results in a host of environmental impacts that are becoming increasingly expensive to manage: fossil fuels are finite and are becoming more costly to produce, landfill is subject to a tax escalator and now CO_2 itself is subject to taxation in the UK. By reducing energy and water consumption, reducing waste and recycling more and finding alternatives to motorised travel, NHS organisations can realise significant financial savings, which can be reinvested into frontline care.

The NHS must help to mitigate the negative impact of climate change on health

According to leading general medical publication The Lancet climate change is the “biggest global health threat of the 21st Century”. Climate change is already impacting on lives and human health through extreme periods of heat and cold, storms and deteriorating air quality. The World Health Organisation has estimated that 150,000 deaths are caused annually as a result of climate change. Unless swift and decisive action is taken now, millions of people around the world will suffer hunger, water shortages and coastal flooding as the climate changes. As one of the world's largest organisations the NHS has a national and international duty to act and to set an important example to the business community and to the public.

The NHS must set an example as a leading public sector organisation

The NHS has a duty to set an example in sustainable development and carbon reduction. To achieve this, the NHS must operate both economically and ethically. It needs to be conscious of delivering safe and cost effective healthcare whilst recognising the negative impact that it has on the environment. As an employer, service provider and procurer of goods and services, the NHS can use its position and buying power to influence the public, partners and suppliers to adopt similar attitudes towards sustainability.

Improving the sustainability of the health and care system can improve the health of its workforce and patients

In addition to reducing the impact of climate change on the health of staff and patients, sustainability improvements within the NHS can bring significant health benefits to staff and patients alike, through increased physical activity with work-related travel, reduced dietary saturated fat consumption from animal products and reducing negative impacts of air pollution.

THE STORY SO FAR

ESHT's vision, set out in "ESHT 2020 – Our journey to be outstanding by 2020", is to 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. There are some 500,000 people who live in East Sussex and the Trust is one of the largest organisations in the county. We employ over 7,500 dedicated staff with an annual turnover of £360 million. Our services are mainly provided from two district general hospitals, Conquest Hospital and Eastbourne DGH, both of which have Emergency Departments and provide care 24 hours a day. In addition we occupy a number of other properties across East Sussex, some of which are owned and managed by NHS Property Services.

Our environmental impacts

In delivering our services we consume a significant amount of energy and water and produce a large volume of waste, which must be disposed of. We also transport Trust staff and patients and purchase a large range of medical and other equipment and services. All of these activities generate CO_2 (carbon dioxide) emissions, which are linked to climate change, and can be collectively summarised as our *carbon footprint*. The overall carbon footprint (measured in tonnes CO_2e[1]) associated with ESHT's services is illustrated in Figures 2 and 3 on the following page.

The most significant contributor to our measured carbon footprint is the energy we use to heat and power our buildings (grid electricity, including losses from transmission and distribution and natural gas). CO_2 emissions are also generated by our travel activities and through our supply chain, however, these are not currently measured as part of our baseline.

At one of our two main acute sites, Eastbourne District General Hospital, we operate a Combined Heat & Power (CHP) system. By using natural gas to generate power onsite and recovering heat from the process we are able to make both cost and carbon savings. We have significantly increased the use of this facility since 2013, which has contributed to a reduction in our carbon footprint of 8% between 2013/14 and 2016/17.

Around 70% of the NHS's carbon footprint is driven by the supply chain. We are committed to accounting for the emissions from our own procurement activity in our carbon footprint and will dedicate effort to identifying an effective calculation methodology.

[1] CO_2e refers to six greenhouse gases including carbon dioxide and methane. The NHS measures its carbon footprint in CO_2e which is in line with national and international conventions and allows all six greenhouse gases to be measured on a like-for-like basis. This is important as some of the gases have a greater warming effect than CO_2.

	2013/14	2014/15	2015/16	2016/17
Fossil Fuels	11,585	12,364	12,127	12,048
Trust vehicles	313	312	477	527
Electricity	7,183	6,125	5,963	5,222
Water & Waste water	182	182	170	179
Grey fleet[3]	1,131	1,323	814	716
Total (tonnes CO_2e)	**20,394**	**20,306**	**19,550**	**18,693**

Figure 2: **ESHT carbon footprint 2013/14 – 2016/17**

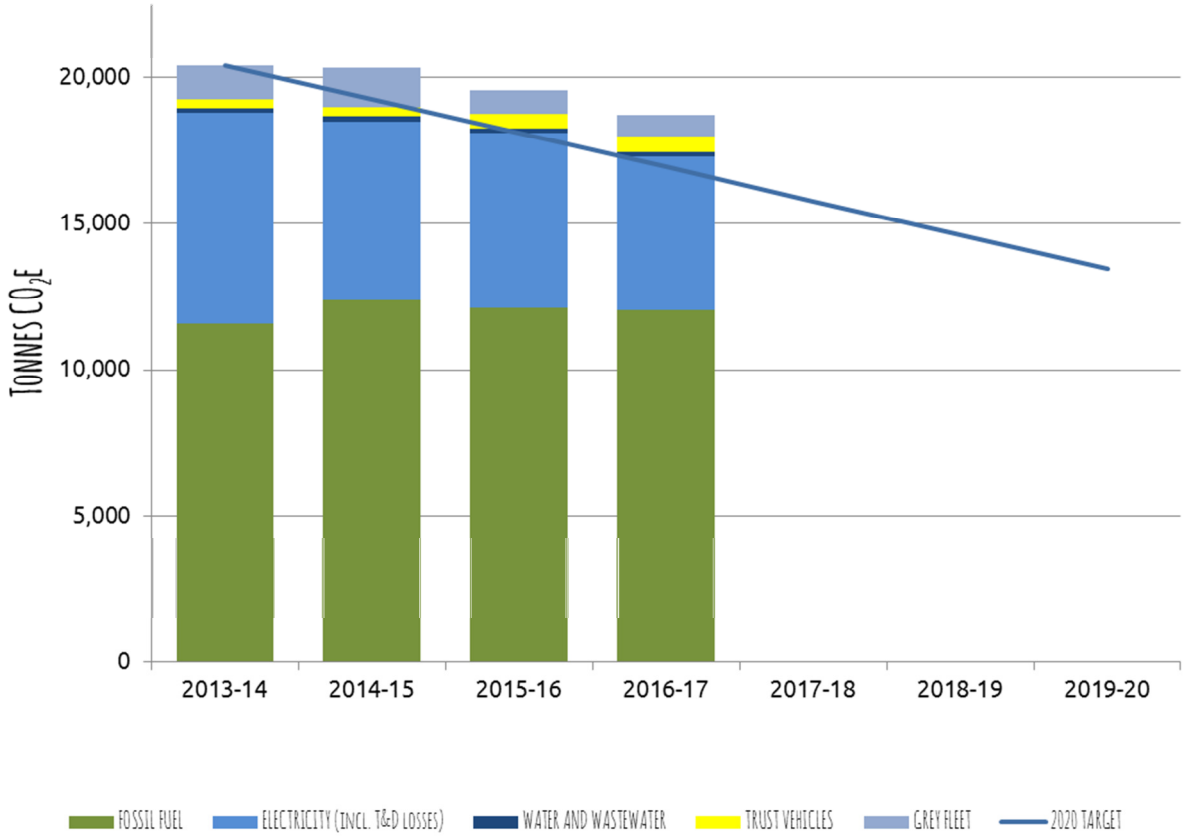


Figure 3: **ESHT carbon footprint breakdown 2014/2015**

[3] "Grey fleet" refers to Trust staff using their own vehicle for Trust business.

We have already made some progress with reducing our environmental footprint. For example, we have been:

> **DEVELOPING** a programme of low cost, short payback energy saving schemes, which we implement each year. These measures include making operational changes to our Combined Heat & Power plant at EDGH and improving and updating our Building Energy Management System and control strategies. These projects will make a major contribution to further reducing our carbon footprint during the coming years.

> **INVESTIGATING** the potential to procure an Energy Performance Contract (EPC) to deliver long-term reductions in energy consumption across our two main acute sites. We anticipate that this project should result in large annual cost savings and will also deliver major CO_2 reductions to help us achieve our 2020 target.

> **RECYCLING** an increasing quantity of our general waste with the remainder converted into fuel to generate electricity, meaning we are able to achieve zero general waste to landfill and reduce our costs. We are working closely with our general waste contractor Veolia to boost our recycling rate by increasing the availability of mixed recycling facilities to staff and patients. We have also undertaken project work to introduce the offensive (non-infectious) healthcare waste stream and improve segregation of healthcare waste to minimise the quantity we send for incineration and sterilisation when that level of treatment isn't necessary.

> **ESTABLISHING** a "green travel" initiative to encourage and support our staff to reduce their car use and adopt more active and sustainable modes of travel. We introduced a car sharing data base in partnership with East Sussex County Council and have dedicated car sharing spaces at both acute sites. We have trialled two hybrid pool cars in Estates & Facilities, which are now being rolled out to other departments. We offer staff free cycling proficiency training and access to a regular cycle maintenance service twice a month and run a salary sacrifice cycle purchase scheme throughout the year. To support cycling we have invested in improved cycle shelters at both acute sites. We offer staff subsidised Stage Coach bus season tickets and have set up a Community Transport Group involving the County Council, district and borough councils and local travel interest groups.

CASE STUDY: BIOSYSTEMS

We have been working with our healthcare waste contractor to roll out reusable sharps containers, "Biosystems", across our services. The containers can be reused up to 600 times and so have a much smaller environmental footprint than our existing containers, which are incinerated after a single use. Following an initial successful trial the system was rolled out across the Trust. This has helped us to reduce our environmental footprint, reduced the risk of needlestick injuries to our staff and saved the Trust around £25,000 at each of our acute sites.

Next Steps

We have already begun to make progress with reducing the environmental impact of our services. Through this SDMP we are keen to maximise the impact of our efforts by developing a comprehensive and integrated set of plans that demonstrate our commitment to sustainability, reduce our impact on the environment and help us become a more sustainable healthcare provider.

What we are trying to achieve with this Sustainable Development Management Plan?

A Sustainable Development Strategy for the Health, Public Health and Social Care System (2014) sets out four priority actions for individual NHS Trusts:

1. Establish a Board approved plan including carbon reduction, adaptation plans and actions across the sustainability agenda
2. Measure, monitor and report on sustainable development and adaptation performance
3. Evaluate performance to ascertain areas of strengths and opportunities for development
4. Engage staff, service users and the public to help support the development of a more sustainable and resilient health and care system

As such, this SDMP clarifies our sustainability objectives and sets out a plan of action to achieve clear and measureable targets.

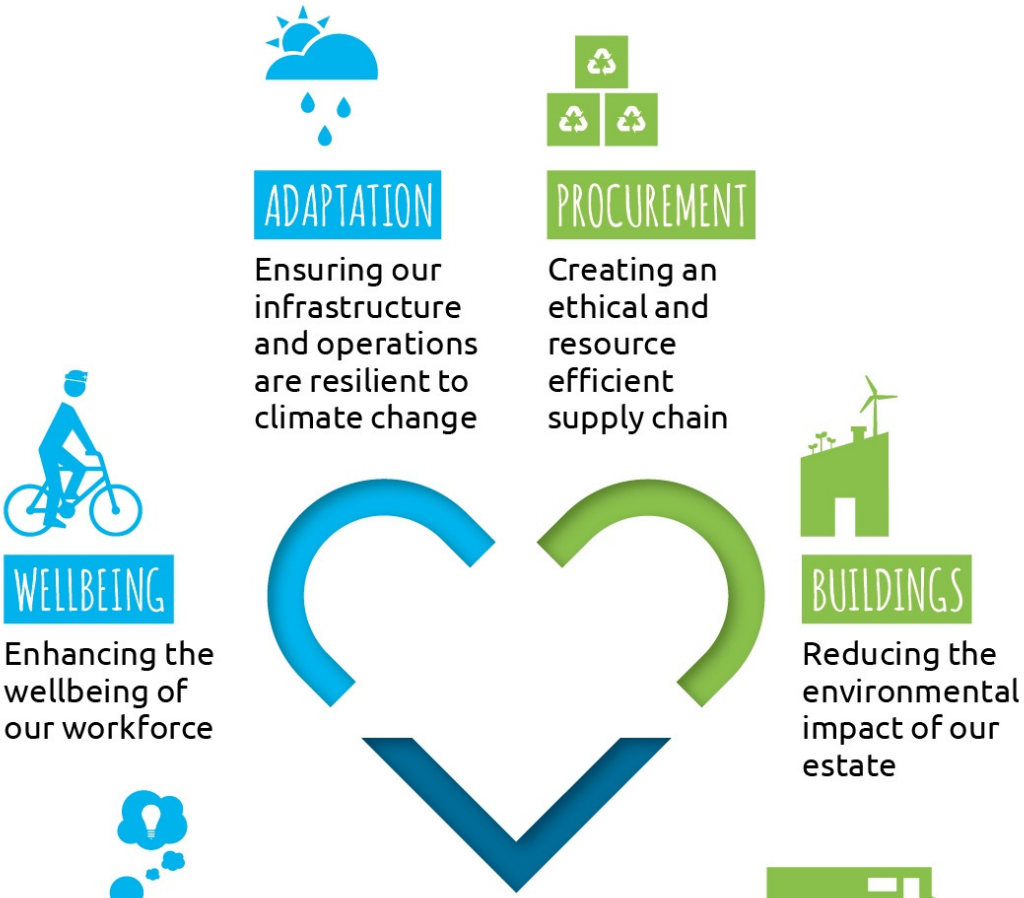
NHS Trusts are also required to establish interim targets and trajectories to meet the provisions of the Climate Change Act and NHS targets by reducing carbon emissions by 34% by 2020.

Our aims and objectives

A Sustainable Development Strategy for the Health, Public Health and Social Care System (2014) sets out three goals to achieve their overarching vision. Working from this we have utilised Sussex Community NHS Foundation Trust's Care Without Carbon model for sustainable healthcare, which addresses seven key areas of NHS activity (The Seven Steps to Sustainable Healthcare), to define our overall objectives and action plans between now and 2020. These are illustrated in Figure 4 (over page).

In the following pages we have identified our commitments under each of the Seven Steps as well as a series of specific actions and the key success measures through which we will monitor our progress.

OUR SEVEN STEPS TO SUSTAINABLE HEALTHCARE



1. Buildings

We recognise the impact that our estate and facilities have on the environment, our staff and patients and our finances. We are committed to decarbonising and raising awareness to reduce our impact of energy use, waste and water use.

Our commitments

> We will decarbonise our facilities in line with NHS and national targets and develop robust reporting systems to monitor progress.

> We will raise awareness of climate change and communicate progress with our own CO_2 reduction efforts to our Board, our staff, our patients and other external stakeholders.

To achieve this we will

> Drive energy efficiency and CO_2 reductions through our Estates Strategy, setting challenging energy efficiency targets for all new premises and refurbishments and achieving the BREEAM Excellent standard for any new-build premises.

> Develop a Metering Strategy to prioritise investment in Automatic Meter Reading (AMR) across our freehold estate, enabling improved carbon management and reporting.

> Benchmark our properties against national energy efficiency standards.

> Develop and implement an energy and carbon reduction investment programme in partnership with the Energy & Carbon Fund. Alongside this we will collaborate with our NHS partners in the STP to develop the case for a joint Energy Performance Contract procurement exercise in order to generate economies of scale and drive innovation in energy and carbon management across the health system.

> Maintain comprehensive carbon measurement and reporting systems and obtain independent, third party validation of our carbon footprint each year, publishing the results on our website and Annual Report.

> Challenge building contractors to propose cost-effective, low carbon solutions when undertaking major refurbishment projects.

> Introduce best-in-class water saving technologies and techniques and develop an action plan to safeguard the Trust from future water shortages, including investigating the potential to increase borehole water extraction at Eastbourne District General Hospital.

> Reduce the energy consumption of our IT infrastructure through the introduction of energy efficient technology and power management techniques.

> Reduce to the lowest level practicable level the number of hazardous substances used by the Trust.

> Where possible, ensure that electricity we purchase from the national grid is generated from 100% renewable energy sources.

> Improve and promote better use of green spaces across our estate to support health, wellbeing and biodiversity. Examples could include use of courtyard spaces for staff gardening projects and green gyms.

KEY SUCCESS MEASURE BY 2020

Absolute CO_2 reduction from buildings energy consumption that is ahead of NHS and UK targets under the Climate Change Act 2008 (34% reduction against our baseline).

2. JOURNEYS

The NHS accounts for 5% of all road traffic in England and travel is responsible for 17% of the NHS carbon footprint. We are committed to minimising the negative environmental and health impacts of movement of staff and materials and promoting active travel.

Our commitments

> We will decarbonise our travel and transport operations and minimise the environmental and health impacts associated with the movement of staff and materials.

> We will contribute to staff and patient wellbeing by supporting a shift away from car dependency and solo car occupancy to more sustainable travel options that deliver additional environmental and health benefits.

To achieve this we will

> Develop and implement a new Trust-wide Travel Plan to target solo car occupancy and support the roll-out and uptake of alternative travel options. This should consolidate existing and planned sustainable travel workstreams.

> Ensure that appropriate resources are made available to support implementation of the Travel Plan.

> Publicise use of a car share scheme to include our community bases. Review business case for investment in subsidised public transport season tickets for all staff.

> Review target investment at improving infrastructure to support active travel, including cycle shelters and showering facilities, and well as increasing access to Webex or similar software.

> Incentivise a shift away from solo car occupancy by reviewing business mileage rates and introducing other reforms such as preferential rates for car sharing and active travel.

> Continue to roll out our hybrid pool car scheme across the Trust.

> Continue to work with our courier and patient transport providers to drive the adoption of cleaner, low emission technologies.

> Review our lease car policy and introduce a cap on emissions from our lease car fleet.

> Facilitate close collaboration between our clinical services, travel group and Estates to ensure all travel options and impacts are taken into consideration when planning new premises.

> Utilise the new electronic business travel claim system to improve data and reporting of CO_2 from business travel.

> Operate a bi-annual staff travel survey to improve engagement with staff and capture data on staff commuting.

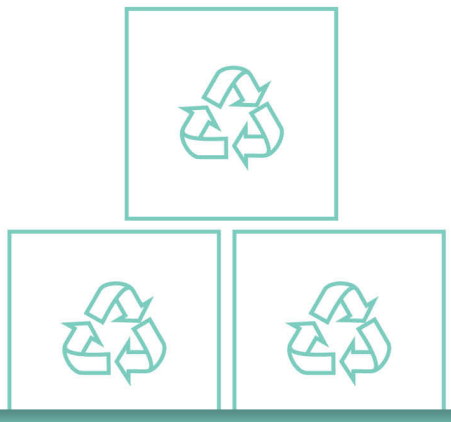
> Strengthen our relationship with local partners through the East Sussex Community Travel Forum to support implementation of our travel plan, reducing traffic impacts and promoting the use of public transport and active travel.

KEY SUCCESS MEASURE BY 2020

Absolute reduction in CO_2 emissions from travel and transport operations (including Trust fleet and business mileage) that is ahead of NHS and UK targets under the Climate Change Act 2008 (34% reduction against our baseline).

3. PROCUREMENT

Procurement is the single largest contributor to carbon emissions in the NHS with around 72% of the health and care system emissions attributable to procurement alongside a £40billion spend each year. We are committed to reducing the impacts associated with our own commissioning, sourcing and buying processes, including minimising waste.



Our commitments

> We will work with our suppliers to reduce emissions and waste from our supply chain wherever possible.

> We will demonstrate a commitment to ethical trade by integrating ethical trade principles into our core procurement processes.

To achieve this we will

> Implement a new Procurement Policy, with sustainability, social responsibility and whole-life costing considerations as a business-as-usual feature of our procurement activity.

> Work with key external stakeholders such as NHS Supply Chain and NHS Commercial Solutions to ensure that equipment and services procured through these routes meet the requirements of the Social Values Act and this SDMP.

> All business cases and business planning processes for new equipment and services should consider sustainability and reflect the requirements of the new Procurement Policy.

> Provide information to other NHS organisations that are developing new tools and metrics to measure the environmental performance of procurement.

> Continue to provide opportunities for local suppliers to support the local economy and reduce delivery miles.

> Monitor stock levels through implementation of the Inventory Management System (IMS) and promote practices that avoid waste generated by our clinical services and through materials management.

> We will work with our NHS provider partners within the STP to jointly tender for waste management services in order to create economies of scale and drive innovation.

> Liaise with waste contractors, suppliers and relevant support agencies to implement the Waste Hierarchy for healthcare and non-healthcare waste streams, aiming to achieve zero waste to landfill across all of our operations and turning residual waste into a resource opportunity wherever possible.

> Continue to introduce non-infectious healthcare waste stream ("tiger bag" waste) across the Trust to an agreed % target to 2020.

> Investigate options for food waste collections and local in-vessel composting at our restaurants to reduce the cost and impacts from using on-site macerators.

> Work with Facilities & Infection Prevention & Control to assess potential for high efficiency hand dryer roll out to replace paper towels in non-clinical wash rooms.

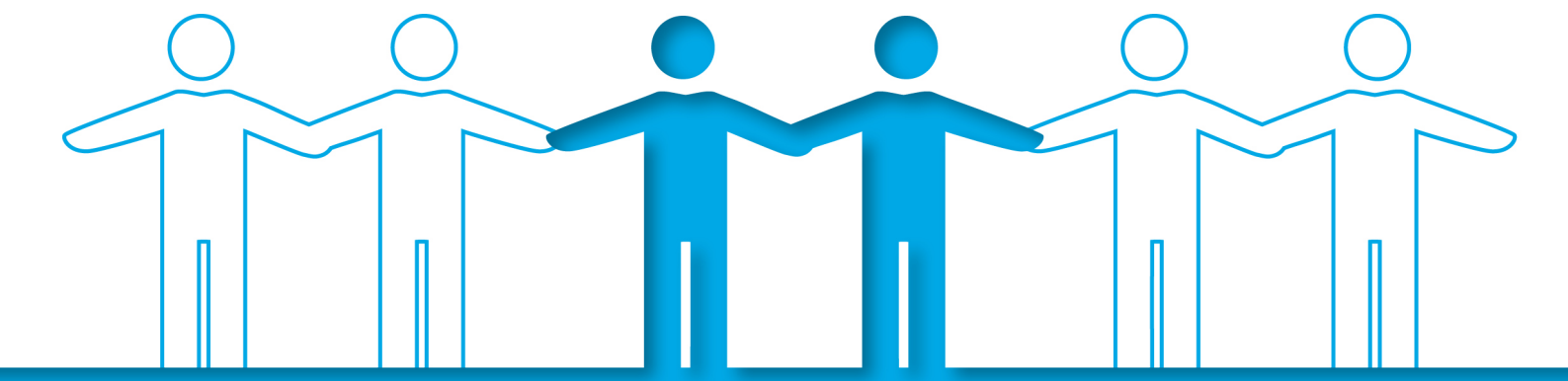
> Promote our Procurement Policy to all staff, Trust stakeholders and potential suppliers, ensuring that anyone procuring for our Trust understands what is required to procure in a sustainable way.

KEY SUCCESS MEASURE BY 2020

We will use every opportunity throughout the procurement tender process to engage suppliers in the sustainability agenda and deliver a measurable reduction in our environmental footprint.

4. CULTURE

Embedding sustainability into everyday practices requires long-term culture change achieved by leadership and system-wide engagement. We are committed to informing, empowering and supporting the workforce to deliver high quality care in a sustainable way.



Our commitments

> We will inform, empower and support our workforce to take action to deliver high quality care today that does not compromise our ability to deliver care in the future, ensuring this becomes integral to the way we operate.

> We will embed sustainability into our HR policies and practices and ensure that staff development processes support a shift to more sustainable and resilient healthcare delivery with clear senior leadership.

To achieve this we will

> Reflecting our values of "working together" and "engagement and involvement" we will design and launch a new communication strategy and staff engagement campaign aimed at raising awareness of the SDMP, communicating core messaging and driving positive action at every level of the Trust. Our approach should be aligned to the Making Every Contact Count (MECC) programme, highlighting environmental co-benefits of healthy lifestyles. A business case for this strategy and campaign will be developed during 2017/18.

> Identify opportunities to include sustainable development objectives in our staff induction programme and development/ appraisal processes that encourage all staff to consider how to include sustainability as a dimension of their daily work. Incorporate sustainability messages into the new Manager's Induction programme and "first 100 days in post" initiative.

> Design and run a Board and senior leaders development programme to strengthen the Trust's strategic awareness of this SDMP and promote leadership competencies that encourage consideration of environmental impacts and projections alongside financial and health outcomes.

> Utilise our ESHT Viners network to support delivery of the SDMP, for example by identifying staff champions to facilitating stronger links between the SDMP and Trust services and staff and incorporating sustainability messaging into the theme of the week.

> Conduct all staff training in a low-carbon manner, for example minimising travel and printing.

> Actively participate in national sustainability campaigns, for example the annual NHS Sustainability Day.

> Initiate an incentive scheme to encourage grass-roots action and innovation in sustainable healthcare delivery and assess the opportunity to include sustainability in our Annual Awards to recognise those supporting the delivery of our SDMP.

> Explore ways to engage the local community in delivery of this SDMP targeting key issues within the local public health agenda.

> Use the staff suggestion scheme for financial savings to generate ideas that consider waste reduction and efficient resource management.

KEY SUCCESS MEASURE BY 2020

100% of Trust staff to demonstrate awareness on sustainability in healthcare, including carbon reduction and climate change adaptation, as appropriate to their role.

5. WELLBEING

With productivity being integrally linked to workforce wellbeing, the Trust is committed to reducing workplace stress and improving the health and wellbeing of its staff.

Our commitments

> We will improve the overall health and wellbeing of our workforce by increasing access for staff to a range of support services, as well as encouraging and supporting staff

> We will involve and engage our workforce in making decisions about our services so that we can achieve our vision of being the provider of choice for our local population

To achieve this we will

> Continue to develop and deliver our Health & Wellbeing Strategy and Action Plan using our Health Promoting Trust status as a basis for planning. We will ensure the objectives of this SDMP are aligned with our work on health and wellbeing. The four priority areas for 2017-2018 are: healthy food; healthy transport; motivational skills and; smoking.

> Increase Occupational Health capacity to deliver training to managers and staff on sickness absence management, stress management, wellbeing, leadership and resilience.

> Increase effectiveness of existing in-house counselling service to increase capacity to deliver training and group sessions.

> Use our Travel Plan to encourage and support active travel.

> Ensure that changes to our property portfolio produce an on-going improvement in working environment for staff and the provision of adequate facilities for break and rest periods.

> Continue to develop and implement healthy eating guidance for staff and increase access to healthy, sustainable food options and information for staff, patients and visitors. Work will target high calorie and high sugar products, e.g. canned drinks.

> Partner with suppliers to work towards CQUIN targets for healthy food.

> Target HR support to services with higher than average sickness levels to ensure that they are supported to follow good absence management and staff support practice.

> Provide advice and support to staff experiencing financial hardship hardship and signpost to other support services where available.

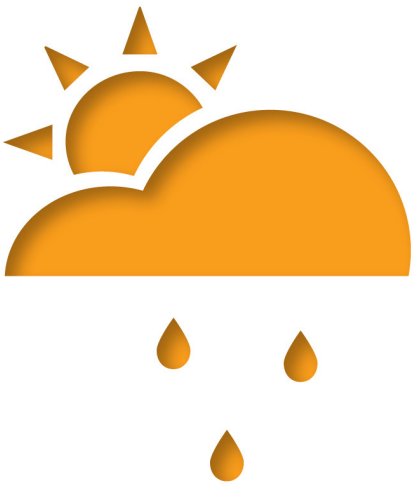
> Promote healthy lifestyles through discounts and benefits offered to all employees.

KEY SUCCESS MEASURE BY 2020

Reduce sickness rate to below 3.5%, reduce the percentage of staff reporting that they have suffered work related stress and increase the percentage of staff participating in physical activity during the working day, including active travel to work.

6. ADAPTATION

With the climate in the UK changing, it is important to ensure that health and care system infrastructure and processes are prepared for and resilient to the rising temperatures, flooding and severe weather events that are becoming more frequent. We are committed to ensuring that our services and workforce are prepared and able to protect our patient community.



Our commitments

> We will create infrastructure, supply chain and logistics operations that are resilient to changes in the climate and extreme weather events.

> We will ensure our workforce is prepared and able to adapt to the projected impacts of climate change, including anticipated health issues for both patients and staff and disruption to our services.

To achieve this we will

> Ensure that all departments have effective business continuity plans in place that consider the impact of climate change, and that staff understand and practice these plans.

> Employ the UK Climate Change Risk Assessment tools and guidance to assess local risks to our patients and staff, infrastructure, supply chain and clinical services and inform our Emergency Planning & Business Continuity procedures.

> Conduct climate change impact risk assessments every two years covering the areas and communities we serve and ensure that high level risks are registered on the Trust's Risk Register.

> Develop a Climate Change Adaptation Action Plan to reduce impact on and ensure continuation of care for our most vulnerable patients during heat waves, floods and other extreme weather events.

> Collaborate with relevant stakeholders across the health system and local authorities in order to share information, raise awareness and help prioritise and agree coordinated action. This includes full engagement with the Sussex Resilience Forum, meeting ESHT's obligations as a Category 1 responder under the Civil Contingencies Act 2004.

> Work with stakeholders to identify likely changes to service requirements resulting from climate change e.g. increase in frequency of heat-related illness and deaths, changes in local pathogens etc.

> Train our staff to recognise and respond to anticipated changes to the local climate and expected increases in the burden on the local health system. Ensure that training for our emergency response plans is suitable and sufficient, and that plans are tested.

> Ensure all new and existing infrastructure is able to cope with rising temperatures, floods and episodes of extreme temperatures, and minimises the risk to staff, patients and visitors. This should be weighed as a key consideration when designing, planning or leasing new premises.

> Assess the risk of disruption climate changes pose to our supply chain and develop appropriate management strategies to ensure continuity of our services.

> Identify risks of disruption to our transport operations and community services and put in place contingency plans to cope with extreme or unexpected events.

KEY SUCCESS MEASURE BY 2020

Climate Change Adaptation risk assessment undertaken every two years as routine component of Emergency Planning and Business Continuity procedures.

7. Governance

It is fundamental to being a sustainable organisation that we operate with integrity and responsibility. Effective governance is critical to ensuring that we deliver on our SDMP, integrating and embedding its principles and processes throughout the Trust and engaging our staff, patients and wider stakeholders.

Our commitments

> We will embed sustainability into our corporate governance structures, ensuring effective, targeted action is possible at all levels of the Trust.

> We will monitor and measure our progress against this SDMP and adopt transparent public reporting as a fundamental principle for improvement and good governance.

To achieve this we will

> Appoint a new Executive Lead for sustainability to champion the aims and objectives set out in this SDMP and ensure sustainability considerations are visible at Board level.

> Form a management group to oversee implementation of this SDMP, comprising a senior for each action plan, clinical/ staff representatives and external stakeholders where appropriate

> Work with departments outside of Estates and Facilities to ensure that new and existing strategies, initiatives and policies within the Trust align with this SDMP's objectives, embedding sustainability into their principles and processes. This should include integration of sustainability principles into the business case process.

> Ensure that appropriate resource is made available to successfully deliver this SDMP.

> Adopt the Treasury sustainability reporting approach FreM (The Government Financial Reporting Manual) and use this as the basis for measuring our sustainability reporting alongside reporting through the SDU.

> Aim to continually improve our annual reporting on sustainability, achieving the SDU's Excellent rating.

> Prepare business cases for any investment (capital or revenue) required to support the programme.

> Develop a new sustainability dashboard to facilitate Board reporting on progress. Report back to Trust Board e on performance against this SDMP at agreed intervals.

> Ensure that this SDMP is accessible to our staff and the public through our website and is reviewed and updated annually.

> Actively support wider collaboration on sustainability across our local STP and work with local partners within the system to identify and implement shared solutions.

> Benchmark ourselves against other NHS Trusts on a number of key sustainability indicators, including CO_2 reduction.

KEY SUCCESS MEASURE BY 2020

To have the SDMP referenced in all Trust policies and procedures, and to have a sustainability impact assessment incorporated into all major strategies and Board papers.

Reaping the benefits

By delivering on this SDMP to become a more sustainable healthcare provider, the Trust can achieve immediate health and wellbeing benefits, significant cost savings and considerably reduce its impact on the environment.

Health and wellbeing benefits

Through this SDMP we have the opportunity to achieve immediate health and wellbeing benefits, including:

> Reduced sickness absence and stress among our staff;

> Improved workforce health with an increased proportion participating in physical activity during the working day including travel to work;

> Greater ability to ensure appropriate care is available for vulnerable patients during heat waves, floods and other extreme weather events caused by climate change; and

> Increased financial inclusion across our workforce with the introduction of a Living Wage.

Value at Stake

By taking action to reduce our emissions as set out in this SDMP we can expect to achieve significant CO_2 reductions and cost savings.

The estimated benefits of implementing this SDMP are summarised in the Value at Stake analysis shown Figures 5 and 6 on the following page. This illustrates the difference between doing nothing (a business-as-usual approach) and a reduced emissions scenario where the Trust takes an active approach to sustainability in line with this SDMP, reducing CO_2 emissions by 34% by 2020.

The Value at Stake analysis takes into account:

> Electricity and gas price inflation at 5% per year

> Natural CO_2 emissions growth of 3.5% per year

The Trust has already achieved an 8% reduction in emissions since its 2013/14 baseyear. Achieving a further 26% savings in line with the targets set out in this plan will deliver:

> Cost savings of £2.7million by 2020

> A reduction of over 13,600 tonnes CO_2 by 2020

The annual revenue cost of implementing this SDMP is ca. £95K.

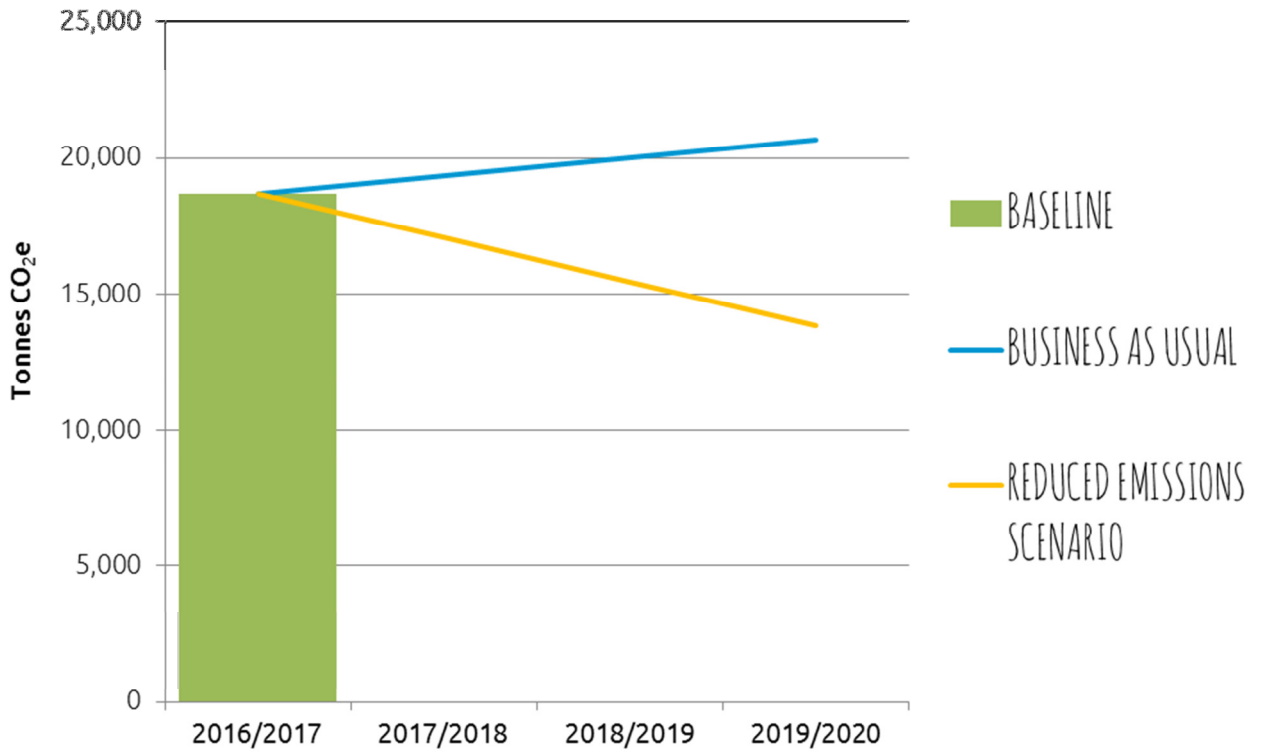


Figure 5: ESHT Value at Stake analysis – carbon emissions (CO_2e)

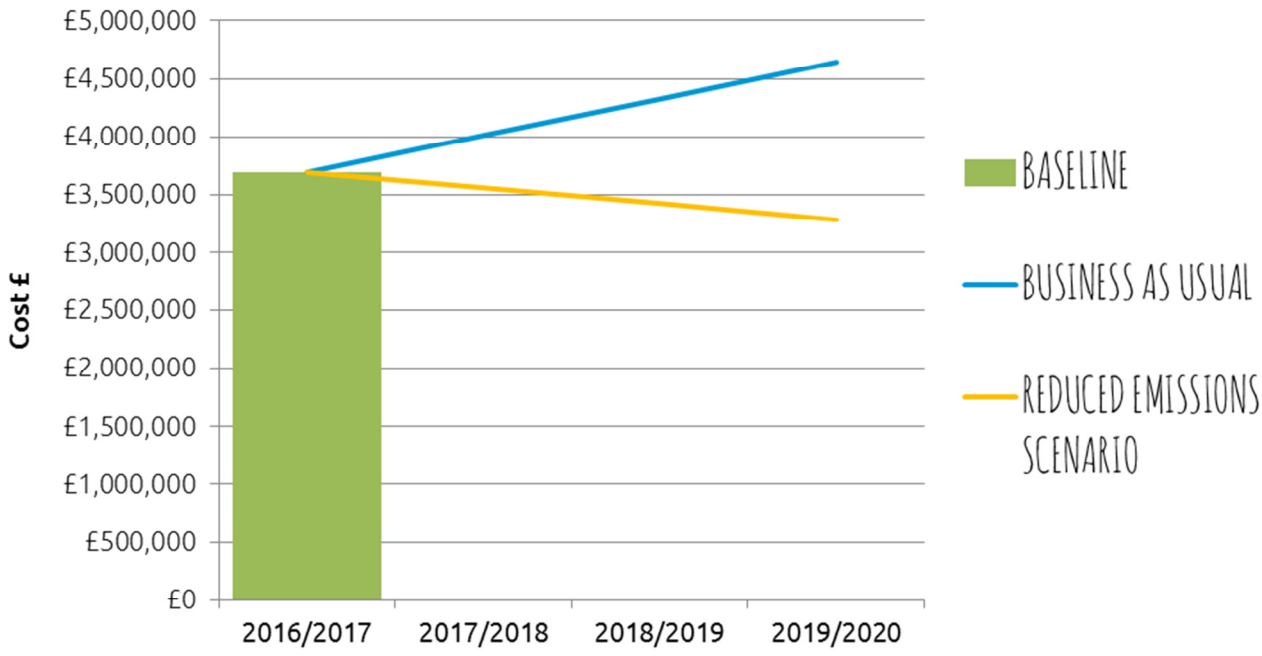


Figure 6: ESHT Value at Stake analysis ESHT – energy cost (£)

How we will achieve this

Delivery of this SDMP will rely on effective governance structures being integrated throughout the Trust. Alongside this, we recognise the vital role our staff can play in helping us deliver this strategy as well as the power of partnership to accelerate progress and achieve our goals.

Engaging staff and patients

We are committed to working with our staff, patients, stakeholders and other individuals and organisations to engage with us, help us deliver our strategy and promote best practice in sustainability, both within our local communities and with other NHS partners.

Sharing best practise and leading by example

By leading by example and openly sharing our experience and learning with other health and social care providers we hope to:

> Promote the importance of adopting sustainable lifestyles to the local communities that we serve.

> Improve the effectiveness of our Management Plan.

> Develop networks to share best practice on sustainable healthcare delivery.

> Become recognised as a leading NHS services provider for sustainable development policy and practice.

Our commitments

To achieve this we will:

> Publish this SDMP on our website and actively promote our work externally.

> Seek opportunities to share best practice with other NHS bodies and openly share information on our sustainability initiatives with providers and commissioners.

> Play an active role in local sustainability networks and participate in local and national events to promote our work.

> Develop joint communication and staff engagement initiatives with other NHS providers in the local health economy and promote collaborative action across our organisations.

> Encourage and support local Clinical Commissioning Groups to develop sustainable commissioning strategies that take an holistic, system-wide approach to sustainable healthcare delivery and pioneer the development of care pathway approaches to carbon footprinting and CO_2 reduction.

> Invite input from service users and community groups into the future development of our sustainability programme.

Appendix 1: Next Steps

Delivery of this Management Plan and the benefits it will bring – economic, environmental and social – will rely on early action on a number of pivotal points and effective governance structures being integrated across the Trust. The first three to six months after Board approval will be critical to maintaining momentum and ensuring most effective delivery of this SDMP. Here we identify the priority actions for this period.

Action	Lead
Buildings **Work stream lead: Chris Hodgson, Associate Director of Estates and Facilities**	
Develop a Metering Strategy to prioritise investment in Automatic Meter Reading (AMR) across our freehold estate.	Mark Paice
Agree a % target for non-infectious healthcare waste stream ("tiger bag" waste) across the Trust.	Michelle Clements
Journeys **Work stream lead: Chris Hodgson, Associate Director of Estates and Facilities**	
Establish a Travel Group with significant staff membership to oversee the implementation of the Travel Transformation Plan.	Michelle Clements
Develop and implement a new Trust-wide Travel Transformation Plan to target solo car occupancy and support the roll-out and uptake of alternative travel options.	John Kirk

PROCUREMENT **Work stream lead: Glyn Freeman, Head of Procurement and Supplies**	
Develop a new Procurement Policy, with sustainability, social responsibility and whole-life costing considerations as a business-as-usual feature of our procurement activity. This will meet the requirements of the Social Values Act and the Lord Carter review.	Glyn Freeman
Liaise with NHS Commercial Solutions and NHS Supply Chain to identify how the requirements of the Social Values Act are incorporated into the decision making process.	Glyn Freeman
CULTURE **Work stream lead: Jenna Khalfan, Head of Communications**	
Participate in national sustainability campaigns, for example the annual NHS Sustainability Day.	Jenna Khalfan
Develop and launch a new communication strategy and staff engagement campaign aimed at raising awareness, communicating core messaging and driving positive action at every level of the Trust.	Jenna Khalfan
WELLBEING **Work stream leads: Lorraine Mason, Workforce Development Manager & Moira Tenney, Deputy Director of Human Resources**	
Create a Band 4 and a Band 7 post as part of the Health & Wellbeing team within our OH team.	Lorraine Mason & Moira Tenney
Develop a business case to allow fast track access to OH physio and further develop rapid access service to mental health.	Lorraine Mason & Moira Tenney
ADAPTATION **Work stream lead: Chris Hodgson, Associate Director of Estates and Facilities**	
Develop a template for the climate change impact risk assessment and trial with 10 departments across the Trust. Develop a plan to roll this out over the next year.	Ian Taylor
Work with stakeholders to identify likely changes to service requirements resulting from climate change.	Ian Taylor

Governance **Executive Lead: Jonathan Reid, Director of Finance**	
Identify the membership, Terms of Reference (TOR) and hold the inaugural meeting for the Sustainability Steering Group, to oversee the delivery of this SDMP.	Chris Hodgson
Develop a dashboard for sustainability reporting which accurately reflects progress in each of the seven steps and use as the basis of our sustainability reporting.	Chris Hodgson

For further information please contact:

Mark Paice, General Manager Estates

Email: mark.paice@nhs.net

East Sussex Healthcare NHS Trust
Conquest Hospital
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CARE WITHOUT CARBON

East Sussex Healthcare NHS
NHS Trust

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE & ORGANISATIONAL DEVELOPMENT (POD) COMMITTEE

Minutes of the People & Organisational Development (POD) Committee meeting held on Thursday 28 September 2017 10.00am – 12.00pm Princess Alice Room, EDGH with v/c to Room 3, Education Centre, 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 Joe Chadwick-Bell, Chief Operating Officer (JCB)
Dr David Walker, Medical Director (DW)
Mrs Moira Tenney, Deputy Director of HR (MT)
Mrs Lorraine Mason, Assistant Director of HR - OD (LM)
Mrs Lesley Houston, Deputy General Manager – Medicine (LH)
Mrs Tina Lloyd, Assistant Director of Nursing (TL)
Mrs Kim Novis, Equality & Human Rights Lead (KN)

In attendance:
Mr Waleed Yousef, Guardian of Safe Working (WY) – item 4
Dr Farida Malik, Schwartz Round Facilitator (FM) – item 9
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 Lynette Wells, Director of Corporate Affairs (LW) Mr Jamal Zaidi, Associate Medical Director – Workforce (JZ) Mrs Jan Humber, Staff Side Chair (JH) Mrs Michele Elphick, General Manager – DAS Division (ME) Mrs Hazel Tonge, Acting DON (HT) – Tina Lloyd deputising Mr Salim Shubber, Director of Medical Education (SS)	
2)	**2.1 Minutes of the last meeting held on 15 June 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:	

	• BME recruitment – KN to provide update at December meeting	**KN**
	• Removal of training posts – junior doctors – added to Medical Education risk register.	
	• Workforce assurance tool – cannot be completed yet as this has not been developed. Action to be closed down.	**SG**
	• Representatives from Women, Children & Sexual Health & Out of Hospital Divisions – The Chair agreed to contact the Associate Directors of Operations for those Divisions to request representation for future Committee meetings.	**Chair**
	• Leadership training package – LM to meet with DW regarding medical engagement/doctor training package. Update to be provided at the next meeting.	**LM/DW**
	• Junior Doctor Committee representation – MG advised this had been circulated by Medical Education. WY advised that there had been low representation from junior doctors at meetings across the Trust. LH advised two chief registrars starting in Medicine and could be approached to join the Committee. LH to provide names to the Chair to invite these to join the Committee.	**LH/Chair**
3)	**Feedback from sub-groups** **3.1 – Engagement & OD Operational Group** LM presented the update paper. She advised the national staff survey would be commencing this week. The Trust had taken a blended approach with an online survey sent to 500 members of staff with easy IT access and the rest to receive a paper survey. The Trust would be aiming for an 80% response rate. Weekly feedback would be provided to staff via as to the current response rate and the Staff Engagement team would be looking at figures in more detail and targeting areas with a poor response rate. JCB asked if there was a reminder system for surveys. LM confirmed this was in place. KN advised that minority groups' responses had been higher in the staff survey in terms of job satisfaction. KN agreed to provide further detail in December as part of the WRES item. LM outlined that the Staff Family & Friends Test and Pulse Surveys would be sent to staff after the staff survey had closed to continue to measure feedback. LM commented that response rates for these had been lower, and a slight dip had been noted in response to the question regarding recommending the Trust as a place to work. LM advised work with HT had been undertaken to increase response rates across nursing staff.	**KN**

	3.2 – Education Steering Group MG advised Dawn Urquhart, Assistant Director of Education (DU) would be starting in post on 22 November 2017 and one of the key priorities would be to draft an Education Strategy. DU would also be a member of this Committee. MG agreed to ask DU to provide an update on apprenticeships and a draft version of the Education Strategy at the March Committee meeting. MG updated regarding Doctors' assistant posts and advised that some had been made substantive. JCC asked whether there had been an evaluation of this and whether it would be continued and funded. MT advised this would be partly covered under her report. JCB suggested looking at converting HCA to doctors' assistants in ED departments to support the doctors. MT/JCB agreed to further discuss this. JCC asked what the value for money was for overseas nurses that had been recruited so far. MG advised this was being looked at. TL commented that there had been some issues with EU nurses not passing the IELTS exam and work was being undertaken to address this. **3.3 – Workforce Resourcing Group** MT outlined discussions held at the first meeting. The group had focused on international recruitment and would be reviewing whether to continue with this at future meetings. MT advised that Penny Wright, Workforce Planning & Resourcing manager had been appointed. A workforce planning toolkit had been developed and would be rolled out. MT commented that turnover was increasing across the Trust, with the biggest increase noted to be with medical staff. **3.4 – HR Quality & Standards Group** Report noted by Committee.	**MG** **MT/JCB**
4)	**Guardian of Safe Working Report** WY was welcomed to the meeting and provided background to the Guardian of Safe Working post remit. He advised the GOSW at CQ had resigned and the post was being recruited to. WY highlighted issues with exception reporting in specialties reported previously had been resolved. General medicine & Orthogeriatrics continue to have higher numbers of exception reports submitted. WY raised that medical staffing issues were not being discussed in terms of planning for winter pressures and asked whether this could	

	be addressed. JCB advised that this could be included in the daily site meetings provided a medical staff representative could be present. JCB clarified the position regarding additional capacity in that there would only be one ward to be opened and outliers put in place and that medical staffing would be built into plans for this. JCB agreed to provide assurance that the winter plan would include that sufficient medical staffing are available. WY asked for recognition and engagement from senior leaders across the Trust for the junior doctors regarding exception reports and highlighting the safe patient care. JCC suggested that divisions should ensure that junior doctors are engaged with. LH advised of actions that the Medicine Division have introduced to engage with junior doctors including visible service manager support and a medicine representative supporting bed flow and discharges across the medical wards that the junior doctors can contact for support. LM advised of the pastoral care group had been set up by medical education to support the junior doctors and this had been well received. The Committee thanked WY for the report.	**JCB** **JCB**
5)	**Workforce Risk Register** MG presented the workforce risk register and outlined that the workforce risks were regularly reviewed. JCB commented that staffing was the biggest risk. MG to check with LW regarding the risk rating cut-off for the committee for future reports. TL advised she would be meeting with GW, recruitment manager re the three highest nursing risks to ensure that all is being done to manage these.	**MG/LW**
6)	**Risk Appetite** The Chair asked the committee to review and determine the level of risk appetite in terms of the ESHT 2020 objectives. Members discussed this at length. Some aspects were felt to be moderate across levels but that it differed across the different areas. Examples were given as to whether they were high risk. Members felt that it would be difficult to quantify this and that further discussion was required to understand the levels allocated. MG to further discuss with LW and report back at the next meeting.	**MG/LW**
7)	**Retention Strategy Presentation** MT provided a brief overview of the retention strategy slides of the current position at ESHT and actions taken to be addressed the turnover rate. MT highlighted that there were different retention strategies for different staff groups and that medical staff turnover had seen the highest increase.	

	TL asked if equality and diversity needed to be included in this strategy. KN to liaise with MT regarding this. MT agreed to circulate the slides with the minutes of the meeting along with a report from NHS employers. This item would be further discussed at the December Committee meeting.	**KN/MT** **MT**
8)	**Succession Planning/Talent Management update** Item deferred to January meeting.	**LM/SG**
9)	**Schwartz Rounds** FM was welcomed to the meeting and gave a presentation to the Committee which provided background to the Schwartz Rounds and the arrangements for these, which are currently held monthly over the lunchtime period on the acute Trust sites, with rounds now being offered at community sites. FM asked for all committee members to attend and support Schwartz Rounds and encourage their teams/departments to attend. FM also requested commitment from Divisions to provide panel members. KN agreed to publicise at induction for new starters. The chair thanked FM for an interesting presentation and commented on the importance of this within the Trust. All felt it was an excellent initiative. JCB suggested involving Divisions when setting dates for 2018 rounds to plan for the release of staff and also to link with key topics or teams. TL asked whether timings could be changed to accommodate other members of staff who may find it difficult to attend at lunch time and attend in the afternoon. TL suggested a future round on overseas recruitment. FM agreed to discuss with the Schwartz round steering group. It was agreed that the committee would receive a yearly update report from FM regarding Schwartz Rounds.	**ALL** **KN** **FM** **FM** **FM**
10)	**Items for information** **10.1 – Workforce Report – August** Item noted.	
11)	**Any other business** No items were raised.	

12)	**The next meeting of the Committee will take place on:** **Thursday 14 December 2017, 10.30am – 12.30pm** **Room 3, Education Centre, Conquest Hospital with v/c to St Mary's room, EDGH**	

East Sussex Healthcare NHS
NHS Trust

Minutes of the Quality and Safety Committee Meeting

Wednesday 20 September 2017
Committee Room, Conquest

Present: Sue Bernhauser, Chair
Adrian Bull, Chief Executive
Jackie Churchward-Cardiff, Non- Executive Director
Joe Chadwick-Bell, Chief Operating Officer
David Walker, Medical Director
Hazel Tonge, Acting Director of Nursing
Lynette Wells, Executive Director, Corporate Affairs
Moira Tenney, Assistant Director, HR (for Monica Green, Director HR)
Ashley Parrott, Associate Director of Governance

In attendance: Emma Tate, (for Catherine Ashton, Director of Strategy)
Lisa Redmond, Senior Infection Prevention & Control Nurse Specialist
Lesley Walton, Senior Project Manager, PMO (For Item 4.5)
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:

James Wilkinson, Assistant Medical Director, Quality
Monica Green, Director HR
Jonathan Reid, Finance Director
Janet Colvert, Ex-Officio Committee Member
David Clayton-Smith, Chair, ESHT
Anne Wilson, Director of Infection Prevention and Control
Catherine Ashton, Director of Strategy

2.0 Report from the Chair and Chair's Actions

The Chair apologised for the late circulation of papers and advised that the issue was being addressed. The agenda was reviewed and items prioritised as follows:

- Review of Terms of Reference – there was more work to do and this would be considered at the November Meeting
- Infection Control Annual Report – this would be deferred to the November meeting.
- Radiology – this would be considered in November and a full written report requested to focus on the backlog of plain film reporting and any resultant impact on patient safety.
- Pressure Ulcer update – this was an important topic and would become the Deep Dive for November.

Adrian Bull reported, for assurance, that radiology and the plain film backlog were being tracked closely through other Trust meetings. It was also being reviewed by NHS Improvement.

It was further noted that End of Life Care was being brought to the Committee for final scrutiny and assurance.

Sue Bernhauser reminded the Committee that the backlog of plain film reporting and the End of Life Care Policy were coming to the Committee in its role of Board assurance in relation to the CQC report.

3.1 Minutes of the Previous Meeting

The minutes of the meeting of 19 July 2017 were approved as an accurate record.

3.2 Matters Arising

Action Log

QSC 72 – Enquiries into how Trusts manage the risk relating to non-compliant devices (spinal epidural connectors) - Ashley Parrott reported that it had been confirmed that there were no suitable alternative devices to the spinal epidural connectors currently in use. A number of Trusts were in the same situation and once an alternative device became available it would be trialed. Action closed.

Action – Ashley Parrott to contact other Trusts to ascertain what mitigations they have in place and to map them against ESHT mitigations. A new paragraph to be added to the notes section of the Risk register.

QSC 73 – Radiology item was on the agenda but had been deferred to the November 2017 meeting where a full, written paper would be submitted and would address the plain film backlog. Action remained open.

QSC 74 – Lynette Wells reported that this had been the result of a one-off uploading issue and this month's report had uploaded correctly. Action closed.

QSC 75 – Ashley Parrott had confirmed that the risk score had been amended. Action closed.

QSC 76 – Ashley Parrott confirmed that the risk had been updated. Adrian Bull confirmed that there had been a verbal update on mitigations at the Estates IPR – these involved preventing inappropriate access. There had been no plan to replace the asbestos but addressing a recent fire compartmentation issue would involve the areas affected by asbestos. Removal of asbestos would therefore be addressed through a 3 year rolling programme. The risk register would be updated to reflect mitigations in place. Action closed.

QSC 77 – Report been submitted for the agenda. See narrative for QSC 76 – in the circumstances it was agreed to close this action. Action closed.

QSC 78 – Risk 1152 - Obsolete medical devices – Ashley Parrott confirmed that the word

obsolete had been removed and the action reworded. Action closed.

QSC 79 – Ashley Parrott confirmed that a request had been made for the lack of inventory and lifecycle plan for medical equipment to be added to the risk register. Action remained open for evidence that it has been added.

QSC 80 – Lynette Wells confirmed that the matrix had been to the Board Sub-Committees and was due to be reviewed by the People and Organisational Development Committee the following week. Once finalised it would be taken to a Board Seminar. Action closed.

QSC 81 – Karen Salt confirmed that the July Tracker had been circulated. Action closed.

QSC 82 – Karen Salt confirmed that the submission of Minutes of the QISG had been added to the Quality and Safety Committee schedule of reports. Action closed.

QSC 83 – Alignment of Improvement Group meetings to ensure that minutes are available for the QSC. Action completed and closed.

QSC 84 – Amendments to Annual Safeguarding Report. All amendments had been made and the paper was being submitted to the Trust Board. Action closed.

QSC 85 – Ashley Parrott confirmed that the template had been amended to contain Red/Green ratings. An update template would be submitted to the meeting in January 2018. Action closed.

QSC 86 – End of Life Care on the agenda. Action closed.

QSC 87 – Deep Dive – Pressure Ulcers – moved to the November 2017 meeting. Action remained open.

4.0 Compliance and Risk

4.1 Patient Safety and Quality – Board Assurance Framework

4.3.1 – Fire Compartmentation had been added. There was a risk of being served a notice of non-compliance with Fire Safety Regulations.

3.3.1 - Compliance with the four core 7 day service standards by 2020. The description had been revised to reflect the wording that appeared on the Risk Register.

Jackie Churchward-Cardiff noted that most of the rating of the risks remained unchanged. Lynette Wells confirmed that once risks turned green they were taken off the BAF quite quickly as sufficient assurance was in place that controls were adequate. There was movement from red to amber and this was dated and some risks did stay on the BAF for some time but they tended to be the significant risks. .

2.1.5 – Effective controls to ensure children requiring an appointment with a community consultant paediatrician are seen in a timely manner. Adrian Bull reported that SystmOne was in place and working and allowed first and follow up appointments to be tracked. The issue was monitored at the division's IPR and controls were effective. While the Women and Children Division had shown some reluctance to take the risk off the BAF it was

agreed that Adrian Bull's update gave assurance and that should that change it could be reintroduced. It was agreed that a verbal recommendation should be put to the Trust Board to remove the risk from the BAF.

Action – Lynette Wells to recommend to the Board verbally that 2.1.5 be taken off the BAF.

Action - Joe Chadwick-Bell to review the risks relating to the Divisions.

4.2 Patient Safety and Quality – High Level Risk Register

Ashley Parrott presented the Risk Register noting that a new risk (1658) around the interpretation of CTG had gone on to the register with a score of 20.

There was a discussion about the score which was high, and involved a high likelihood. Ashley Parrott had queried the score.

Adrian Bull noted that this was an ongoing issue and had been discussed at length at the Women and Children Division IPR.

There was an active audit and re-training taken place and the issue was being monitored by the Maternity Clinical Board as a priority area. There was concern but following discussion it was felt to be a dynamic issue. He was confident from a clinical point of view, that Dexter Pascall and Sarah Blanchard-Stow were monitoring closely and actions were being taken to address the issue.

There was a discussion about the rating of likely and possible. The Assistant Director of Midwifery and Nursing (Sarah Blanchard-Stow) had been concerned – there had been a recent Serious Incident related to poor interpretation. The Committee needed absolute assurance that the issue was being addressed. Hazel Tonge noted that one of the mitigations in place was that two people were now routinely reviewing high risk CTGs. There had been a very recent positive example of CTG monitoring leading to a good outcome for a baby.

It was agreed to leave the risk as it was on the risk register and to review at the next meeting. The risk was expected to come down quickly.

Action – Risk 1658 to remain on the risk register with a score of 20, actions taken to be reviewed at the next meeting.

Risk 1656 – Mental Health Act training. It was noted that staff were finding it difficult to attend this non-mandatory training that was being delivered by Sussex Partnership NHS Foundation Trust who provided the Trust's Mental Health Act assessments. This issue had been picked up by the CQC. There had been a recent incident of a patient who had tried to self-harm and the training aimed to raise staff awareness of patients presenting in A & E with Mental Health issues.

There was some confusion as to what the risk related to.

Action – Hazel Tonge to confirm what the risk represented with a clear reference to the Mental Health Act and who the target audience is. Who are trained, clear

definition of what the training represented and how many staff on shift need to be trained in MHA.

Joe Chadwick-Bell noted that there was a new risk relating to fire compartmentation. Following a meeting with Estates staff and the Fire Brigade it was likely that an enforcement notice would be issued. The Fire Brigade had sought that work be completed on fire compartmentation within three months but this would be extremely difficult to achieve as wards would need to be closed to allow ceilings to be taken down. The risk needed to be written in a very specific way to reflect that the closing of wards (and reduction of capacity) to refurbish at pace was a greater risk to patient safety than the risk of not completing required works quickly. The risk needed to be shared with the Fire Brigade.

Action – Joe Chadwick-Bell to write the fire compartmentation risk for the High Level Risk Register and if appropriate it would escalate to the Board Assurance Framework.

Risk 1426 – VTE Risk Assessment – David Walker noted that a lot of work had raised the level of assessments from the 40s to over 95% and questioned whether the rating should still be Extreme. He acknowledged that some work still needed to be done on the rechecking of assessments but felt that a score of 15 was more appropriate. There was a discussion about whether the risk related to a manual system of recording (and the resulting risk of not being able to find the assessment in patient notes) or to do with a delay in input of data by ward clerks. The risk had last been reviewed in July.

Action – David Walker to ask the Clinical Outcomes Group to review Risk 1426 - VTE and consider rewording it.

4.3 Asbestos Risk Update

This item was not presented due to the absence of a member of the Estates Team. It was noted that the report outlined the issue and the cost of rectifying, but little about any plan to mitigate and manage the risk.

Action – Estates Team to provide the Asbestos Action Plan to the next meeting.

4.4 CQC Progress Report

Lynette Wells presented the CQC Progress Report and reported that a progress meeting at the end of August had gone well and the staff had demonstrated significant improvements across a number of services. Items on Urgent Care, End of Life Care and a Trust Overview had been presented and well received. It had been confirmed that the inspection would not take place until early in 2018 due to a lack of capacity within the CQC.

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The unannounced inspection would be focused, targeting specific areas such as Urgent Care, End of Life and the Well Led domain but could also look at other areas. The CQC preparation group was meeting regularly and had very good representation A mock inspection was due to take place on both site on 21 September – End of Life Care, A & E and the Discharge Lounges would be reviewed.

It was noted that there would be a system-wide CQC review in November and this was

being coordinated by East Sussex County Council with support from the Trust and CCG.

Action – Outcome of Mock Inspection to be presented to the next meeting.

In respect of item 2A on the tracker – investigation of incidents – Ashley Parrott noted that he wanted to obtain assurance from A & E around how medical and nursing staff learn from Serious Incidents and that this recommendation was appropriately green. It was noted that there would be a call for evidence from the CQC.

Jackie Churchward-Cardiff commended the report and noted that the Trust was in a better place than it had been a few months ago. A lot of good work had gone into this and it was noted that it would be good to cascade this in a future Leadership Conversation.

Action – Ashley Parrott to discuss assurance around the investigation of incidents (Action 2A) with Urgent Care.

38 – Human Resources. There was a discussion about the medical and nursing models and what the new, wider workforce model would look like. A new workforce planning manager was in post and the nursing model had been run through already. The aim was to address the here and now, establish what was needed.

Hazel Tonge noted that the Divisions were all doing something slightly different and owning their actions and CQC preparation. It was important to ensure there was consistency.

End of Life Care – Hazel Tonge reported that there were 3 actions scoring red but two were now green (SOP and Voices Survey). The Training Needs Analysis action was outstanding – it had been started a month before with an ambitious deadline. The aim was to review the method of delivering training and moving it from classroom-based to face to face on the wards and involving patients. David Walker noted that more than 80% of areas in the Trust had received training but staff were still stating that they had not been trained and awareness therefore needed to be raised.

ESHT 2020 Improvement Programme

4.5

Lesley Walton presented the report noting that the programme had been running for 18 months delivering a significant number of improvements across the Trust. A bottom up review had been conducted to look at what had been achieved, what had become business and usual and focus on the future direction.

Sue Bernhauser reported that the Non-Executive Directors, at their meeting with the CQC had emphasized that planning and implementation had occurred but that assurance of embedding within the organisation was needed. It was therefore timely to do this review, look back at the journey and benefit/learn from the methodology.

The following successful improvements were noted:

- Medical records
- Cleanliness and hygiene
- Mortality
- Maternity
- Serious Incidents and complaints

- Evidence based care, VTE Sepsis
- Bullying
- Leadership and culture

Five projects remained in the improvement program

- Urgent and Emergency Care
- Theatre Improvement Project
- Excellence in Care – Ward Accreditation
- End of Life Care
- 7 Day Services
-

EOLC presented the biggest challenge but good progress had been made in the last 4/5 months. Embedding was not yet being demonstrated. Jilly Alexander had been brought on board to assist in reviewing the EOLC Strategy.

7 Day Services – core standard 8 would be the hardest to achieve. Joe Chadwick-Bell had visited University Hospital Southampton NHS Trust to take a look at an approach that could be implemented at ESHT. Digital process enablers were seen as essential - for example doctors evidencing visits to patients with a click of a button rather than a stamp.

Joe Chadwick-Bell commented that while it was important to aim to meet the standards, it was also important to note that the 7 Day Services Project was one of a number of projects aimed at improving patient flow and there needed to be a relation to the patient flow programme.

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Further comments were noted as follows:

- Concerns over affordability of extending ultrasonography and echography services into the weekend.
- Capacity for consultant review of patients at weekends, and how to avoid deterioration of patients admitted at or just before the weekend.

There was a discussion about the capacity for consultant reviews of patients at the weekends and how to avoid the deterioration of patients admitted at, or just before, the weekend. 7 Day working needed to include therapy, theatres etc. It was noted that District General Hospitals would find it very difficult to meet the weekend review standard but mitigation of that would be around better analysis of patients at the end of the week.

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Hazel Tonge reported that the Trust was looking at Criteria Led Discharge which should help with patient flow and contribute to improved management of unwell patients.

It was noted that the Trust had a new Workforce Planning Manager, Claire Rix, who would need to include 7 Day Working in that planning.

Safety and Quality

5.0

Governance Quality Report

5.1

Ashley Parrott presented the report noting the following key highlights:

- Reduction of complaints backlog to 0 in the week commencing 18 September.
- FFT – Inpatient rate at 45% - in the top third nationally

- FFT - A & E significant improvement in August
- DoC – continued good compliance
- Incident reporting rate had dropped due to the improvement in the health records system.
- Falls – a new multifactorial risk assessment had been agreed at TNMAG and would be trialed on high reporting 5 wards (2 DAS Division, 2 Medicine Division and 1 OOH Division). Two champions would be identified to design (with the help of the Resuscitation Team) new, scenario based training.
- Radiology – David Walker and Ashley Parrott had met with members of the Radiology Team and a plan had been agreed to use current systems to flag test results electronically. An options appraisal would be written.
- Inpatient Survey – this had been presented to Patient Experience Group the previous week.

Jackie Churchward-Cardiff highlighted that the trend for Trust acquired category 2 pressure ulcers was increasing. Hazel Tonge reported that a significant amount of work was being done to address pressure ulcers and there was an action plan in place, including reviews of mattresses and equipment training. The detail would be presented at the Deep Dive at the November meeting.

Action – Hazel Tonge to present Pressure Ulcer Deep Dive at the November 2017 meeting.

Jackie Churchward-Cardiff further noted that in the National Inpatient Survey – section 5 (Doctors) the Trust responses were at the bottom end of national scores. While the Trust was not a significant outlier in any of the scores – it was noted that the score may relate to patient perception of whether there were enough doctors.

Action – Ashley Parrott to look into the reasons for the Trust scoring at the lower end of national scores for question 5 – Doctors.

With reference to para 2.3 - it was agreed that following the meeting with the radiology lead to discuss the issues around abnormal investigation reports not being followed up and to consider the use of Rad Alert, an update on this should be included in the Quality Governance Report at the next meeting.

Action – Ashley Parrott to include an update on follow up of abnormal investigation reports in the next Clinical Governance Report in November 2017.

There followed a discussion about NCEPOD audits. There had been a lot of progress with most closed down. Monitoring was being done through the Clinical Effectiveness Group which was receiving a Trust wide report.

Jackie Churchward-Cardiff commended the report.

Joe Chadwick-Bell raised a governance question relating to the Joint Rehabilitation Service which was a jointly managed service but not under the Trust's CQC registration There was a query regarding responsibility for incidents (such as falls at Firwood House) as the staff were ESHT employees but operating under the Social Care service and CQC registration..

Action – Joe Chadwick-Bell to confirm accountability/responsibility for the Joint Community Rehabilitation Service.

National Cancer Experience Survey

5.2

Hazel Tonge presented the annual Survey that had been conducted in April and published in July 2017. The survey had not been presented to the last Cancer Board meeting due to overrunning of the meeting but it was being presented to the Committee to avoid losing time.

Against national peers the Trust had performed reasonably well. There were areas where the Trust could do better such as information regarding free prescriptions.

An action plan would be developed to address any issues raised.

Action – Cancer Board to produce a report outlining the findings and presenting an action plan. To be presented to the Quality and Safety Committee.

Quality Section of the Integrated Performance Report Month 4

5.3

Hazel Tonge presented the report with the following highlights:

- SHMI at 109 however, disappointingly the next one for January 2017 had gone up to 111. 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) tended to be a much better indicator for integrated providers.
- Never Events - in addition to the June incident a further Never Event had been recorded in September and related to a procedure earlier in the year in which a wrong size prosthesis had been used.
- Infection Control – there had been a spike in surgical site infections which was under investigation. No single surgeon had been involved.

End of Life Care Policies – including verbal update

5.4

At the July meeting the Committee had noted that there were no references to End of Life Care in the community, paediatrics and maternity and a further review of the policy had been requested. HT became the lead. Even though CQC actions for EoLC were being tracked evidence of good practice was still needed. It had been noted that during Quality Walks staff were reporting that they had not seen the policy. It was acknowledged that while good work was ongoing and things were in place, there had been a failure to evidence and demonstrate the governance.

Due to some conflicting priorities the End of Life Care paper had not been received for scrutiny and it was agreed that a report, with the full policy should be presented to the next meeting of the QSC in November 2017 for comprehensive scrutiny. It was noted that David Barclay and David Walker were reviewing the clinical elements of the policies that sat under the main End of Life Care policy.

Action – Full report to include the End of Life Care policy and an action plan on how to implement it to be presented at the next meeting.

There was a discussion about the East Sussex Better Together End of Life Care Strategy and noted that Jilly Alexander was conducting a gap analysis between that and what ESHT was doing.

EQDS2

5.5

Kim Novis presented the Equality Delivery Service Annual Report which represented a legal requirement to report on workforce and patient data.

There were 4 goals with 18 outcomes.

Key highlights noted:

- BME staff and those with disabilities expressed greater satisfaction with flexible working arrangements and job satisfaction than staff from the white group.
- 12% of staff didn't declare their ethnicity and so the Trust Board had been asked to declare equalities data (see page 35). The aim was to encourage other staff to declare.
- Only two areas rated red – equal pay audit and complaints data. Equal pay was likely to remain red for some time; complaints data was due to data not being collected or triangulated.

Equal pay reporting was a legal requirement for organisations of over 250 employees and the Trust would have to report this in 2018. There was a discussion about the difference in pay for medical career and junior doctors – it was thought that this related to seniority.

The Committee thanked Kim for a comprehensive report and assurance that the Trust was meeting Equality and Duty requirements.

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Quality Impact Assessments Update

5.6

Hazel Tonge presented the update reporting that the CIP schemes had been reviewed in a phased approach. There were 93 projects aiming to achieve £36.4m in savings.

Quality Impact Assessments had been conducted on all of the schemes and they had all been assessed as being the right schemes to progress. KPIs would be added to ensure that the schemes did not impact on quality.
The schemes had been reviewed at the Executive Directors meeting – there would continue to be regular reviews to ensure that unintended consequences did not materialise.

There had been one or two schemes where the QIA had erroneously recommended rejecting or appending. This had been due to concerns regarding the scale of savings potentially impacting the service, and not concerns regarding the impact on quality of the actions proposed. The judgement should only be on the actions proposed and their impact on quality. Reservations regarding the level of savings or pace of change were not within the scope of QIA.

Hazel Tonge and Lesley Walton were commended for the significant piece of work that had gone into the reviews.

Jackie Churchward Cardiff and David Walker retired from the meeting at this point.

Winter Pressures

5.7

Joe Chadwick-Bell presented the East Sussex Local A & E Delivery Board Winter Plan for 2017-18. This was a robust plan, developed by the Opex Team to ensure that the system is able to manage effectively the capacity and demand pressures anticipated during the Winter period. The plan had been submitted to the Local A & E Delivery Board, Alliance Executive Group and Senior Leaders Forum.

It was acknowledged that the winter period would be challenging but the plan was considered to be deliverable with realistic modelling. Current winter funding would cover the 28 additional beds but any further beds would require additional funding from the CCG – this was being discussed with the Finance Director (Jonathan Reid).

Last year's Surge and Escalation Plan had been circulated but it was noted that a new version was due to be circulated. There was one further document (Christmas and New Year Plan) being worked on which when finished would be submitted to NHS E.

Other key highlights were:

- Gaps in Out of Hospital were being managed through the new integrated support worker service and an increase in crisis response to divert patients from the Emergency Departments.

- Care home plus – there was capacity in care homes but a lack of skill set due to the residential nature. Rates for nursing homes had been increased to open up the market but despite this 28 Conquest patients and 10 EDGH patients were waiting for placements in homes.

- Flu vaccination – this important campaign was due to launch shortly with the vaccines due to be available at the end of September. All wards would have peer vaccinators. A flu planning meeting was due to take place with Ian Taylor the following week to check that all measure were in place. It was noted that another Trust had introduced vaccination of members of the public (including children) and that this could be considered at ESHT. Pregnancy uptake had been good but schools uptake had been low.

6.0 Papers for noting – Healthwatch Round the Clock Care Report

The paper was noted.

7.0 Deep Dive for next meeting

Pressure Ulcer Report to be presented to the next meeting.

8.0 AOB

There were no items raised under Any Other Business.

East Sussex Healthcare NHS
NHS Trust

Minutes of the Quality and Safety Committee Meeting

Wednesday 22 November 2017
St Mary's Boardroom

Present:
Sue Bernhauser, Chair
Jackie Churchward-Cardiff, Non- Executive Director
David Walker, Medical Director
James Wilkinson, Assistant Medical Director, Quality
Vikki Carruth, Director of Nursing
Lynette Wells, Executive Director, Corporate Affairs
Monica Green, Director HR
Korron Spence, Hospital Director (for Joe Chadwick-Bell)
Ashley Parrott, Associate Director of Governance

In attendance:
Hazel Tonge, Deputy Director of Nursing
Jilly Alexander, Interim Assistant Director of Strategy (End of Life Care)
Jenna Khalfan, Associate Director for Communications & Engagement
Lisa Redmond, Senior Infection Prevention & Control Nurse Specialist
Dawn Urquhart, Assistant Director HR – Education
Tony Humphries, Operational Property Manager
Karen Salt, PA to Director of Nursing (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:

Adrian Bull, Chief Executive
Joe Chadwick-Bell, Chief Operating Officer
Lesley Walton, Head of Programme Management Office
Anne Wilson, Director of Infection Prevention and Control
Alan Thorne, Improvement Director

2.0 Patient Story

This month, the learning from a Serious Incident (ophthalmology) was presented. There had been concern from commissioners around the process flow, and there had been a number of incidents in the past two years.

The Serious Incident involved age-related macular degeneration and had resulted in a patient suffering permanent sight loss in one eye and temporary sight loss to the other. Ashley Parrott explained that the patient, who had been due to be seen by a consultant in a normal time frame, had revisited his GP after becoming concerned about his vision following his own research. The referral letter from the GP had not given sufficient information to prompt an earlier appointment and the consultant had decided the patient should be seen as already arranged.

The learning from the incident had been that if a letter from a GP did not provide enough information the GP should be asked to arrange an eye test. It was noted that the process mapping for ophthalmology was complex and work was being done to streamline and an action plan was in place.

Ashley Parrott reported that the service, while benefitting from a new consultant, was stretched and struggling to deliver. The service was in great demand due to a large increase in macular degeneration treatment. It was proving challenging to manage the day to day workload while also driving forward changes that were needed. Administrative support was being sought.

The CCG had noted poor medical engagement and there was general concern about the service. There had been a 2nd Never Event although this was understood to be unrelated to the circumstances outlined above. Learning from that had led to the implementation of a new process.

There was a discussion about whether enough was being done to keep the service safe. Human Resource was supporting in an area of challenge and the service manager was being supported by the clinical lead. An advert was out for a new consultant.

Action – Vikki Carruth and David Walker to discuss the way forward for Ophthalmology with Adrian Bull.

Action - Michele Elphick to be advised of concerns of the Committee and asked to provide an Opthalmology update to the next meeting.

3.1 Minutes of the Previous Meeting

The minutes of the meeting of 20 September 2017 were approved as an accurate record subject to the amendment the second sentence of Action 85 to read:

'An updated template would be submitted to the next meeting in January 2018.

It was noted that the Pressure Ulcer Deep Dive would be presented at the January 2018 meeting and would address the issue of avoidable harm.

3.2 Matters Arising

Action Log

QSC 73 – Radiology – plain film backlog. A verbal update was on the agenda. It was agreed to keep the action open. Action remained open.

QSC 79 – Risk relating to the lack of inventory and lifecycle plan for medical equipment. Ashley Parrott confirmed that a request had gone to Sim Beaumont, EME, to add this to the register. Action closed.

It was noted that despite there being a register of equipment that formed part of a 5 year programme of replacement, a lack of funding was having an impact on following the

programme and the Trust was therefore being put into a position where devices were continuing to be used beyond manufacturer recommended use by dates and there was a risk of failure of devices.

Hazel Tonge arrived – 14.58

Action – Ashley Parrott to discuss with Jonathan Reid how to resolve the capture of the risk.

QSC 87 – Deep Dive – Pressure Ulcers – It was agreed to move this item to the January 2018 meeting. Action remained open.

QSC 88 – A new alert had issued and some new devices were available already. A full range was due to be available from April 2018 and each Trust needed a plan for obtaining the new devices. In the meantime the Trust was mitigating the risk but was unable to resolve it pending the arrival of a solution. Risk remained on the risk register. Action closed.

QSC 89 - Lynette Wells to recommend to the Board verbally that 2.1.5 (paediatric waiting lists) be taken off the BAF. This was considered at Trust Board and it was agreed to remove the risk as there was sufficient assurance in place. Action closed

QSC 90 - Joe Chadwick-Bell to review the risks relating to the Divisions. No update – to be followed up with Joe Chadwick-Bell.

QSC 91 - Risk 1658 to remain on the risk register with a score of 20, actions taken to be reviewed at the next meeting. The risk was being considered as part of the Risk Register at the November meeting. Action closed.
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It was noted that there remained concerns relating to the risk. Efforts were being made to mitigate through training, awareness, education. There had been discussion at the Patient Safety and Quality Group around whether or not the issues were catastrophic. There had been another Serious Incident a few weeks before and Sarah Blanchard-Stow considered the issue to be persistent and current.

Action – Sarah Blanchard-Stow to provide an update on CTG monitoring at the next meeting in January 2018.

QSC 92 – Risk 1656 – Detained patients at risk of not receiving their MHA rights whilst inpatients. Risk updated 14 Nov 17. Action closed.

QSC 93 - Joe Chadwick-Bell to write the fire compartmentation risk for the High Level Risk Register and if appropriate it would escalate to the Board Assurance Framework. Korron Spence reported that following a further meeting with the Fire Brigade it was agreed that the buildings were compliant at the time they were built and were therefore deemed to be compliant. A risk was therefore not required. Action closed.

QSC 94 – Risk 1426 – David Walker to ask the Clinical Outcomes Group to review Risk 1426 – VTE and consider rewording it. David Walker confirmed that the risk had been reviewed. The Trust had moved from being a major outlier for post-operative Pulmonary Embolism a year ago to being a minor outlier following a series of actions that had been put into place. Action closed.

QSC 95 - Estates Team to provide the Asbestos Action Plan to the next meeting. Item on the agenda of the meeting. Action closed.

QSC 96 – Outcome of Mock Inspection to be presented to the next meeting. Item on the agenda. Action closed.

QSC 97 - Ashley Parrott to discuss assurance around the investigation of incidents (Action 2A) with Urgent Care. No update – action remained open.

QSC 98 - Hazel Tonge to present Pressure Ulcer Deep Dive at the November 2017 meeting. This was a duplicate of Action 87 – agreed to close.

QSC 99 - Ashley Parrott to look into the reasons for the Trust scoring at the lower end of national scores for question 5 – Doctors. Ashley Parrott reported that there were three questions within this category and all 3 the Trust scored 8.4, 8.9, 8.7. 2015 and in 2016 only slightly worse. Action complete.

QSC 100 - Ashley Parrott to include an update on follow up of abnormal investigation reports in the next Clinical Governance Report in November 2017. Ashley Parrott reported that the follow up was not in the Report but a separate paper had been written. David Walker was arranging a further meeting with Justin Harris. The aim was to go paperless but Esearcher needed the functionality to prompt users and to be able to forward in the event of consultants being away. Action remained open.

QSC 101 – Joe Chadwick-Bell to confirm accountability/responsibility for the Joint Community Rehabilitation Service. Ashley Parrott reported that he was following up this action with Debbie Lennard (ADN Out of Hospital) and Mark Stainton ESCC. Action remained open.

QSC 102 - Cancer Board to produce a report outlining the findings and presenting an action plan. To be presented to the Quality and Safety Committee. Item on the agenda. Action closed.

QSC 103 - Full report to include the End of Life Care policy and an action plan on how to implement it to be presented at the next meeting.

Compliance and Risk

4.1 - Review of Terms of Reference

The reviewed Terms of Reference were taken as read and comments invited. It was noted that the ex-officio (patient representative) member had not attended recent meetings due to ill health.

There was a discussion about membership of the Committee and it was agreed as follows:

- Director of Finance did not need to be a member of the Committee. Given the impact that finance issues could have on quality it was agreed that Finance representation should be at the Patient Safety and Quality Group.
- Representation by both the Chief Executive Officer and the Chief Operating Officer was not necessary

- Vikki Carruth suggested that from a clinical and governance point of view it would be useful to have Assistant Directors of Nursing for the Divisions join the meetings to feedback to the Divisions.

Action – Jo Brandt to be invited to the membership of the Patient Safety and Quality Group

4.2 – Patient Safety and Quality – Board Assurance Framework

The Board Assurance Framework was presented and the following noted:

- 2.2.2 - Clinical leadership. Proposal to amend the score to green would wait until after the well-led element of the next CQC Inspection.
- 2.1.2 - Emergency Department reconfiguration. Score was red but was likely to move to green and come off the BAF.
- 2.1.3 - Patient flow. Jackie Churchward-Cardiff suggested that the score move to amber.
- 4.1.1 - Financial Plan. This remained red due to the impact on quality of the Trust's financial position.
- 4.4.1 – Threat of Cyber Attack on Trust systems. Addition of this new risk.

4.3 – Patient Safety and Quality – High Level Risk Register

The High Level Risk Register was presented and taken as read. The Committee was asked to consider the score of Risk 1660 – Cyber Attack which was felt to be too high. While there was potential for a catastrophic impact much had been done to mitigate the risk. It was noted that risks scoring 15 or higher had to be approved through Integrated Performance Report meetings or signed off by an Executive Director.

It was agreed that score should be amended to 15.

Action – Ashley Parrott to arrange for the score of Risk 1660 – Cyber Attack to be amended to 15.

4.4 – Asbestos Risk Action Plan

The Asbestos Risk Action Plan was presented by Tony Humphries and expanded on the previous report, giving an indication of timescales. Key points were as follows:

- Full Management Surveys were mandatory (by law) and a survey at Conquest was outstanding.
- Surveys at EDGH had identified asbestos debris in a number of ceiling voids. The aim was to clear by the end of the financial year but this would be subject to access to the wards affected.
- The final two actions were aspirational and would only be undertaken during large scale renovations or if there were a change of government policy.

It was noted that following the CQC preparation meetings a list of all outstanding works was now available on the Extranet for staff members to interrogate. Estates and Facilities were looking at introducing software to allow web based self-reporting of works and minor improvements.

It was noted that there were frustrations with the lack of capital money to achieve works that were needed.

4.5 – CQC Progress Report – Nov 17 including results of Mock Inspection 21 September 2017

A revised Action Tracker was presented and it was noted that good progress had been made. The tracker had been reduced in size and the narrative had been strengthened. 9 actions remained red due to an element of over ambition relating to timescales.

There had been a positive meeting with the CQC Team and it had been noted that more plaudits about the Trust were being received.

Key points to note were:

- CQC preparation group was meeting regularly
- The next Inspection was likely to be around end February/early March 2018
- Alan Thorne had taken up the role of Improvement Director
- Provider Information request had been sent to the Trust
- Staff focus groups were due to take place on 12 December

It was noted that the CQC Insight Tool which was refreshed monthly, was a useful, high level tool and could indicate the areas that the CQC may want to focus on.

Jackie Churchward-Cardiff commented that a lot of progress seemed to have been made.

4.6 – ESHT 2020 Improvement Programme (including notes of QISG)

In the absence of representation from the Project Management Office Vikki Carruth agreed to take questions away from the meeting.

Jackie Churchward- Cardiff queried the issue relating to the lack of a dashboard solution. Ashley Parrott noted that the wording needed to change and that a lack of dashboard solution would not delay the project which was being rolled out. The project was moving at pace and a further report would be brought back to the next meeting.

Action – Ashley Parrott to ensure presentation and the example of work being done on Folkington Ward is presented at the next meeting in January 2018.

4.7 – Improvement Group Exception Report

In the absence of Catherine Ashton the report was not presented but was taken as read. The committee noted the progress with the Improvement Group and the ongoing work to identify, co-ordinate and prioritise the range of improvement initiatives being undertaken at ESHT.

Safety and Quality

5.1 – End of Life Care Deep Dive Update

Hazel Tonge and Jilly Alexander presented the End of Life Care Deep Dive update which was taken as read.

The End of Life Care policy had had a comprehensive review involving Emergency Department and mortuary staff. The definition of End of Life had been clarified, roles described and 31 related policies were referenced in the final version.

It was confirmed that there would be a summary page.

Vikki Carruth commended the work that had gone into End of Life Care through the Steering Group which included patient representation. It was important to now focus on how to simplify what needed to be done.

It was noted that most of the actions arising from the CQC Inspections had been closed and the actions needed to be embedded in practice.

DNACPR was a remaining action scoring red – the Resuscitation Committee would report into the End of Life Care Steering Group on this. It was noted that the audit tool may need to be reviewed as discussions with families that happened after a patient was admitted and was recorded in the patient notes rather than on the DNACPR form were not being captured. It was noted that the documentation of these difficult discussions was a challenge but the introduction of ReSPECT was expected to help address this.

David Walker noted reported that he had written to consultants to ask them to check quality of DNACPR in patient notes.

Jackie Churchward-Cardiff pointed out that the wording of 3.1.1 of the main report indicated that compliance with DNACPR was the responsibility of the Resuscitation Committee when in fact this sat with the clinicians and matrons on the wards. The Resuscitation Committee had responsibility for the audits.

There was a discussion about Board level ownership – see page 10, fourth bullet point (before para. 4.2). It was noted that the Chair and Non-Executive Directors were due to discuss this at Trust Board the following week.

It was noted that it was important for the Quality and Safety Committee to retain oversight of End of Life Care.

5.2 – Governance Quality Report (includes PSQG Report)

Ashley Parrott presented the Report. Key highlights were as follows:

- Falls assessment pilot was being rolled out on 5 wards from the beginning of December.
- Ophthalmology Never Event. Learning related to checking procedures and measures were in place to address.
- Theatres External Review – good initial feedback which had been passed to the Head of Nursing, Paul Relf.
- Implementation of Executive sponsors for red flag events.

Jackie Churchward-Cardiff queried the higher rate of complaints against activity in the Women and Children Division (4.1 complaints per 1000 bed days).

Action - Ashley Parrott to investigate the reason for the higher rate of complaints against activity in the Women and Children Division.

Ashley Parrott reported that action plans were being monitored by the Patient Safety and Quality Group using the 'closing the loop' activity. Of the 30 actions identified from September 2016, 13 had full assurance, 9 partial and 8 no assurance.

It was noted that the Trust's rate of reporting in the NRLS Organisation Patient Safety Incident Report was very good.

Jackie Churchward-Cardiff commended the report and its evidence.

5.3 – External Visits and Reviews Report

The report was noted and the following upcoming visits/reviews highlighted:

- Peer Review of Special Care Baby Unit
- Theatres and HSDU reviews

5.4 – Quality Section of the Integrated Performance Report Month 6

The report was noted with the following key points:

- Pressure Ulcers – the methodology of investigation was being reviewed with the aim of providing context.
- Night moves – there had been a discussion at the Patient Safety and Quality Group around the validity of data – work had been done on this in the past. An action had been taken away to confirm the validity of the data being submitted.

Action – Vikki Carruth to update on the validity of 'night move' data at the next meeting.

- RAMI reporting had been temporarily withdrawn due to a CHKS review of the system for reporting RAMI.
- HSMR – this was reducing in the acutes and SHMI was going well, better than peer. For deaths in community hospitals documentation was an issue but the Out of Hospital Team were working on improvements to coding. Matrons were doing the mortality reviews and the next step was for nurses to capture co-morbidities.
- Sepsis mortality rate was coming down.
- Good Pulmonary Embolism outcomes.

5.5 – Health and Safety Annual Report

Ashley Parrott presented the report which was due to be presented to the Trust Board. It was noted that while improved in terms of size of content, the report was not quite where it needed to be with some data not available. While good work had been done, assurance and evidence of that work needed to be improved going forward. Vikki Carruth, as Executive Lead for Health and Safety, had met with some of the team.

It was agreed that the report be sent to the Trust Board with the proviso that steps would be taken to improve the standard of the report for 2017/18.

Monica Green and David Walker left the meeting at 16.30

5.6 – Infection Control Annual Report

Lisa Redmond presented the report.

Key points noted were:

- Improvement in CDiff in 2017/18
- Policy change – specimens to be taken within 3 days for patients admitted with diarrohea
- Challenge around influenza, mostly type A but the Trust peak matched national peaks. Robust flu plan in place for 2017/18 and vaccinations were being offered to patients coming in to the hospitals
- Haematology – learning from a Serious Incident had led to a change in practice relating to the avoidance of social mixing of haematology day and in patients.

Jackie Churchward-Cardiff commended the report which demonstrated good progress.

It was agreed that where lessons were learned this should be noted in the Annual Report. It was noted that there were significant vacancies in the team due to the departure of the Head of Infection Prevention and Control and the retirement of the Infection Control Clinical Lead. A plan was in place for interim support and plans were underway for substantive recruitment. The situation, while unsettling, was not seen as a significant risk.

The Chair commended the team for the step change in the profile of Infection Control in the Trust and asked Lisa Redmond to convey the Committee's appreciation for the work undertaken during the year.

5.7 – Radiology – Plain Film Backlog Update – verbal

Vikki Carruth reported that Justin Harris had had to send his apologies and the lack of a report on the radiology backlog. A recent CQC visit to look at radiation had necessitated re-prioritisation of work. A report would be produced for the next meeting.

The context was:
11 or 12 consultant vacancies across the Trust
Archaic backlogs going back to 2012 – each year had had to be reviewed using a time consuming, manual process. 2016, 2015 and 2014 CTs, MRIs, fluoroscopy had been reviewed. There was assurance that the backlog related to a change from one system to another, not that the films had not been reported on. 2012 and 2013 remained to be done. The focus was on CT/MRI of chest and abdomen due to the higher risk. 70,000 orthopaedic films would remain unreviewed as they would have been looked at by an orthopaedic surgeon.

Concerns had been raised about 12 consultant vacancies. Other Trusts were also experiencing issues. It was noted that there had been no increase in resource to cope with a 10% to 12% increase in referrals.

It was hoped that over the next few weeks the numbers of plain film backlogs would reduce. Justin Harris had stated that he did not have concerns about the backlog.

Sue Bernhauser noted that the CQC had brought the backlog to the attention of the Trust

and may want to look at the issue again.

It was agreed that the fact that orthopaedic xrays would have been seen by an orthopaedic doctor was reassuring. There was a discussion about the level of imaging being requested and it was noted that some doctors were more risk averse than others and some junior doctors were over-requesting. James Wilkinson would be addressing this with senior staff.
.
Action – Justin Harris to be asked to provide data on the latest plain film backlog figures and improvement trajectory.
.
Action – Results of CQC IRMER Report to be presented to a future meeting.

5.8 – Patient Experience and Public Engagement Strategy

Jenna Khalfan presented the strategy which had been presented to the Patient Experience and Environment Steering Group with some very minor comments noted. The strategy demonstrated a commitment to patient experience and public engagement. The main change had been a greater focus on public engagement supporting health, wellbeing and self-management via a website.

The aim was to focus on patient experience with a particular focus on complaints and the Friends and Family Test. There was an exercise underway to reinvigorate the 6000 strong membership and to recruit some people into a volunteer programme which would offer training to those who wanted to play a more active role in the Trust's Committees.

Ashley Parrott reported that volunteers were now being used to take a fresh eyes look at clinic appointment letter templates and test some of the access numbers to check how easy it was for patients to make contact. The results would be fed back to Liz Fellows. There was also an aspiration to use volunteers as ESHT ambassadors for East Sussex Better Together.

Sue Bernhauser commented that the Trust had improved the way it asked patients what they wanted and also communicating to patients what the Trust was doing. She had met patients who felt very positive about this.

5.9 – National Cancer Patient Experience Survey

In the absence of Dee Daly, Vikki Carruth agreed to take away any questions from the Committee. It was noted that the response rate had been 73% (mostly breast and haematology) and there were some areas of positive feedback.

The Survey had not yet been discussed at the Cancer Board but an action plan would be developed to address some of the areas for improvement, such as communication. This would be monitored through the Patient Experience and Environment Group and would also come back to the Quality and Safety Committee.

The Committee noted the survey and it was agreed that next year the survey should be discussed at an earlier stage.

Action – Action plan to be emailed out by Karen Salt when available.

Deep Dive – Pressure Ulcers

It was agreed to defer this to the next meeting.

AOB

Risk and Quality Delivery Strategy – Ashley Parrott reported that this strategy needed to be submitted, by Monday 27 November to the CQC, in response to a provider information request. In order to avoid sending an out of date strategy it was requested that the Strategy be extended to March 2018 after which it would be reviewed. There was an interdependency with the current review of the Committees but the system within had not changed.

It was agreed to extend the Risk and Quality Delivery Strategy to March 2018.

Meeting duration – it was agreed that the agenda for the meeting was too long for a two hour meeting and half an hour should be added to future meetings.

Use of Trust Seal

Meeting information:			
Date of Meeting:	6th February 2018	Agenda Item:	16
Meeting:	Trust Board	Reporting Officer:	Lynette Wells, Director of Corporate Affairs

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

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

Executive Summary:

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

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

18th January 2018 – Customised service proposal for agreement between ESHT and British Telecommunications for an N3 managed virtual COIN provided over a five year period.

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

Not applicable.

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

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