**EAST SUSSEX HEALTHCARE NHS TRUST**

**TRUST BOARD MEETING IN PUBLIC**

**A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 17th April 2018, commencing at 09:30 in St Mark's Church Hall, Bexhill**

| | AGENDA | | Lead: | Time: |
|---|---|---|---|---|
| 1. | 1.1 Chair's opening remarks<br>1.2 Apologies for absence<br>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 6th February 2018 | A | | |
| 4. | Matters arising | B | | |
| 5. | Speak Up Guardian's Report | C | Ruth Agg | |
| 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 11 (February)<br><br>1. Quality & Safety<br>2. Access & Responsiveness<br>3. Sustainability<br>4. Leadership & Culture | Assurance | G | DN/MD COO HRD | 1030 - 1130 |
| 11. | Finance and Financial Special Measures Update | Assurance | H | DF | |
| 12. | Nursing Establishment Review | | I | DN | |

**BREAK**

## STRATEGY

| | | | | | Time: |
|---|---|---|---|---|---|
| 13. | Developing and Delivering Safe and Sustainable Services | Assurance | J | DS | 1140 - 1150 |

## GOVERNANCE AND ASSURANCE

| | | | | | Time: |
|---|---|---|---|---|---|
| 14. | Staff Survey Results | Assurance | | DHR | 1150 - 1215 |
| 15. | Clinical Excellence Awards 2017 | Assurance | K | | |
| 16. | Delivering same sex accommodation annual declaration of compliance | Assurance | L | DN | |
| 17. | Delegation of approval of Annual Report and Accounts 2016/7 | Assurance | | DCA | |
| 18. | Annual Self-Certification | Assurance | M | DCA | |
| 19. | Board sub-committee minutes:<br><br>18.1 Audit Committee<br>18.2 Finance & Investment Committee<br>18.3 POD Committee<br>18.4 Quality & Safety Committee | Assurance | N | Comm Chairs | |

## ITEMS FOR INFORMATION

| | | | | Time: |
|---|---|---|---|---|
| 20. | Use of Trust Seal | O | Chair | 1215 - 1230 |
| 21. | Questions from members of the public (15 minutes maximum) | | Chair | |
| 22. | Date of Next Meeting:<br>Tuesday 5th June 2018, St Mary's Boardroom, EDGH | | Chair | |

David Clayton-Smith

**David Clayton-Smith**

Chairman

19th March 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, 6th February 2018 at 09:30 in the Oak Room, Hastings Centre.**

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

**In attendance:**
Mrs Sharon Gardner-Blatch, Deputy Director of Nursing
Miss Jan Humber, Joint Staff Committee Chairman
Dr James Wilkinson, Assistant Medical Director
Ms Stacey Beard, Project SEARCH Co-ordinator (for item 005/2018 only)
Mr Will Clark, Environmental Manager, Sussex Community NHS Foundation Trust (for item 014/2018 only)
Mr Mark Paice, General Manager Estates (for item 014/2018 only)
Mrs Jeanette Williams, Staff Engagement Manager (for item 005/2018 only)
Mr Pete Palmer, Assistant Company Secretary (minutes)

001/2018 **Welcome**

1. Chair's Opening Remarks
Mr Clayton-Smith welcomed everyone to the meeting of the Trust Board held in public. He noted that Ms Carruth had been appointed as Director of Infection Prevention and Control for the organisation, and that Dr Subramanian Umasanker had been appointed as Clinical Lead for Infection Control.

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

Mr Barry Nealon, Vice Chairman
Ms Vikki Carruth, Director of Nursing
Dr David Walker, Medical Director

3. Monthly Award Winners
Mr Clayton-Smith reported that the monthly award winners for November had been The Hastings Health Visiting Team. December's winner was Staff Nurse Anete Zielinska, who works on Hailsham 2 ward at EDGH.

002/2018 **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.

003/2018 **Minutes**
The minutes of the Trust Board meeting held on 28th November 2017 were considered and 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.

004/2018 **Matters Arising**
*084/2017 – IPR Month 6 - Activity*
Mrs Chadwick-Bell clarified that day-case activity had increased substantially during the year while in-patient cases had decreased compared to planned activity levels.

005/2018 **Project Search Update**
Ms Beard presented an update on Project Search's progress during 2016/17. The programme was entering its fifth year and was undertaken in partnership with Sussex Downs College and East Sussex County Council. The project had seen amazing success in enabling young people to find employment following completion of their programme and had been shortlisted as a finalist for the HSJ awards in 2017. During 2016/17 a number of new departments had joined the programme, including A&E and maintenance who had dedicated 6 mentors to their student.

Miss Green noted that the initiative had proved to be very valuable to students and to managers within the organisation. She explained that plans were being developed to replicate the programme at the Conquest hospital. Mr Clayton-Smith explained that he had met many of the interns and was very proud of the work that was being undertaken. Ms Williams thanked the Board for the high level of support they gave to the Project, noting that departments in the Trust were hugely supportive.

006/2018 **Quality Walks**
Mrs Bernhauser reported that she had recently undertaken Quality Walks to Pevensey Unit and the Day Surgery Unit at EDGH. In each area she had found a great atmosphere, and patients had been very positive about the care they were receiving. The excellent teamwork of staff had been obvious, with staff happy to offer support colleagues when needed. A member of staff had raised an equipment issue which Mrs Bernhauser had escalated to the Executive team where it had been swiftly resolved.

She also visited the Community nursing service in Westfield, and had found consistency with her visits to other community teams. She explained that she had found good practice throughout the community teams, who held regular meetings with the Director of Nursing. New roles for community staff were being developed and these opportunities had been welcomed by staff. She had been impressed by manner in which nurses had expanded their roles in practice, commending them for embracing new technology which improved outcomes for patients. Concerns had been raised about the quality of links to Trust IT services, although the recent installation of a new server in Westfield had improved matters.

Mrs Bernhauser reported that a review of Quality Walks was being undertaken to ensure that they were being utilised appropriately. She noted that Quality Walks and Getting to Know You visits would be merged to prevent confusion. She praised the way in which matters that were escalated were managed by the Executive team, and noted that it was a pleasure to meet with staff during the walks.

007/2018 **Board Committees' Feedback**

1. Audit Committee

Mr Stevens reported that the Audit Committee had met on 31st January. He reported that the Board Assurance Framework had been reviewed by the Committee. The work of the Trust's Counter Fraud team had been discussed, and work was being undertaken to ensure that all staff received counter fraud training. The Trust's new external auditors, Grant Thornton, had made a presentation to the Committee and had set out their anticipated approach to auditing at ESHT.

Mr Stevens reported that requirements for General Data Protection Regulations (GDPR) which would be introduced in May 2018 had been discussed, with the Trust confident that it would be able to meet these requirements. The Out of Hospital Division and ESHT Digital had made presentations which provided assurance about their risk register and audit progress. Tenders and Waivers issued by the Trust had been reviewed to ensure that these were being issued in an appropriate fashion.

Mr Clayton-Smith asked whether the 2018/19 internal audit programme had been finalised and Mr Stevens reported that a programme of work had been agreed that would be updated during that year as new issues emerged.

2. Finance and Investment Committee

Mrs Churchward-Cardiff reported that the Finance and Investment (F&I) Committee had met on 31st January and had also held an extraordinary meeting on 17th January. She commended the work on information coding and model hospital data that had been undertaken within the Trust, anticipating that this would influence business planning for 2018/19.

Lessons learned from the implementation of ambulatory care had been reviewed, and the impact that this had had on Trust finances had been discussed. The development of the Trust's MRI service and capital programme had also been discussed.

3. People and Organisational Development Committee

Mrs Kavanagh reported that the People and Organisational Development (POD) Committee had met on 17th January and presented a summary of the meeting. She reported that the National Workforce Strategy had been discussed, explaining that work would be undertaken to ensure that this was implemented appropriately within the organisation.

An HR incident report had been presented which demonstrated that the Trust was, when appropriate, pursuing a mediation based approach in order to resolve issues at an earlier stage than had previously been the case. Trust procedures were being reviewed to soften that language that was used in order to make them less of a barrier for use.

A review of "Well Led" within the organisation had been undertaken, and Mrs Kavanagh noted that this would form a key part of the CQC's upcoming inspection. While much progress had been made, further work would be needed in order to drive continued improvement. Succession planning and talent management within the Trust had been reviewed.

The POD Committee would be meeting on a more regular basis in 2018.

4. Quality and Safety Committee

Mrs Bernhauser reported that the Quality and Safety (Q&S) Committee had met on 24th January. The Committee had undertaken a review of requirements that had arisen from the CQC's previous inspection. A renewed End of Life Care policy had been approved by the Committee.

The rating of risks within the organisation, including those on the Trust's Risk Register, had been reviewed in detail. The Trust had made good progress on improving the management of patient complaints, with timely responses now being issued as business as usual.

The Trust had seen greatly improved responses from Friends and Family tests and was now rated in the in the top third in England for responses received. Mrs Bernhauser noted that the Q&S Committee had a much improved attendance, and a refined agenda which provided additional assurance.

Mr Clayton-Smith thanked the Non-Executives for the huge amount of work that they did in chairing and attending Committees, noting the important role they played in ensuring that the Board fulfilled its responsibilities.

**The Board noted the Committee Reports.**

008/2018 **Board Assurance Framework**

Mrs Wells reported that the BAF and risk register had been recently reviewed by both the Audit and Q&S Committees. There were no additions to the BAF and no proposals to remove or change grading of gaps in control or assurance.

**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.**

009/2018 **Chief Executive's Report**

Dr Bull reported that the festive period had been one of high pressure for the organisation, with significantly more attendances at A&Es and admissions to the hospitals compared to the same period in the previous year. Despite the increases in patient numbers, the Trust had maintained a level of performance that was 10-12% better than had been seen in the previous year. The Trust's performance relative to organisations across the country had been very strong and was a real credit to the Trust's staff. Staff had maintained the values of the organisation throughout the difficult period and senior colleagues and medical leaders had been fully engaged with resolving issues.

The Trust had maintained elective activity during the winter, with very few operations having been cancelled as a result of winter pressures. He reported that over 100 patients with flu had been admitted to the organisation during the winter period, which had increased operational pressures.

Dr Bull reported that KPMG had undertaken a review of the Trust's underlying deficit for 2016/17 which had shown this to be £57m. The Trust was forecasting a deficit of £57m for 2017/18, with an underlying position of £54m. The stabilisation of the Trust's finances demonstrated the improvements in financial grip and control that had been achieved.

Dr Bull noted that the Trust had not achieved the level of financial improvement that had been realised in performance, quality and safety and anticipated that improvements would be seen in 2018/19.

Dr Bull reported that the Trust would be inspected by the CQC during March. He reported that the Secretary of State had visited the Trust during the previous week to talk to members of staff. Over 100 staff had attended and had asked Mr Hunt challenging questions about the difficulties they faced.

Mr Clayton-Smith asked about the levels of flu vaccinations for staff within the Trust and Miss Green reported that over 70% of staff had been vaccinated. Peer vaccinators had visited meetings and departments to provide vaccinations. Learning from the success of the year would be used to try to improve performance in 2018.

**QUALITY, SAFETY AND PERFORMANCE**

010/2018 **Integrated Performance Report Month 9 (December)**

Access and Responsiveness

Mrs Chadwick-Bell reported that the Trust had achieved 86.7% against the four hour clinical standard during December compared to performance of 77.6% in December 2016. The average length of stay for patients during December 2017 had reduced by a day since December 2016, while readmissions levels had improved by 1%, providing assurance that patients were being discharged appropriately.

Between 22nd December and 7th January the Trust had seen a 9% increase in attendances across the two main sites. On more than one occasion daily attendances had increased by 42% from the previous year with significant increases on other days. Non elective admissions had increased by 24% from the previous year.

Mrs Chadwick-Bell reported that the local healthcare system had found itself under significant pressure during the busy period. Partners in the system had worked closely in developing plans for the winter period which had been effective with additional capacity not being opened in the Trust until 26th December. The Trust had maintained December's performance levels during January which was a great improvement on the previous year.

Mr Clayton-Smith asked about the learning the Trust could take from the busy period in order to improve planning for 2018/19. Mrs Chadwick-Bell explained that staffing had been challenging, especially when additional capacity had been opened. The system would review how the 40% spikes in attendance could be better managed. She anticipated that further improvements to patient pathways would be realised with the introduction of primary care streaming and Acute Medical Units during 2018.

The Trust achieved 90% performance against Referral to Treatment targets in

December, compared to performance of 85.6% the previous year. The backlog of patients waiting for over 18 weeks for operations had reduced by 1,500 compared to the previous year and the Trust was working closely with the CCG to address issues of demand and capacity.

Mrs Chadwick-Bell reported that performance against cancer metrics had been good, with the exception of cancer screening where a single patient who exceeded the waiting time had resulted in performance to 62%. Performance against the 62 day cancer target had improved from November to December but remained below target. An additional member of staff was now working with the team to manage the issue and a management plan was being developed in order to improve performance.

Mr Clayton-Smith noted that limited community metrics were included within the IPR and requested that more detail be included in future IPRs. Mrs Chadwick-Bell updated that community nursing continued to work to well above capacity and that this increase was being discussed with the CCG. Activity undertaken by crisis response teams was increasing, and additional recruitment to these teams was being undertaken. She noted that between December 2016 and December 2017, the average length of stay in community hospitals had reduced by 1.6 days.

Mr Stevens asked whether administrative issues caused delays in cancer treatment and Mrs Chadwick-Bell explained that work was undertaken to minimise these avoidable breaches when they were identified. She explained that patient choice was the highest cause of breaches, followed by delays to diagnostics both inside and outside the organisation.

Mrs Churchward-Cardiff commended the improvements being realised to the urgent care pathway and hoped that the improvements could be replicated in diagnostics. She noted that two week cancer referrals had increased by 3%, and Dr Bull explained that clinical guidelines for two week referrals had changed, causing the increase. The implications of the change had been discussed by the Cancer Board and work was being undertaken with CCGs to lower the number of patients referred by GPs by clarifying correct pathways.

Quality & Safety

Ms Gardner-Blatch reported that a single way of recording mixed sex accommodation breaches had been introduced which would standardise reporting across organisations. She anticipated that this would see a change in the number of breaches being reported in the future. A nursing staff establishment review was being undertaken and would be reviewed by both the Q&S and F&I Committees prior to being presented to the Board. Three Serious Incidents had been reported during December, all of which were under investigation.

Mr Clayton-Smith asked about the reduction in patient safety incidents being reported during the year to date and Dr Bull explained that this was a result of the huge improvements seen in medical records leading to fewer reports of missing records. He emphasised that the reduction did not indicate that staff were not reporting incidents when they arose.

Mrs Churchward-Cardiff noted that falls assessment compliance had reduced during December and Ms Gardner-Blatch explained that focussed work was being undertaken, alongside the introduction of a revised falls assessment

which was expected to improve this metric.

Dr Wilkinson reported that the Trust's RAMI had reduced and that the Trust was below the national average for acute Trusts. The Trust SHMI showed a reducing trend and the Trust was no longer an outlier. He explained that Crude mortality would always be higher than national averages as this reflected the population demographic of the region. He explained that timely mortality reviews remained an area of concern, but that progress was being made.

In response to a question from Mr Clayton-Smith, Dr Wilkinson explained that the Trust's acute cerebrovascular disease index was reviewed on a regular basis and remained within the target range. He explained that the Trust's SHMI was inclusive of deaths that occurred following discharge from acute care into community care, which meant that when compared to trusts which did not provide community services, the Trust's SHMI appeared to be higher.

Leadership & Culture

Miss Green reported that substantive workforce had continued to increase, leading to a lower reliance on agency and bank staff. Increased numbers of staff had moved from agency to the staff bank and work had been undertaken to agree rates of pay for medical staff with divisions. Incentives for staff to work additional shifts on the bank were being introduced. A 2% drop in staff vacancies had been seen during the year, and medical staffing vacancy rates had reduced from 15% to 7% since July 2017.

The Trust had a turnover rate of 11.3%, which was small compared to national rates, but retention of nurses remained a national issue. Sickness had risen slightly during December and had remained static in January. Initial staff survey results demonstrated an increase in both the number and quality of appraisals being carried out.

Ms Humber reported that staff had worked extremely hard during the winter period, noting concern that the workforce was becoming tired. Dr Bull reported that an action plan was being developed to offer systematic support to nursing and HCA staff across the Trust to help relieve some of the pressure they experienced.

Mr Stevens asked about plans that were being developed to improve appraisal rates in the organisation. Miss Green explained that appraisals were discussed with divisions during their IPR meetings, and agreed to present a detailed update on progress at the next meeting of the POD Committee. **MG**

**The Board noted the IPR Report for Month 9.**

011/2018 **Mortality Learning From Deaths Policy**

Dr Wilkinson presented the quarterly Mortality Learning From Deaths report to the Board, explaining that mortality review processes had been updated to ensure that the Trust met new reporting requirements. The report showed the combined results from the old reporting system and the updated system and recorded deaths that were probably or definitely avoidable.

Concerns raised by families or carers at the time of deaths were reviewed in detail and were included within the report. Learning from deaths was shared throughout the organisation and doctors were encouraged to look at deaths in detail to ensure that the Trust could continue to improve the care offered to

patients.

Mrs Chadwick-Bell asked whether future reports could incorporate lessons learned. Dr Wilkinson explained that the format of the report was mandated, but agreed to explore if more detail could be included in the future.

Mr Clayton-Smith asked if consultants were becoming familiar with the new requirements. Dr Wilkinson explained that aspects of the new requirements had been difficult for doctors to adjust to. He anticipated that in 2019 processes would move to a more medical examiner type process to enable greater objectivity in the review of deaths.

Mrs Kavanagh asked why only 60% of reviews of deaths occurred within three months and Dr Wilkinson explained that the main issue was one of job planning to allow consultants the time to undertake reviews. He explained that job planning processes were being improved.

012/2018 **Finance and Financial Special Measures Update**

Mr Reid reported that the Trust's financial position at the end of month nine had led to the need for a formal reforecasting of the financial position for 2017/18. The reforecasting had been extensively reviewed by the F&I Committee, and had been had been discussed and agreed with NHSI.

Mr Reid reported that the Trust had planned to deliver a £36.4m deficit, before Sustainability and Transformation Funding (STF) and was now forecasting a £57.4m deficit, before STF funding. Key drivers for the changed position were the non-delivery of £6.1m of Cost Improvement Programmes (CIPs), a reduction in elective activity, cost pressures associated with drugs, clinical and supporting equipment and adverse mediation. Mr Reid noted the excellent performance of staff in delivering £22m of savings during the year.

Enhanced grip and control processes within the organisation were expected to deliver an improvement of £4.6m to the financial position during Quarter 4. Financial improvements being introduced were intended to be both realistic and sustainable in order to realise greater improvements during 2018/19. The control total that had been issued for 2018/19 was a very challenging £26.9 deficit.

Mr Reid explained that formally reforecasting the financial position would allow the Trust to draw down the full cash value of the reforecast, enabling planning for the end of the year to be undertaken in a structured fashion with a reduction in waits for creditors to be paid.

The second part of the paper set out lessons that had been learnt that could be taken forward to the following year. Mr Reid noted the significant improvements that had been seen within the organisation to quality, safety and performance during 2017/18 and explained that the Trust aimed to realise similar improvements to finances in 2018/19. He emphasised the importance of agreeing a challenging, but achievable plan for 2018/19. Mr Reid explained that detailed financial plans for 2018/19 would be presented at the following Board meeting.

Mr Clayton-Smith noted that the Board had remained fully informed about the change in the Trust's financial position. He noted that the finance team were utilising benchmarking data from model hospitals in order to improve efficiency

with the organisation as well as developing CIPs. Improvements were being undertaken in a systematic fashion, rather than in a non-sustainable manner.

Mr Stevens emphasised the importance of ensuring that the Trust's financial target for 2018/19 was realistic. Mrs Churchward-Cardiff noted her concern about the speed of progress in completing financial plans for 2018/19, noting that the new financial year was only two months away.

Dr Bull explained that the Trust had developed a medium term plan to reach a sustainable financial position in 3-5 years as not all the CIPs would realise savings in the short term. A true trajectory to becoming sustainable would be developed to give context to both short and long term financial planning.

**The Board approved the revision to the Trust Forecast for 2017/18**

013/2018 **East Sussex Better Together Progress Report**

Ms Ashton updated that the Trust continued to work closely with partners in ESBT. She explained that the Alliance Governing Board had driven system-wide work and changes which had added real value to the system wide plan that had been developed to meet winter pressures.

A self-assessment tool and review, supported by the Allied Health Science Network, on the Trust's digital roadmap had been undertaken. This had looked at interchanges between different systems and access to ensure that the flow of information between different providers worked as effectively as possible.

She reported that CCGs were undertaking a survey asking patients when they would like to have appointments with their GPs, explaining that this could help to limit inappropriate attendances in A&E, a direct benefit for the Trust.

014/2018 **Sustainability Development Management Plan Update**

Mr Paice explained that the plan being presented represented an update on the plan agreed by the Board in July 2015. It took into account a number of mandatory requirements including carbon reduction strategy. The "Care Without Carbon" model, developed by Sussex Community Foundation Trust (SCFT), had been adopted by the Trust. Mr Paice reported that the Trust had received an award for its carbon reporting in 2017, explaining that a review of processes was being undertaken to help the Trust meet mandatory requirements.

Mr Clark presented an update on sustainable development to the Board.

Mrs Churchward-Cardiff asked whether the work being undertaken within the Trust to become more sustainable was challenging enough. She asked about the targets that had been set. Mr Clark explained that the Trust's plan was a high level strategy designed to give a broad overview of sustainability. He agreed that more could be done to set specific objectives, noting that a lot of work was being undertaken at STP level to make improvements across the system, using economies of scale. Targeted work would be carried during the next 3-6 months which would lead to more specific objectives.

Mrs Kavanagh suggested that messages about key drivers could be improved with an improved focus on cost savings and health benefits to make sustainability more attractive for staff. She suggested that a Board level champion could be appointed to help drive the message, and that the message

should proliferate throughout the organisation, embodied by managers with regular communication to staff. Mr Clark reported that an annual sustainability report had been produced the previous year which set out the potential cost savings available along with how these savings could be realised. He explained that he would be happy to talk to staff about how they could change the way they worked in order to make improvements.

Mr Stevens noted that no details of a budget for making improvements had been included within the plan. Mr Clark explained that the Trust would have to invest in order to make further improvements and realise additional savings, noting the difficulty of doing this in the current financial environment. Dr Bull explained that Executives would work closely with SCFT colleagues to develop future plans for sustainability within the Trust.

**The board agreed to support the Sustainability Development Management Plan and agreed to receive updated plans in the future.**

015/2018 **Board Subcommittee Minutes**

The following sub-committee minutes were reviewed and noted:

- People and Organisational Development Committee minutes of 28th September 2017
- Quality and Safety Committee minutes of 20th September 2017 and 22nd November 2017

**The Minutes were received by the Board**

016/2018 **Use of Trust Seal**
Mrs Wells noted that the Trust Seal had been used on one occasion since the previous meeting, for a customised service proposal agreement between ESHT and British Telecommunications for an N3 managed virtual COIN provided over a five year period.

017/2018 **Questions from Members of the Public**
Mr Campbell explained that he hoped that a public meeting of the Board could take place in the future, which would allow members of the public to ask any questions they wanted. He thought it would be a valuable exercise for both the public and the Board.

Mr Campbell thanked Mr Reid for his efforts in addressing the Trust's financial issues. He asked whether the budget that would be agreed for 2018/19 would be achievable. Dr Bull replied that that the Trust was aiming to agree an achievable budget for the next year with the aim of becoming sustainable in 3-5 years' time.

Mr Campbell asked if it was possible to present financial information split between areas that the Board could control and those, such as CIPs, that the board had no control over. JR agreed that financial reports presented to the Board could be presented in a more straightforward fashion. He noted that didn't feel that it was appropriate to split the financial reporting as suggested.

018/2018 **Date of Next Meeting**

Tuesday, 17th April 2018, in Bexhill

Signed ……

Position ……..

Date ……

# East Sussex Healthcare NHS Trust

## Progress against Action Items from East Sussex Healthcare NHS Trust 6th February 2018 Trust Board Meeting

| Agenda item | Action | Lead | Progress |
|---|---|---|---|
| *010/2018 – IPR Month 9 - Leadership & Culture* | Miss Green agreed to present a detailed update on plans to improve appraisal rates at the next meeting of the POD Committee. | **MG** | Update was presented to POD Committee on 14th March 2018. |

# Speak Up Guardian's Report April 2018

| Meeting information: | | | |
|---|---|---|---|
| Date of Meeting: | 6th February 2018 | Agenda Item: | 5A |
| Meeting: | Trust Board | Reporting Officer: | Ruth Agg |

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

| Has this paper considered: (Please tick) | | | |
|---|---|---|---|
| **Key stakeholders:** | | **Compliance with:** | |
| Patients | ☒ | Equality, diversity and human rights | ☒ |
| Staff | ☒ | Regulation (CQC, NHSi/CCG) | ☒ |
| | | Legal frameworks (NHS Constitution/HSE) | ☐ |
| **Other stakeholders** please state: | ..... | | |
| Have any risks been identified ☐<br>*(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

"Every organisation needs to foster a culture of safety and learning in which all staff feel safe to raise a concern… We need to get away from the culture of blame, and the fear that it generates, to one which celebrates openness and commitment to safety and improvement"
*Robert Francis QC*

The Freedom to Speak Up Guardian has now been in post at ESHT for two years. The role is now fully embedded within the organisation, there is continued learning shared with staff and the Trust Board have fully supported the role. The role supports all staff within the organisation and the increasing number of contacts received by the Freedom to Speak Up Guardian provides assurance that staff feel able to contact her when necessary.

ESHT staff are supported to raise and share concerns without fear of reprisal. Inductions for new staff and mandatory training include information about the Freedom to Speak Up Guardian, how staff can raise concerns and the support that is available to staff along with how to access this. Training is being developed for managers and leaders within the organisation to ensure that they are able to appropriately manage and support any concerns raised by members of staff.

**CURRENT WORK BY SPEAK UP GUARDIAN**

- Continued review of Datix incidents relating to behaviour/conduct/culture/bullying and harassment. This is undertaken alongside HR to ensure robust investigation and review of incidents is carried out and fedback to staff. Checks are also undertaken to ensure that staff wellbeing is supported by the organisation.
- Datix and Freedom to Speak up: Raising concerns policy newsletter circulated to staff.
- Patient safety concern regarding a collapse in a reception area prompted a "Collapse Protocol" relaunch with the Resuscitation Lead visiting Reception areas at EDGH, Conquest, Bexhill and Irvine Unit.

- New Violence and Aggression Poster.
- Undertaken Train the Trainers course with the National Guardian Office.
- ESHT Vine Thank you events and expressions of interest for Ambassador Role for Freedom to Speak up planned.
- Ongoing face to face support for staff across sites
- Attendance at team meetings, and training events (Recent embedded learning event by OOH)
- Interview with CQC during recent Well-Led inspection
- New Freedom to Speak up Guardian Job Description issued by National Guardian office. Current local Job Description to be reviewed with Dr Adrian Bull. http://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf
- Recent case review by National Office (Northern Lincolnshire and Goole NHS Foundation Trust) to benchmark ESHT against the 23 Recommendations. http://www.cqc.org.uk/sites/default/files/20180131_ngo_nlinconshire_goole.pdf
- Work underway to implement training for Management and Leadership courses to cover how to respond to concerns including bullying and harassment.

**Speak Up Guardian Log for 2017/18 Quarters 3 and 4 – Categories**

| Categories | Quarter 3 | Quarter 4 |
|---|---|---|
| Behavioural / Relationship | 18 | 29 |
| Bullying / Harassment | 18 | 20 |
| Leadership | 2 | 0 |
| Patient Safety / Quality | 13 | 8 |
| Cultural | 0 | 1 |
| Middle Management Issue | 0 | 2 |
| Senior Management Issue | 0 | 1 |
| Reprisal | 1 | 0 |
| Staff Safety | 2 | 1 |
| System / Process | 20 | 23 |
| **Total** | 74 | 85 |

**Bullying and Harassment update from staff survey**

- KF27 Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse is above the National average (47%) It is 50% at ESHT which provides evidence that staff are confident about raising concerns about bullying and harassment.

  In 2016, 48% of staff reported against a national average of 45%, while in 2015 only 37% of ESHT staff reported incidents.

  **Action:** Continued monitoring of incidents in relation to bullying and harassment. Support will be provided to staff to ensure continued confidence in reporting issues.

- KF26 Bullying remains at the same level as 2016 at 27% which is above the National Average (the National average is up to 24%, from 23% last year). In 2015 32% of staff reported bullying and harassment.

  **Action:** We are awaiting drilled down data to identify any trends or areas that require additional support with culture or behaviours. We will continue to address concerns and to provide training and support for all staff in order to reduce incidences of bullying at ESHT.

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

None.

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

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

# East Sussex Healthcare NHS Trust

## Audit Committee

**1. Introduction**
An Audit Committee was held on 31st March 2018, but as the final minutes have not yet been approved a summary of the items discussed at the meeting is set out below.

**2. Board Assurance Framework and High Level Risk Register**
The Board Assurance Framework and High Level Risk Register were presented having previously been reviewed by the Quality & Standards Committee. Proposals for revisions to ratings around Emergency Department Reconfiguration, Patient Flow, Mandatory Training/Appraisal Compliance and Developing and Supporting Clinical Leadership were discussed. A Board seminar session to review the BAF would be arranged in the future.

**3. Urgent Care - Clinical Audit and Risk Register Review**
The division reported that their highest risk related to consultant and middle grade vacancies, with long term locums in place to address the issue and robust plans for future recruitment developed.

**4. Clinical Audit Update**
The Clinical Audit Forward plan for 2018/19 was presented and approved by the Committee. The Trust would be undertaking sixty nationally mandated audits in 2018/19 alongside appropriate local audits.

**5. Internal Audit Progress Report**
There had been four final audit reports issued. Three had given "Limited" assurance and one had provided "Reasonable" assurance. The internal audit plan for 2018/19 was discussed and it was agreed that, following discussion with Trust Executives, a revised plan would be presented for approval at the next meeting of the Audit Committee.

**6. Local Counter Fraud Service Progress Report**
Local Counter Fraud had recently completed an annual self-review, and had received a 'green' rating. The annual work plan for 2018/19 was due to be presented for approval to the next meeting of the Audit Committee, following approval by Trust Executives.

**7. External Audit Progress Report**
The External Audit plan for 2018/19 was presented to the Committee.

**8. Information Governance Toolkit Report and Registration Authority Report**
The Trust's Information Governance Toolkit was due to be submitted on 31st march 2018, with an expected score of 72%. For 2018/1 the IGT would be replaced by the Data Security and Protection Toolkit which was more closely aligned with new data protection regulations.

An update on progress in meeting General Data Protection Regulation was provided, and it was noted that full compliance with the regulations was included on the Trust's Risk register.

**9. Annual Review of Board Effectiveness**
Committee members were asked to complete an annual review of effectiveness.

**Mike Stevens**
**Chair of Audit Committee**

6th April 2018

**East Sussex Healthcare NHS Trust**

**People & Organisational Development (POD) Committee**

## 1. Introduction

Since the Board last met a POD Committee meeting was held on 14th March 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. Staff Survey – Presentation of 2017 results

The Committee received a presentation from Charlie Bosher, Senior Consultant Quality Health, outlining the Staff Survey results for the Trust. There had been an overall improvement in both the response rate and feedback from staff. The Trust is compared nationally to other similar Trusts and has improved its position within this comparator group. It was noted that there had been a significant improvement in the staff appraised and that the Trust was within top 4 Trusts and an improvement in recognition and value of staff by managers.

It was agreed that the results would be shared with each Division who would, in turn share them with staff and work with staff in developing subsequent action plans. The top three priorities for action across the whole trust would also be identified as it can be evidenced that when there is such targeted action this results in improved results.

## 4. Response to draft health and Care Workforce Strategy

Monica Green reported that the strategy had been discussed at various meetings and staff groups and highlighted that the format of the response was prescriptive; only comments could be added and those detailed had been collated from all different groups that had been involved. MG asked for any further comments or suggestions prior to the submission deadline of 23rd March 2018. Covering letter to be written and response to be published on ESHT website with a link to the draft strategy.

## 5. Appraisal Rates

The Committee received a presentation from Dawn Urquhart outlining the appraisal process and the different levels of information supplied to managers about compliance.

It was noted that the Staff Survey indicated that there had been a significant improvement in appraisals; one of the top performing Trusts. Staff had reported favourably regarding the quality of appraisals, which had included the Trust organisational values.

Those areas with lower compliance rates would be targeted for action and an escalation process put in place

## 6. The Nursing Workforce

The Nursing Workforce paper had been circulated for information. This National Report from the House of Commons Health Committee reviewed the position of the nursing workforce within England focusing on the NHS.

It was highlighted that more fundamental challenges to the nurse training model and nursing workforce report were required. It was agreed that a full strategy of supporting nurses in the workforce should be built into next year's plan.

7. **Physicians Associates**
The Committee received a presentation from Dawn Urquhart explaining the work being undertaken on implementing the Physicians Associates role within the Trust. The Physicians Associates compliment the role of doctors and nurses in supporting them to manage patient care, undertake assessments as well as day to day clinical tasks. The Royal College of Physicians had requested a decision to be made for them to prescribe.

**8. 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.

Leadership/Management Pathway Summary
Lorraine Mason gave an overview of the summary and highlighted key areas: Leading Service and Leading Excellence programmes had been evaluated, Management Essentials included a new manager's orientation programme and a buddy programme for junior doctors to be introduced.

Approved minutes of the meeting held on 17th January 2018 are attached for the Board's information.

**Miranda Kavanagh**
**Chair of POD Committee**

14th March 2018

# Quality and Safety Committee

1. **Introduction**
   Since the Board last met a Quality & Safety Committee meeting was held on 21 March 2018 and minutes are due to be approved at the next meeting on 18 May 2018. A summary of the items discussed at the meeting is set out below.

2. **Patient Story**
   The learning from the following RCAs were discussed:
   - Serious Incident relating to a fall
   - Never Event relating to hip surgery.

3. **Board Assurance Framework**
   Key points
   - Agreed to remove Emergency Department Reconfiguration risk as effective controls in place.
   - Agreed to remove Patient Flow risk as had moved from amber to green and being monitored elsewhere.

   **High Level Risk Register**
   The risks were looked at line by line, it was agreed that a number needed review and the following downgrades were agreed to be recommended to the Board:
   - 1502 – Non-compliance with 4 hour Waiting Time Standard and delay in the provision of optimal care
   - 1642 – Management of the Trust when it is at Full Capacity.

4. **ESHT 2020 Improvement Programme**
   This would be refreshed in June 2018 when a full set of data would be available.

5. **Improvement Group Exception Report**
   Work was progressing and a 2nd improvement forum was being planned and would take place at the Conquest site.

6. **Governance Quality Reports**
   - Falls work had led to a reduction in falls.
   - Medicine incidents noted and need for Deep Dive.
   - New guidance for Never Events had been published.
   - Discussion around how to support the Divisions (particularly Medicine and DAS) to follow up on actions.
   - Ongoing work to improve ED Friends and Family Test response rates.

7. **Risk and Quality Delivery Strategy**
   - Strategy had been reviewed and was endorsed.
   - Ongoing piece of work (Director of Nursing and Director of Strategy) to align various strategies in the Trust.

8. **External Visits and Reviews**
   - Audiology accreditation obtained.
   - JAG conditional accreditation but with very good feedback.

9. **Independent Review of Theatres Operation - Action Plan**
   - Action plan noted and update to go to next IPR meeting.

10. **IPR Month 10 – Quality and Safety**
    - Change to monitoring and reporting of SSA breaches.

11. **Maternity Strategy**
    - Strategy noted and Director of Strategy would support the Division in the further development of the strategy.

12. **ESHT Staff Survey 2017 – Results**
    - Paper due to be presented to Trust Board to feedback.
    - Staff concerns over raising clinical concerns to be on the agenda of the next meeting for discussion.

**Sue Bernhauser, Chair, Quality and Safety Committee**
9 April 2018

# Board Assurance Framework

| Meeting information: | | | |
|---|---|---|---|
| Date of Meeting: | 17th April 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 ☐<br>*(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 the high level risk register which documents those risks scored 15 and above.

BAF
Updates to the BAF are shown in red. The Committee is asked to consider the following:

- 2.1.2 Emergency Department Reconfiguration – revision of rating amber to green and proposal to recommend to Board that it is removed from BAF as effective controls in place.
- 2.1.3 Patient Flow – revision of rating amber to green as robust controls in place. COO requesting review at Q&S as to status on BAF as this will remain a challenge, but no specific gaps in controls.
- 2.2.1 Mandatory training/appraisal compliance – improved and sustained compliance in both areas. Consider recommending removal from BAF.
- 2.2.2 Developing and supporting clinical leadership - proposal to recommend to Board that it is removed from BAF as no longer a gap in assurance.

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

Quality and Safety Committee – 21st March 2018
Audit Committee – 28th March 2018

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

The Trust Board is asked to review and note the revised Board Assurance Framework and consider whether the main inherent/residual risks have been identified and that actions are appropriate to manage the risks. In addition, the Trust Board is asked to consider the proposals to remove items from the BAF.

| | |
|---|---|
| | **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.<br>Review and responding to internal and external reviews, national guidance and best practice.<br>Feedback and implementation of action following "quality walks" and assurance visits.<br>Reinforcement of required standards of patient documentation and review of policies and procedures<br>Accountability agreed and known eg HN, ward matrons, clinical leads.<br>Annual review of Committee structure and terms of reference<br>Effective processes in place to manage and monitor safe staffing levels<br>PMO function supporting quality improvement programme<br>iFIT introduced to track and monitor health records<br>EDM implementation plan being developed<br>Comprehensive quality improvement plan in place with forward trajectory of progress against actions. |
| **Positive assurances** | Internal audit reports on governance systems and processes<br>Weekly audits/peer reviews eg observations of practice<br>Monthly reviews of data with each CU<br>'Quality walks' programme in place and forms part of Board objectives<br>External visits register outcomes and actions reviewed by Quality and Standards Committee<br>Financial Reporting in line with statutory requirements and Audit Committee independently meets with auditors<br>Deep dives into QIP areas such as staff engagement, mortality and medicines management<br>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.<br>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.<br>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.<br>Jan-17 Draft report expected this month<br>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.<br>May-17 Good progress in implementing CQC actions. Mock inspections planned for May-17<br>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.<br>Sep-17 QIP with focus on programmes of work. 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<br>Nov-17 Inspection anticipated early 2018. Tracker being strengthened and prep group meeting. Community mock planned for Nov.<br>Jan-18 Ongoing preparation for inspection. CQC information request completed Dec 2018. CQC first focus groups also taken place.<br>Mar-18 CQC inspection 6/7 March core services and 20/21 Mar Well Led, expect draft reports by end of May | end May-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:<br>Monthly performance meeting with clinical units<br>Clear ownership of individual targets/priorities<br>Daily performance reports<br>Effective communication channels with commissioners and stakeholders<br>Healthcare Associated Infection (HCAI) monitoring and Root Cause Analysis<br>Single Sex Accommodation (SSA) processes and monitoring<br>Regular audit of cleaning standards<br>Business Continuity and Major Incident Plans<br>Reviewing and responding to national reports and guidance<br>Cleaning controls in place and hand hygiene audited. Bare below the elbow policy in place<br>Monthly audit of national cleaning standards<br>Root Cause Analysis undertaken for all IC outbreaks and SIs and shared learning through governance structure<br>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.<br>Exception reporting on areas requiring Board/high level review<br>Dr Foster/CHKS HSMR/SHMI/RAMI data<br>Performance delivery plan in place<br>Accreditation and peer review visits<br>Level two of Information Governance Toolkit<br>External/Internal Audit reports and opinion<br>Patient Safety Thermometer<br>Cancer - all tumour groups implementing actions following peer review of IOG compliance.<br>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 supplementing KSS Cancer network work on pathway management. Focused work to improve 2 week wait (2WW) position<br>Jul-16 - Nov 16 Achieved 2WW and 31 day standard for quarter. Clinically led Cancer Partnership Board commenced June . Cancer Action Plan providing continued improvements such as the reduction on 2WW triage delays. Nurse Advisor commenced Oct 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 CCGs for specialist endobronchial ultrasound local provision<br>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.<br>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.<br>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<br>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.<br>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.<br>Mar-18 – 62 day performance remains a challenge, on-going operational improvement work, capacity and demand and pathway analysis and improvement. Operational cancer board established and service managers to be prioritised to focus on cancer, with financial and RTT. Remains amber due to 62 day performance delivery. | end-May 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. | Jul-16 - Dec 16 Meet SECAMB monthly to review on going issues and joint working to resolve. Action plan and escalation process in place<br>Capital bid with TDA for review to support expansion; outcome awaited, planning permission being sought in advance. Trust prioritising reconfigurations from own capital programme to support effective patient pathways and address privacy and dignity issues. Urgent Care Programme Board established. Multi-disciplinary summit being planned to further support improved patient flow. Number of improvements being implemented in A&E although some not fully introduced due to staffing and space concerns, particularly at Conquest site.<br>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.<br>Jul-17 Project in place streaming redevelopment commencing to be in place by Oct 17<br>Sep-17 Building work commenced at DGH for ambulatory care.<br>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.<br>Jan-18 New builds at both 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 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. Medical Ambulatory unit opened at DGH in Dec, offering additional space to increase activity and offer improved privacy and dignity. Similar unit 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.<br>Mar-18 – Suggest remove from BAF as effective controls in place. Both units have physical capacity to ambulance handover areas (requires dedicated staffing). Paediatric areas in place on both sites. On-going scoping to develop the units to accommodate urgent treatment centres and co-locate SPAUs. Actions above include the development of the AEC (DGH in place, CQ plans for delivery by autumn), which support flow, but not specifically part of the EDs. | end-Mar 18 | ▲<br>Mar-18 | 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. | 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.<br><br>May-Jul 17 Achievement of key constitutional targets and trajectories remains challenging however, performance is improving . 4 week improvement challenge started June with 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 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.<br><br>Sept-Nov 17 A&E Attendance increased by 6.9% year to date. A&E performance 87.7% July, and improved to 92.5% in August. Reduction in delayed transfers of care and continued improvement in ED performance Oct 92% Systemwide winter plan in place.<br><br>Jan-18 Urgent care and patient flow programme re-scoped for 2018, building on the existing work. DToCS reduced by approx 7%, with NEL LOS reducing by 0.9 days. Benefits seen through increased performance of 4 hour standard, which improved from 82.5% in Nov 16 to 94.1% in Nov 17, despite increase in attendances and admissions. Start of winter has been challenging but flow through department has been sustained at a 10% improvement on previous year.<br><br>Mar-18 – as for Jan 18. DTOC and LOS performance sustained. Renewed focus on SAFER and working with partners to reduce medically fit and stranded patients. Controls in place to manage on-going risk associated with increased demand. New LOS targets, refreshed plan, continue to work with the system, stranded patient review weekly, enhanced bi weekly discharge control etc. Request review at next Quality and Safety as to status on BAF as this will remain a challenge, but no specific gaps in controls. | end Mar-18 | ▲<br>Mar-18 | 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. | Training requested from mental health team at CAMHS for ward nurses to ensure a competent and confident workforce. Liaising with SPT and commissioners re purchasing adequate tier 4 beds. Continued working with CAMHS and SPT to develop pathway.<br><br>May-16- Sep 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. 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. Improving system CAMHs Liaison nurse available every day. Some inappropriate admissions still but these are individually reviewed.<br>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<br>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.<br>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<br>Sep-17 - Meeting arranged end Sept to review issues. Audit of children admitted to the paediatric ward with mental health diagnosis commenced.<br>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<br>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 children require a hospital bed until the assessment is undertaken. Initial meeting with CAMHS and another planned Feb.<br>Mar-18 Met CAMHS Feb and shared results audit. Acknowledged mental health nurse support 09h00 – 17h00 is useful and should remain but that there is a need for this cover into the evening. Trust to provide numbers of children presenting at ED after 16h00 needing this input to CAMHS who will then put together a business case for extended cover. | end May-18 | ◄► | COO | SLF<br>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.<br>Local systems in place but require Trust wide system for monitoring and analysis. Liaising with supplier regarding options for reporting.<br>May-17 Position resolved with community paediatrics due to data transition to Systm One. Ongoing discussion to find Trustwide solution.<br>Jul-17 All doctors validating Follow Up waiting lists and telephone Follow Ups now taking place. Longest waiter 36 weeks.<br>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<br>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.<br>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.<br>Mar-18 PAS team commenced work on e-follow up database and aim to complete this by end May 18. In the meantime. the Clinical Admin service continues to appoint at requested time and where unable to do so highlights this information to the service managers on a weekly basis. | end May-18 | ◄► | COO | SLF<br>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<br>Clinicians engaged with clinical strategy and lead on implementation<br>Job planning aligned to Trust aims and objectives<br>Membership of SLF involves Clinical Unit leads<br>Appraisal and revalidation process<br>Implementation of Organisational Development Strategy and Workforce Strategy<br>National Leadership and First Line Managers Programmes<br>Staff engagement programme<br>Regular leadership meetings<br>Succession Planning<br>Mandatory training passport and e-assessments to support competency based local training<br>Additional mandatory sessions and bespoke training on request |
| **Positive assurances** | Effective governance structure in place<br>Evidence based assurance process to test cases for change in place and developed in clinical strategy<br>Clinical engagement events taking place<br>Clinical Forum being developed<br>Clinical Units fully involved in developing business plans<br>Training and support for those clinicians taking part in consultation and reconfiguration.<br>Outcome of monitoring of safety and performance of reconfigured services to identify unintended consequences<br>Personal Development Plans in place<br>Significant and sustained improvement in appraisal and mandatory training rates |

| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
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| 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<br>Review being undertaken to address compliance and quality of appraisal.<br><br>Jan-Nov 17 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.<br>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; continued work with managers to maintain levels where possible. Highlighting drop in sessions, e-learning and workbooks for quick updates in many subjects.<br><br>Jan-18 Mandatory Training 88.2% Appraisals 81.3% (Dec data). Targeted intervention continues for areas requiring support. Reviewing Workforce Business metrics to ensure robust, 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.<br><br>Mar-18- Mandatory Training Compliance 88.7% Appraisal training deep dive completed and presented to POD. Governance processes reviewed. Reviewing education services to identify gaps in provision and find solutions through better use of existing resources. Inductions/refresher days Task and Finish Group met in Feb/Mar- proposal to combine HCA and Clinical Induction to 3-3.5 days has been mapped. PID completed to reflect possible savings a reduction in Induction programme may deliver. Revised proposed programme to be shared with Subject Matter experts and will follow Trust Approval processes to secure a pilot to commence end of Apr-18<br><br>Appraisal data currently at 81.3%, National Survey results indicate Trust has significantly improved on 2016 data measured against comparator organisations however more work needs to be done on securing additional resources which will be undertaken as part of educational service review and will not involve additional income request. Escalation processes are not robust and do not support enhancing the compliance data- this will be improved as part of the quality assurance/management agenda. | end Mar-18 | ◄► Mar-16 | HRD | POD<br>SLF |

| Gaps in Control (C) or Assurance (A): | | | Actions: | Date/ milestone | RAG | Lead | Monitoring Group |
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| 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.<br>Sept-16 New Medical Director in post, progressing appointments of Chiefs and deputies.<br>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.<br>Jan-17 Final FMLM training end of Jan. All Chiefs now appointed, including Women's and Children. Specialist leads advertised.<br>Mar-17 Most speciality leads now appointed. Job planning training to follow. Other training possibilities arranged eg for “case investigation”<br>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.<br>Jul-17 Cohort 1 of Leading excellence programme identified and invited to attend first programme commencing in August<br>Sep-17 The first Cohort for Leading service programme has been identified and will commence in October.<br>The pilot for the new managers induction programme will take place in September.<br>A stakeholder event is being held in September to discuss the new Leadership and talent management strategy<br>Nov-17 Leading excellence course progressing, good feedback received. Propose move to green.<br><br>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.<br><br>Mar-18 Evaluation of refreshed Leadership Briefings for top 160 leaders very positive and will help cascade key information through the organisation. 16 new managers attended New Managers orientation – there will be regular contact with these managers in their first year in post. 54 managers have almost completed Leading Service and leading excellence . formal evaluation being carried out through Kingston University .Further 58 are just about to start the next round of these programmes Trust is working with colleagues across the system to develop joint opportunities for Talent Management and Leadership development.<br><br>Propose remove from BAF as sufficient assurance in place | 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.**

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| **Key controls** | Develop effective relationships with commissioners and regulators<br>Proactive engagement in STP and ESBT<br>Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work.<br>Relationship with and reporting to HOSC<br>Programme of meetings with key partners and stakeholders<br>Develop and embed key strategies that underpin the Integrated Business Plan (IBP)<br>Clinical Strategy, Workforce Strategy, IT Strategy, Estates Strategy and Organisational Development Strategy<br>Effective business planning process |
| **Positive assurances** | Trust participates in Sussex wide networks e.g. stroke, cardio, pathology.<br>Monthly performance and senior management meetings with CCG and TDA.<br>Working with clinical commissioning exec via East Sussex Better Together and Challenged Health Economy to identify priorities/strategic aims.<br>Board to Board meetings with stakeholders.<br>Membership of local Health Economy Boards and working groups<br>Two year integrated business plan in place<br>Stakeholder engagement in developing plans<br>Service delivery model in place<br>Refreshing clinical strategy to ensure continued sustainable model of care in place<br>Trust fully engaged with SPT and ESBT programmes |

| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
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| 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-Jun 17 Continuing to work with 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. STP Programme Board 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.<br>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 to review pathology provision along with other acute services.<br><br>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.<br><br>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<br><br>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<br><br>Mar-18 2018/19 plans being finalised for sign off later in the month. Trust budgets and CIP plans will then be aligned with the system-wide budgets through the ESBT Alliance Executive. The Trust is still working on a long term financial plan that will align with the transformation plan for clinical and financial sustainability which we are preparing and expect to be completed at the end of June 2018. | end June-18 | ◄► | DS | F&I<br>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.**

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| **Key controls** | Development of communications strategy<br>Governance processes support and evidence organisational learning when things go wrong<br>Quality Governance Framework and quality dashboard.<br>Risk assessments<br>Complaint and incident monitoring and shared learning<br>Robust complaints process in place that supports early local resolution<br>External, internal and clinical audit programmes in place<br>Equality strategy and equality impact assessments |
| **Positive assurances** | Integrated performance report that links performance to Board agreed outcomes, aims and objectives.<br>Board receives clear perspective on all aspect of organisation performance and progress towards achieving Trust objectives.<br>Friends and Family feedback and national benchmarking<br>Healthwatch reviews, PLACE audits and patient surveys<br>Dr Foster/CHKS/HSMR/SHMI/RAMI data<br>Audit opinion and reports and external reviews eg Royal College reviews<br>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<br><br>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.<br><br>Nov-17 Project initiation document being progressed will be considered by 7 day steering group.<br><br>Jan-18 PID agreed by 7DS steering group. All divisions incorporating 7DS needs into their 2018-19 business planning.<br>Standard 2 New MAU post-take round proforma agreed and incorporated in IPD. Includes ceilings of care and stratification.<br>Work ongoing on recruiting additional AMU consultants. Intermittent weekend additional AMU consultant cover at both acute hospital sites.<br>Standard 5 Guidance for clinical staff on accessing investigations nearly complete. Will be available on intranet and entry points.<br>Standard 6 Work ongoing on changes to GIM rotas to support 24/7 GI bleeding service. Will require changes to consultant job plans<br>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.<br><br>Mar-18 Continuing Support provided by NHSE Programme Lead. Liaison with neighbouring Trusts (MTW, EKH). Admission documentation updated to facilitate recording of clinical reviews. Work ongoing on formal prioritisation of inpatient acuity and delegation of review.<br>Project team visited EKH to investigate functionality of CareFlow as tool for effective medical handover, and for tailored review lists. Careflow scheduled to start roll-out in Q1 2018-19. Guide to accessing investigations and interventions within Trust and with external providers is nearly complete. Divisions assessing additional staffing requirements to support 7DS access to immediate and urgent investigations (particularly cardiac imaging and ultrasound); incorporating this into business planning 2018-19 and 2019-20. | end Apr-18 | ◄► Jul-17 | COO | SLF<br>Q&S |

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| **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<br>QIPP delivery managed through Trust governance structures aligned to clinical strategy.<br>Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work<br>Modelling of impact of service changes and consequences<br>Monthly monitoring of income and expenditure<br>Accountability reviews in place<br>PBR contract in place<br>Activity and delivery of CIPs regularly managed and monitored. | | | | | | |
| **Positive assurances** | Trust participates in Sussex wide networks e.g. stroke, cardio, pathology.<br>Written reports to SLF on progress with QIPP targets to ensure improvements in patient outcomes are planned and co-ordinated.<br>Performance reviewed weekly by CLT and considered at Board level. Evidence that actions agreed and monitored.<br>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. | Nov-17 – Month 6 Trust 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.<br><br>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.<br><br>Mar-17 – confirmed forecast from Jan 2018 at £257.4m is on track for delivery, with the key commissioning disputes resolved, and focus is now on the development of a robust plan for 2018/19. Following agreement of the financial plan for 2018/19, the risks to delivery will need to be reflected on the refreshed BAF. A key risk arising from the financial position in 2017/18 has now lessened, with the receipt of a £20m drawdown of cash in February 2018 reflecting the movement in the forecast. This will ensure that supplier debts are reduced, which will reduce the clinical and operational risks arising from creditor pressures. The Trust is now working on a robust, stretching but deliverable plan for 2018/19, with all proposed savings reviewed through the QIA process, and with appropriate risk management arrangements in place. | 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.**

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

| Gaps in Control (C) or Assurance (A): | | | Actions: | Date/ milestone | RAG | Lead | Monitoring Group |
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| 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 capital plan forecast remains under 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. 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.<br>Nov-17 – Month 6 Trust 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 Oct and Nov 17, 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.<br>Jan-18 – Month 9 the Trust 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 undertaking full review of remaining capital expenditure in Q4, to 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 F&I.<br><br>Mar-18 – Overall capital plan for year will be on budget; budget has increased from £11m to £15m as a result of successful capital bids by clinical and operational leaders across the Trust. Work commenced on the development of the 2018/19 capital plan with a broadly-based prioritisation process. At the same time, the Trust has to finalise the five year capital plan. Key risks include overall financing for the capital programme, and the early finalisation of the fire strategy business case – both of which will be presented in outline to the Mar F&I | 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 as unable to decant wards and asbestos issues. Fire doors replaced and Stairs wells upgraded. EDGH Compartment project 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<br>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.<br>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.<br>Mar-18 Seaford and Hailsham areas surveyed and reports and plans produced. Survey identified fire walls in areas previously thought to be deficient of them. The walls roughly reflect Ward areas. Surveys have been commissioned to identify the breaches and pictorial evidence sourced. ESFRS visited early Feb-18 to check on progress. advised that breaches in both areas will be rectified by the end of May 2018. As there has been a reduction in risk the opportunity for an enforcement notice has decreased but is still being considered. Business case for investment to introduce new smaller fire compartments at EDGH will be presented to the F&I committee in Mar-18. | end May-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.** | |
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| **Key controls** | Horizon scanning by Executive team, Board and Business Planning team.<br>Board seminars and development programme<br>Robust governance arrangements to support Board assurance and decision making.<br>Trust is member of FTN network<br>Review of national reports<br>Clear process for handling tenders/gathering business intelligence and mobilisation or demobilisation of resources<br>Participating in system wide development through STP and ESBT Alliance<br>Strategy team monitoring and responding to relevant tender exercises<br>Anti-virus and Anti-malware software<br>Client and server patching<br>NHS Digital CareCert notifications<br>Information Governance Toolkit |
| **Positive assurances** | Policy documents and Board reporting reflect external policy<br>Strategic development plans reflect external policy.<br>Board seminar programme in place<br>Business planning team established<br>SESCSG Sussex and East Surrey Cyber Security Group |

| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
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| 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<br>Staff Training - Phishing Simulation software<br>Formal information security certification for internally provided digital services<br><br>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.<br><br>Mar-18 Ongoing development and implementation of action plan, progress presented to IG Steering Group. Phishing simulation being undertaken. | end Sept-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.**

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

| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
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| 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-Jun 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 appointable from Aug-18. Recruitment hotspots identified and regular vacancy review and action plans to address priority vacancies. R&R Policies examined to address turnover and attraction issues. 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. 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.<br><br>Jul-Nov17 Recruitment Incentives developed to attract 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. Developing new roles. Workforce reviews and planning sessions linked to business planning. Discussions with external Recruitment Agencies to assist with recruiting 50 most difficult to recruit medical posts. Ongoing International Nurse recruitment -16 candidates to join between Dec 2017 and April 18. UK student nurse recruitment event -21 candidates confirmed. Workforce meeting with Nursing to agree future recruitment plans. Continued social media activity to drive candidate traffic to Trust website. Targeted activity around ED vacancies.<br><br>Jan-18 Hard to recruit vacancies identified with Medacs Agency who are assisting the Trust in a targeted approach to sourcing candidates. Medacs will also be targeted with AHP difficult to recruit vacancies. Overseas nurse recruitment continues with c16 candidates due to arrive Apr-18. Planned attendance at nurse/medical recruitment events in 2018. Out Of Hospital recruitment campaign commenced, 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.<br><br>Mar-18 Medacs recruitment agency on site Apr-18; issued with list of difficult to recruit medical posts and will have exclusivity on these vacancies for 4 weeks. Medacs tasked with creating pipeline of candidates for these posts. Since Apr-17 vacancies reduced in all staff groups excluding nursing. % of nursing vacancies relatively constant at 10%. Recruitment strategy for nurses widened to include return to practice; offering OSCE assistant to overseas nurses already in UK. Launching return to Trust project for nursing leavers. Monthly Divisional meetings to review vacancies versus establishment. From Mar-18 new starters will be offered the opportunity to auto-enrol on the bank. Workforce Resourcing Group being established which will develop a longer term strategy to meet workforce requirements, taking into account the age profile of the population and will look at new roles and skill mix to meet patient demand. Work continues on driving roster efficiency and job planning. | end Jul-18 | ◄► | 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.**

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

| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
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| 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 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<br><br>Jul-17 - Sept 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. Renewed focus on medical engagement .Consultants and SAS doctors asked their views on their experience of working 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 results are positive but we are investigating further how we are involving staff in decisions.<br><br>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<br><br>Jan-18 National staff survey response rate 49% - 3% above national average and 4% improvement on last year. Survey results will be published in early Mar18. Results of The Medical engagement score have been published and shared with a great improvement in all areas.<br><br>Mar-18 National Staff survey results published: • 11 key findings significantly better than average • 6 key findings significantly worse than average • 5 key findings shown significant improvement since 2016 • O key findings shown significant decline since 2016<br>All results will be shared with each division and Corporate priorities agreed at People and Organisational Development Committee in March 2018 and then shared more widely in the trust | end May-18 | ◄► | HRD | POD<br>SLF |

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| | **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. |

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

| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/milestone** | **RAG** | **Lead** | **Monitoring Group** |
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| 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.<br>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.<br>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.<br>Jan-17 Draft report expected this month<br>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.<br>May-17 Good progress in implementing CQC actions. Mock inspections planned for May-17<br>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.<br>Sep-17 QIP with focus on programmes of work. 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<br>Nov-17 Inspection anticipated early 2018. Tracker being strengthened and prep group meeting. Community mock planned for Nov.<br>Jan-18 Ongoing preparation for inspection. CQC information request completed Dec 2018. CQC first focus groups also taken place.<br>Mar-18 CQC inspection 6/7 March core services and 20/21 Mar Well Led, expect draft reports by end of May | end May-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.**

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| **Key controls** | Robust monitoring of performance and any necessary contingency plans. Including:<br>Monthly performance meeting with clinical units<br>Clear ownership of individual targets/priorities<br>Daily performance reports<br>Effective communication channels with commissioners and stakeholders<br>Healthcare Associated Infection (HCAI) monitoring and Root Cause Analysis<br>Single Sex Accommodation (SSA) processes and monitoring<br>Regular audit of cleaning standards<br>Business Continuity and Major Incident Plans<br>Reviewing and responding to national reports and guidance<br>Cleaning controls in place and hand hygiene audited. Bare below the elbow policy in place<br>Monthly audit of national cleaning standards<br>Root Cause Analysis undertaken for all IC outbreaks and SIs and shared learning through governance structure<br>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.<br>Exception reporting on areas requiring Board/high level review<br>Dr Foster/CHKS HSMR/SHMI/RAMI data<br>Performance delivery plan in place<br>Accreditation and peer review visits<br>Level two of Information Governance Toolkit<br>External/Internal Audit reports and opinion<br>Patient Safety Thermometer<br>Cancer - all tumour groups implementing actions following peer review of IOG compliance.<br>Consistent achievement of 2WW and 31 day cancer metrics |

| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
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| 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 supplementing KSS Cancer network work on pathway management. Focused work to improve 2 week wait (2WW) position<br>Jul-16 - Nov 16 Achieved 2WW and 31 day standard for quarter. Clinically led Cancer Partnership Board commenced June . Cancer Action Plan providing continued improvements such as the reduction on 2WW triage delays. Nurse Advisor commenced Oct 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 CCGs for specialist endobronchial ultrasound local provision<br>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.<br>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.<br>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<br>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.<br>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.<br>Mar-18 – 62 day performance remains a challenge, on-going operational improvement work, capacity and demand and pathway analysis and improvement. Operational cancer board established and service managers to be prioritised to focus on cancer, with financial and RTT. Remains amber due to 62 day performance delivery. | end-May 18 | ◄► | COO | SLF |

| Gaps in Control (C) or Assurance (A): | | | Actions: | Date/ milestone | RAG | Lead | Monitoring Group |
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| 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. | Jul-16 - Dec 16 Meet SECAMB monthly to review on going issues and joint working to resolve. Action plan and escalation process in place<br>Capital bid with TDA for review to support expansion; outcome awaited, planning permission being sought in advance. Trust prioritising reconfigurations from own capital programme to support effective patient pathways and address privacy and dignity issues. Urgent Care Programme Board established. Multi-disciplinary summit being planned to further support improved patient flow. Number of improvements being implemented in A&E although some not fully introduced due to staffing and space concerns, particularly at Conquest site.<br>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.<br>Jul-17 Project in place streaming redevelopment commencing to be in place by Oct 17<br>Sep-17 Building work commenced at DGH for ambulatory care.<br>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.<br>Jan-18 New builds at both 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 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. Medical Ambulatory unit opened at DGH in Dec, offering additional space to increase activity and offer improved privacy and dignity. Similar unit 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.<br>Mar-18 – Suggest remove from BAF as effective controls in place. Both units have physical capacity to ambulance handover areas (requires dedicated staffing). Paediatric areas in place on both sites. On-going scoping to develop the units to accommodate urgent treatment centres and co-locate SPAUs. Actions above include the development of the AEC (DGH in place, CQ plans for delivery by autumn), which support flow, but not specifically part of the EDs. | end-Mar 18 | ▲ Mar-18 | 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. | 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.<br><br>May-Jul 17 Achievement of key constitutional targets and trajectories remains challenging however, performance is improving . 4 week improvement challenge started June with 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 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.<br><br>Sept-Nov 17 A&E Attendance increased by 6.9% year to date. A&E performance 87.7% July, and improved to 92.5% in August. Reduction in delayed transfers of care and continued improvement in ED performance Oct 92% Systemwide winter plan in place.<br><br>Jan-18 Urgent care and patient flow programme re-scoped for 2018, building on the existing work. DToCS reduced by approx 7%, with NEL LOS reducing by 0.9 days. Benefits seen through increased performance of 4 hour standard, which improved from 82.5% in Nov 16 to 94.1% in Nov 17, despite increase in attendances and admissions. Start of winter has been challenging but flow through department has been sustained at a 10% improvement on previous year.<br><br>Mar-18 – as for Jan 18. DTOC and LOS performance sustained. Renewed focus on SAFER and working with partners to reduce medically fit and stranded patients. Controls in place to manage on-going risk associated with increased demand. New LOS targets, refreshed plan, continue to work with the system, stranded patient review weekly, enhanced bi weekly discharge control etc. Request review at next Quality and Safety as to status on BAF as this will remain a challenge, but no specific gaps in controls. | end Mar-18 | ▲ Mar-18 | COO | |

| Strategic Objective 2: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health. | | | | | | | |
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| **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. | Training requested from mental health team at CAMHS for ward nurses to ensure a competent and confident workforce. Liaising with SPT and commissioners re purchasing adequate tier 4 beds. Continued working with CAMHS and SPT to develop pathway.<br><br>May-16- Sep 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. 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. Improving system CAMHs Liaison nurse available every day. Some inappropriate admissions still but these are individually reviewed.<br>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<br>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.<br>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<br>Sep-17 - Meeting arranged end Sept to review issues. Audit of children admitted to the paediatric ward with mental health diagnosis commenced.<br>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<br>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 children require a hospital bed until the assessment is undertaken. Initial meeting with CAMHS and another planned Feb.<br>Mar-18 Met CAMHS Feb and shared results audit. Acknowledged mental health nurse support 09h00 – 17h00 is useful and should remain but that there is a need for this cover into the evening. Trust to provide numbers of children presenting at ED after 16h00 needing this input to CAMHS who will then put together a business case for extended cover. | end May-18 | ◄► | COO | SLF<br>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.<br>Local systems in place but require Trust wide system for monitoring and analysis. Liaising with supplier regarding options for reporting.<br>May-17 Position resolved with community paediatrics due to data transition to Systm One. Ongoing discussion to find Trustwide solution.<br>Jul-17 All doctors validating Follow Up waiting lists and telephone Follow Ups now taking place. Longest waiter 36 weeks.<br>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<br>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.<br>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.<br>Mar-18 PAS team commenced work on e-follow up database and aim to complete this by end May 18. In the meantime. the Clinical Admin service continues to appoint at requested time and where unable to do so highlights this information to the service managers on a weekly basis. | end May-18 | ◄► | COO | SLF<br>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.** | |
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| **Key controls** | Clinical Unit Structure and governance process provide ownership and accountability to Clinical Units<br>Clinicians engaged with clinical strategy and lead on implementation<br>Job planning aligned to Trust aims and objectives<br>Membership of SLF involves Clinical Unit leads<br>Appraisal and revalidation process<br>Implementation of Organisational Development Strategy and Workforce Strategy<br>National Leadership and First Line Managers Programmes<br>Staff engagement programme<br>Regular leadership meetings<br>Succession Planning<br>Mandatory training passport and e-assessments to support competency based local training<br>Additional mandatory sessions and bespoke training on request |
| **Positive assurances** | Effective governance structure in place<br>Evidence based assurance process to test cases for change in place and developed in clinical strategy<br>Clinical engagement events taking place<br>Clinical Forum being developed<br>Clinical Units fully involved in developing business plans<br>Training and support for those clinicians taking part in consultation and reconfiguration.<br>Outcome of monitoring of safety and performance of reconfigured services to identify unintended consequences<br>Personal Development Plans in place<br>Significant and sustained improvement in appraisal and mandatory training rates |

| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
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| 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<br>Review being undertaken to address compliance and quality of appraisal.<br><br>Jan-Nov 17 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.<br>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; continued work with managers to maintain levels where possible. Highlighting drop in sessions, e-learning and workbooks for quick updates in many subjects.<br><br>Jan-18 Mandatory Training 88.2% Appraisals 81.3% (Dec data). Targeted intervention continues for areas requiring support. Reviewing Workforce Business metrics to ensure robust, 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.<br><br>Mar-18- Mandatory Training Compliance 88.7% Appraisal training deep dive completed and presented to POD. Governance processes reviewed. Reviewing education services to identify gaps in provision and find solutions through better use of existing resources. Inductions/refresher days Task and Finish Group met in Feb/Mar- proposal to combine HCA and Clinical Induction to 3-3.5 days has been mapped. PID completed to reflect possible savings a reduction in Induction programme may deliver. Revised proposed programme to be shared with Subject Matter experts and will follow Trust Approval processes to secure a pilot to commence end of Apr-18<br><br>Appraisal data currently at 81.3%, National Survey results indicate Trust has significantly improved on 2016 data measured against comparator organisations however more work needs to be done on securing additional resources which will be undertaken as part of educational service review and will not involve additional income request. Escalation processes are not robust and do not support enhancing the compliance data- this will be improved as part of the quality assurance/management agenda. | end Mar-18 | ◄► Mar-16 | HRD | POD<br>SLF |

| Gaps in Control (C) or Assurance (A): | | | Actions: | Date/ milestone | RAG | Lead | Monitoring Group |
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| 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.<br>Sept-16 New Medical Director in post, progressing appointments of Chiefs and deputies.<br>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.<br>Jan-17 Final FMLM training end of Jan. All Chiefs now appointed, including Women's and Children. Specialist leads advertised.<br>Mar-17 Most speciality leads now appointed. Job planning training to follow. Other training possibilities arranged eg for “case investigation”<br>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.<br>Jul-17 Cohort 1 of Leading excellence programme identified and invited to attend first programme commencing in August<br>Sep-17 The first Cohort for Leading service programme has been identified and will commence in October.<br>The pilot for the new managers induction programme will take place in September.<br>A stakeholder event is being held in September to discuss the new Leadership and talent management strategy<br>Nov-17 Leading excellence course progressing, good feedback received. Propose move to green.<br><br>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.<br><br>Mar-18 Evaluation of refreshed Leadership Briefings for top 160 leaders very positive and will help cascade key information through the organisation. 16 new managers attended New Managers orientation – there will be regular contact with these managers in their first year in post. 54 managers have almost completed Leading Service and leading excellence . formal evaluation being carried out through Kingston University .Further 58 are just about to start the next round of these programmes Trust is working with colleagues across the system to develop joint opportunities for Talent Management and Leadership development.<br><br>Propose remove from BAF as sufficient assurance in place | 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.**

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| **Key controls** | Develop effective relationships with commissioners and regulators<br>Proactive engagement in STP and ESBT<br>Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work.<br>Relationship with and reporting to HOSC<br>Programme of meetings with key partners and stakeholders<br>Develop and embed key strategies that underpin the Integrated Business Plan (IBP)<br>Clinical Strategy, Workforce Strategy, IT Strategy, Estates Strategy and Organisational Development Strategy<br>Effective business planning process |
| **Positive assurances** | Trust participates in Sussex wide networks e.g. stroke, cardio, pathology.<br>Monthly performance and senior management meetings with CCG and TDA.<br>Working with clinical commissioning exec via East Sussex Better Together and Challenged Health Economy to identify priorities/strategic aims.<br>Board to Board meetings with stakeholders.<br>Membership of local Health Economy Boards and working groups<br>Two year integrated business plan in place<br>Stakeholder engagement in developing plans<br>Service delivery model in place<br>Refreshing clinical strategy to ensure continued sustainable model of care in place<br>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-Jun 17 Continuing to work with 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. STP Programme Board 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.<br>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 to review pathology provision along with other acute services.<br><br>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.<br><br>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<br><br>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<br><br>Mar-18 2018/19 plans being finalised for sign off later in the month. Trust budgets and CIP plans will then be aligned with the system-wide budgets through the ESBT Alliance Executive. The Trust is still working on a long term financial plan that will align with the transformation plan for clinical and financial sustainability which we are preparing and expect to be completed at the end of June 2018. | end June-18 | ◄► | DS | F&I<br>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.**

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|---|---|
| **Key controls** | Development of communications strategy<br>Governance processes support and evidence organisational learning when things go wrong<br>Quality Governance Framework and quality dashboard.<br>Risk assessments<br>Complaint and incident monitoring and shared learning<br>Robust complaints process in place that supports early local resolution<br>External, internal and clinical audit programmes in place<br>Equality strategy and equality impact assessments |
| **Positive assurances** | Integrated performance report that links performance to Board agreed outcomes, aims and objectives.<br>Board receives clear perspective on all aspect of organisation performance and progress towards achieving Trust objectives.<br>Friends and Family feedback and national benchmarking<br>Healthwatch reviews, PLACE audits and patient surveys<br>Dr Foster/CHKS/HSMR/SHMI/RAMI data<br>Audit opinion and reports and external reviews eg Royal College reviews<br>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<br><br>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.<br><br>Nov-17 Project initiation document being progressed will be considered by 7 day steering group.<br><br>Jan-18 PID agreed by 7DS steering group. All divisions incorporating 7DS needs into their 2018-19 business planning.<br>Standard 2 New MAU post-take round proforma agreed and incorporated in IPD. Includes ceilings of care and stratification.<br>Work ongoing on recruiting additional AMU consultants. Intermittent weekend additional AMU consultant cover at both acute hospital sites.<br>Standard 5 Guidance for clinical staff on accessing investigations nearly complete. Will be available on intranet and entry points.<br>Standard 6 Work ongoing on changes to GIM rotas to support 24/7 GI bleeding service. Will require changes to consultant job plans<br>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.<br><br>Mar-18 Continuing Support provided by NHSE Programme Lead. Liaison with neighbouring Trusts (MTW, EKH). Admission documentation updated to facilitate recording of clinical reviews. Work ongoing on formal prioritisation of inpatient acuity and delegation of review.<br>Project team visited EKH to investigate functionality of CareFlow as tool for effective medical handover, and for tailored review lists. Careflow scheduled to start roll-out in Q1 2018-19. Guide to accessing investigations and interventions within Trust and with external providers is nearly complete. Divisions assessing additional staffing requirements to support 7DS access to immediate and urgent investigations (particularly cardiac imaging and ultrasound); incorporating this into business planning 2018-19 and 2019-20. | end Apr-18 | ◄► Jul-17 | COO | SLF<br>Q&S |

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| **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<br>QIPP delivery managed through Trust governance structures aligned to clinical strategy.<br>Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work<br>Modelling of impact of service changes and consequences<br>Monthly monitoring of income and expenditure<br>Accountability reviews in place<br>PBR contract in place<br>Activity and delivery of CIPs regularly managed and monitored. |
| **Positive assurances** | Trust participates in Sussex wide networks e.g. stroke, cardio, pathology.<br>Written reports to SLF on progress with QIPP targets to ensure improvements in patient outcomes are planned and co-ordinated.<br>Performance reviewed weekly by CLT and considered at Board level. Evidence that actions agreed and monitored.<br>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. | Nov-17 – Month 6 Trust 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.<br><br>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.<br><br>Mar-17 – confirmed forecast from Jan 2018 at £257.4m is on track for delivery, with the key commissioning disputes resolved, and focus is now on the development of a robust plan for 2018/19. Following agreement of the financial plan for 2018/19, the risks to delivery will need to be reflected on the refreshed BAF. A key risk arising from the financial position in 2017/18 has now lessened, with the receipt of a £20m drawdown of cash in February 2018 reflecting the movement in the forecast. This will ensure that supplier debts are reduced, which will reduce the clinical and operational risks arising from creditor pressures. The Trust is now working on a robust, stretching but deliverable plan for 2018/19, with all proposed savings reviewed through the QIA process, and with appropriate risk management arrangements in place. | 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.**

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| **Key controls** | Development of Integrated Business Plan and underpinning strategies<br>Six Facet Estate Survey<br>Capital funding programme and development control plan<br>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.<br>Essential work prioritised within Estates, IT and medical equipment plans |
| **Positive assurances** | Draft assessment of current estate alignment to PAPs produced<br>Essential work prioritised with Estates, IT and medical equipment plans.<br>Significant investment in estate infrastructure, IT and medical equipment required over and above that included in the Clinical Strategy FBC.<br>Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly.<br>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 capital plan forecast remains under 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. 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.<br>Nov-17 – Month 6 Trust 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 Oct and Nov 17, 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.<br>Jan-18 – Month 9 the Trust 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 undertaking full review of remaining capital expenditure in Q4, to 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 F&I.<br><br>Mar-18 – Overall capital plan for year will be on budget; budget has increased from £11m to £15m as a result of successful capital bids by clinical and operational leaders across the Trust. Work commenced on the development of the 2018/19 capital plan with a broadly-based prioritisation process. At the same time, the Trust has to finalise the five year capital plan. Key risks include overall financing for the capital programme, and the early finalisation of the fire strategy business case – both of which will be presented in outline to the Mar F&I | 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 as unable to decant wards and asbestos issues. Fire doors replaced and Stairs wells upgraded. EDGH Compartment project 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<br>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.<br>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.<br>Mar-18 Seaford and Hailsham areas surveyed and reports and plans produced. Survey identified fire walls in areas previously thought to be deficient of them. The walls roughly reflect Ward areas. Surveys have been commissioned to identify the breaches and pictorial evidence sourced. ESFRS visited early Feb-18 to check on progress. advised that breaches in both areas will be rectified by the end of May 2018. As there has been a reduction in risk the opportunity for an enforcement notice has decreased but is still being considered. Business case for investment to introduce new smaller fire compartments at EDGH will be presented to the F&I committee in Mar-18. | end May-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.** | |
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| **Key controls** | Horizon scanning by Executive team, Board and Business Planning team.<br>Board seminars and development programme<br>Robust governance arrangements to support Board assurance and decision making.<br>Trust is member of FTN network<br>Review of national reports<br>Clear process for handling tenders/gathering business intelligence and mobilisation or demobilisation of resources<br>Participating in system wide development through STP and ESBT Alliance<br>Strategy team monitoring and responding to relevant tender exercises<br>Anti-virus and Anti-malware software<br>Client and server patching<br>NHS Digital CareCert notifications<br>Information Governance Toolkit |
| **Positive assurances** | Policy documents and Board reporting reflect external policy<br>Strategic development plans reflect external policy.<br>Board seminar programme in place<br>Business planning team established<br>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<br>Staff Training - Phishing Simulation software<br>Formal information security certification for internally provided digital services<br><br>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.<br><br>Mar-18 Ongoing development and implementation of action plan, progress presented to IG Steering Group. Phishing simulation being undertaken. | end Sept-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.**

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| **Key controls** | Workforce strategy aligned with workforce plans, strategic direction and other delivery plans<br>On going monitoring of Recruitment and Retention Strategy<br>Workforce metrics reviewed regularly by Senior Leadership Team<br>Quarterly CU Reviews to determine workforce planning requirements<br>Monthly IPR meetings to review vacancies.<br>Review of nursing establishment quarterly<br>KPIs to be introduced and monitored using TRAC recruitment tool<br>Training and resources for staff development<br>In house Temporary Workforce Service |
| **Positive assurances** | Workforce assurance quarterly meetings with CCGs<br>Success with some hard to recruit areas e.g. Histopathology and Paeds<br>Full participation in HEKSS Education commissioning process<br>Positive links with University of Brighton to assist recruitment of nursing workforce.<br>Reduction in time to hire<br>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-Jun 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 appointable from Aug-18. Recruitment hotspots identified and regular vacancy review and action plans to address priority vacancies. R&R Policies examined to address turnover and attraction issues. 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. 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.<br><br>Jul-Nov17 Recruitment Incentives developed to attract 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. Developing new roles. Workforce reviews and planning sessions linked to business planning. Discussions with external Recruitment Agencies to assist with recruiting 50 most difficult to recruit medical posts. Ongoing International Nurse recruitment -16 candidates to join between Dec 2017 and April 18. UK student nurse recruitment event -21 candidates confirmed. Workforce meeting with Nursing to agree future recruitment plans. Continued social media activity to drive candidate traffic to Trust website. Targeted activity around ED vacancies.<br><br>Jan-18 Hard to recruit vacancies identified with Medacs Agency who are assisting the Trust in a targeted approach to sourcing candidates. Medacs will also be targeted with AHP difficult to recruit vacancies. Overseas nurse recruitment continues with c16 candidates due to arrive Apr-18. Planned attendance at nurse/medical recruitment events in 2018. Out Of Hospital recruitment campaign commenced, 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.<br><br>Mar-18 Medacs recruitment agency on site Apr-18; issued with list of difficult to recruit medical posts and will have exclusivity on these vacancies for 4 weeks. Medacs tasked with creating pipeline of candidates for these posts. Since Apr-17 vacancies reduced in all staff groups excluding nursing. % of nursing vacancies relatively constant at 10%. Recruitment strategy for nurses widened to include return to practice; offering OSCE assistant to overseas nurses already in UK. Launching return to Trust project for nursing leavers. Monthly Divisional meetings to review vacancies versus establishment. From Mar-18 new starters will be offered the opportunity to auto-enrol on the bank. Workforce Resourcing Group being established which will develop a longer term strategy to meet workforce requirements, taking into account the age profile of the population and will look at new roles and skill mix to meet patient demand. Work continues on driving roster efficiency and job planning. | end Jul-18 | ◄► | 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.**

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| **Key controls** | Leading for Success Programme<br>Leadership meetings<br>Listening in Action Programme<br>Clinically led structure of Clinical Units<br>Feedback and implementation of action following Quality Walks.<br>Organisation values and behaviours developed by staff and being embedded<br>Staff Engagement Plan developed<br>OD Strategy and Workstreams in place<br>Management Essentials Programme |
| **Positive assurances** | Clinical engagement events taking place<br>Clinical Forum being developed<br>Clinical Units fully involved in developing business plans<br>Embedding organisation values across the organisation - Values & Behaviours Implementation Plan<br>Staff Engagement Action Plan<br>Leadership Conversations<br>National Leadership programmes<br>Surveys conducted - Staff Survey/Staff FFT/GMC Survey<br>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 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<br><br>Jul-17 - Sept 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. Renewed focus on medical engagement .Consultants and SAS doctors asked their views on their experience of working 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 results are positive but we are investigating further how we are involving staff in decisions.<br><br>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<br><br>Jan-18 National staff survey response rate 49% - 3% above national average and 4% improvement on last year. Survey results will be published in early Mar18. Results of The Medical engagement score have been published and shared with a great improvement in all areas.<br><br>Mar-18 National Staff survey results published: • 11 key findings significantly better than average • 6 key findings significantly worse than average • 5 key findings shown significant improvement since 2016 • O key findings shown significant decline since 2016<br>All results will be shared with each division and Corporate priorities agreed at People and Organisational Development Committee in March 2018 and then shared more widely in the trust | end May-18 | ◄► | HRD | POD<br>SLF |

# Chief Executive's Report

| Meeting information: | | | |
|---|---|---|---|
| Date of Meeting: | 17th April 2018 | Agenda Item: | 9F |
| 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 ☐<br>*(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

Since the last meeting we have had the CQC inspection and the results of the national NHS staff survey. The inspection went well from our perspective, and the informal feedback from the inspection team was positive and encouraging. They made particular comment on the welcome they had received in all areas, the commitment and enthusiasm of the teams they met, and the openness with which progress and issues were discussed. They commented that we are well on our trajectory towards outstanding in 2020. There were no immediate actions required. The draft report will be sent for accuracy in May, recommendations submitted to the CQC panel at the end of May, and publication of the report in June.

The NHS staff survey was encouraging. Last year (from a low base) we were one of three most improved Trusts in the country for staff engagement. This year we have made small but statistically significant improvements in five areas, and have had no statistical reductions in any measure. It is particularly encouraging that some improvements were in areas to which the Trust has been giving particular focus – such as commitment to the wellbeing and health of members of staff, and the frequency and quality of appraisals.

At the end of the financial year the Trust anticipates delivering the re-forecast agreed with NHS Improvement and reported last month of a deficit of £57.4m against the control total of £37m. The key elements in this are less than planned elective activity, one off unexpected costs in year (e.g. historic VAT), shortfall of £6m against planned CIP of £28m, and loss of income on mediated contract dispute. This is a disappointing outcome, which will improve in 2018/19. In 16/17 our headline deficit was £46.5m but the underlying deficit was £57m deficit, which has improved to £54m in 2017/18. Across the Trust colleagues are working to develop the financial plan for 2018/19 to improve the position further, with an initial plan being considered by the Board which reduces the deficit to £47.8m with work in train to establish options for further improvement.

## 2. Quality and Safety

The number of patient falls reported in February showed a decrease from January and was below the target limit of 5.5 falls per 1000 bed days. We are currently on target to achieve this if March falls remain low. Increased numbers of wards are now using the trial assessment form which is being altered based on feedback and will then be taken to the falls group for final approval.

Patient experience feedback continues to be an important quality measure in terms of score and response rate. A&E response rates for patient experience feedback remain a challenge. This has been discussed at the Urgent Care Integrated Performance Review and the departments have been asked to focus on improvements to this by embedding requests for feedback within the culture. Feedback overall remains very positive.

A new 'real time' system of recording mixed sex accommodation breaches was implemented in February. This has resulted in an expected increase in reporting. We are continuing with point prevalent monitoring in tandem to verify that the increases relate to the change of system of reporting and not due to increased mixing.

## 3. People, Leadership and Culture

### Recruitment

- A targeted approach to medical vacancies (in particular ED) has seen a reduction to 5.2% in M11; this was at 14.390 in April.
- International recruitment is continuing in the Philippines and Indian sub-continent for Medical and AHP staff groups, including radiographers.
- 31 International Nurses will join the Trust by August 2018.
- Two new initiatives to support Nurses back to work have launched. 5 offers made to date.

### Workforce Planning

- Submission and publication of ESHT Gender Pay Gap Review with further insight analysis to drive action plans as appropriate. The only area in which there are significant gender related differences are in consultant pay, this being largely explained by the difference in gender balance across the age groups and thus seniority.
- Roll out of Safecare as part of the electronic rostering system has been completed successfully with the live staffing information accessible on iPads, being used in twice daily staffing meetings on each site to inform staffing decisions.
- Doctors rostering continues on plan and will be completed by April. The Activity Manager and eJobPlan implementations are progressing and are key to enabling Consultant and SAS Doctors activities to interface into the existing modules in order to complete rosters.

### Staff Engagement

- Leading Excellence cohort 2 commenced in February.
- Health & Wellbeing roadshows promoting staff health & wellbeing were attended by 180 staff.
- 850 staff received Health Checks.

### Education

- Preparing to introduce Physicians Associates role within the Trust and working with divisions to identify suitable positions and rotations in conjunction with primary care.
- Pilot of 3-4 months introduced to manage the accommodation for doctors on call and working nights.
- Developing a revised corporate and clinical induction programme that will reduce time that staff attend and identify key elements for inclusion.

## 4 Access and Delivery

### Urgent Care

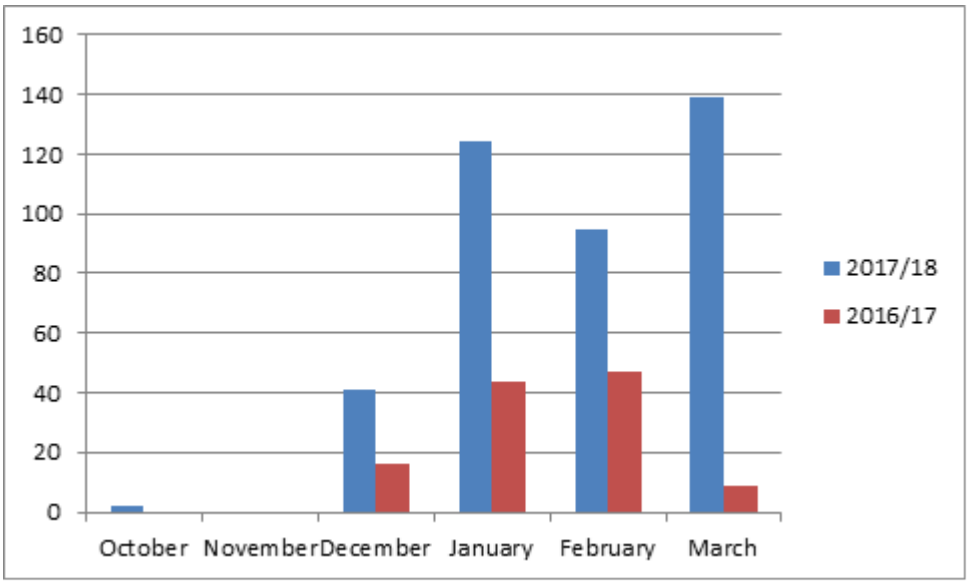
As in previous years the winter months provided a challenge with increased activity and patient acuity. Staff have worked well together to support timely discharge and manage some very unwell patients. There has been significant work pressure on all teams. However the effort has benefited patients and can be seen through more timely treatment times and reductions in delayed discharges.

In respect of the 4 hour clinical standard, we continue to perform in the top third and often top quartile of the country. Performance for the two acutes sites has been consistent at 86.6% through December to March, although as a system (which includes the Walk in Centre type 3

activity), we continue to perform at or above 90%. This demonstrates an improvement (acutes sites only) of 10% on the same period last year, despite significantly higher demand.

Our new Medical Ambulatory Unit and extended assessment ward at Eastbourne DGH has seen an increase of 35% in patients who stay less than one day, which supports patients going home, but also reduces pressure on the rest of the hospital and improves patient flow. A similar unit is planned for the Conquest Hospital in the Autumn.

We have also been impacted by high levels of flu, which requires patients to be managed in dedicated areas, and impacts on the immediate availability of beds.




Comparison of positive flu admissions

**Elective Care**

We have continued to treat our elective patients, recognising that they too have urgent needs and therefore have prioritised our cancer, urgent patients, as well as those who have been waiting the longest.

90.2% of patients were treated in less than 18 weeks and our waiting list has further reduced.

However, despite significant focus, in February, 29 patients with cancer have not received their treatment within 62 days. For some this is clinically appropriate or due to patient choice, but for others we are focusing on reducing any unnecessary delays within the Trust and working with partners, for those who require diagnostics or treatment elsewhere.

We have also seen a significant increase in 2 week wait referrals due to a number of recent campaigns and high profile cases, but the teams are working hard to ensure these patients are seen quickly. We are yet to understand how many of these referrals are identified as cancer as opposed to an increase in appropriate cause for concern and investigation.

**Community Services**

Our teams continue to care for patients in the community and are providing therapy services to all patients within the target treatment times. Community nursing continues to remain pressurised, although referrals and contacts are recorded at a lower level than the same time

last year. However our crisis response service has developed well and has seen twice as many patients, supporting admission avoidance and reducing delayed discharges.

Building Layouts for the proposed twin MRI unit at the Conquest have been agreed in principal with clinical lead for Radiology. Following the return of the PQQ for the construction of the new MRI unit, tenders are being sought for its construction in April 2018. Supporting infrastructure e.g. new high voltage substation is being implemented in parallel with the new building.

## 6. Communication and engagement

Over this period we launched a new Trust-wide campaign, 'commit to change', which began in February. Each week we release a new 'call to action' that includes a fact about waste or efficiency at ESHT, and what each member of staff can do to change. We are asking people to 'commit to change', and make small changes to their everyday work lives to cut waste and inefficiency. The most recent staff magazine, Connect, featured examples of people's commitments to change. Connect has also undergone a revamp turning it into an e-zine which allows more staff to access the articles.

We have also seen the installation of new posters across the Trust. Each poster focusses on a single Trust value and highlights how different members of staff and teams demonstrate that value. To coincide with the launch of the new posters, each ward and service was given "our guide to outstanding care" which is a completion of all the new posters, guidance and information that has been offered through the weekly communications and FocusOn. These new guides were delivered to each ward by the Director of Nursing.

Ahead of the CQC visit we developed a new Trust video highlighting the many improvements that we have made in the eighteen months since the last CQC visit. This video was shared with the CQC and has been made available to all members of staff. In January we also saw thirty members of the public come together to discuss the priorities in the next quality account.

Over this period, we saw a great deal of positive press coverage, especially relating to new ESHT services, innovations and facilities. We saw positive coverage of the Secretary of State's visit to the Trust, the improvements to maternity highlighted in the CQC's maternity survey, the refurbishment of Maxillo-Facial Unit and the UK's first operation to fit a heart failure device. We also worked with local press on a feature to ask local people for stories and memorabilia to support the celebrations for the NHS's 70th birthday, coming up in July.

## 8. Finance

Planning for 2018/19 is well-developed. The Trust has, working with teams across the organisation, constructed an initial financial plan for a £47.8m deficit in 2018/9, and the Board is working to review this plan to establish if further improvements are possible. The plan for 2018/19 requires cost improvements of £23.5m, and with the help of clinical units and our newly established PSO team, £12.5m of schemes have been identified and rated as 'green' and a pipeline of schemes to a total value of £26m has been identified. There is work to do to bring all of these schemes to delivery, but a robust process is in place, and work is in train to secure this by the end of May.

Detailed negotiations are taking place with our Clinical Commissioners over the activity and financial plan for 2018/19. The system financial challenge is significant, and the indicative activity levels are unaffordable. As a result, the Trust and the CCGs have not yet been able to sign a contract for 2018/19, but a positive and productive dialogue is in train and we are

working through the East Sussex Better Together Alliance arrangements to identify approaches to improving the financial position for the whole health economy. A provisional cash payment for April has been agreed to maintain the cash position for the Trust, and avoid losing the improvements in cash flow which we have seen in February and March.

The Trust has agreed an initial capital plan for 2018/19. This is an ambitious plan, and recognises the need for substantial investment in our infrastructure, in technology and in clinical equipment to support our continued improvement in quality and delivery. The plan uses both our own internally-generated capital, and access to capital which comes from working together with our key partners, including the Friends for each of our hospitals and NHS Improvement.

East Sussex Healthcare NHS
NHS Trust

Month 11 – February 2018

# TRUST INTEGRATED PERFORMANCE REPORT

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East Sussex Healthcare NHS
NHS Trust

# Contents

East Sussex Healthcare NHS
NHS Trust

# February 2018

**Key Successes**

- RTT sustained over 90% (90.2%), and reduction in waiting list
- Sustained same level of performance in A&E, through December to February, showing a typical 13% improvement on the previous year. System level performance is over 90%, type 1, 86.8%

**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. February shows a 20% increase in non-elective spells
- 62 day cancer performance 65% in January, this is a seasonal drop, impacted patient choice and reduced capacity. February shows an improvement, although yet to be validated.

**Key Risks**

- Delivery of the financial targets and savings plans
- Continued pressure on divisional teams, performance, business planning and CIPs

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

Quality and Safety

# QUALITY AND SAFETY

# Indicators

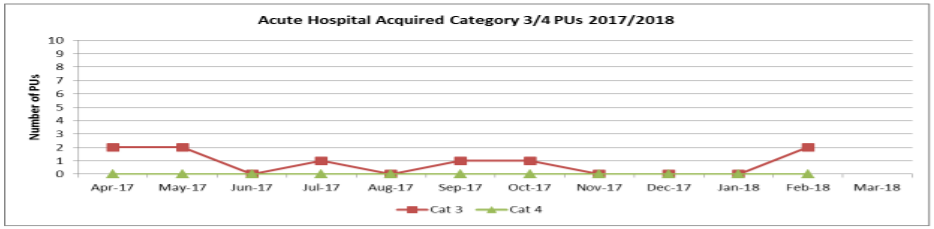
East Sussex Healthcare NHS
NHS Trust

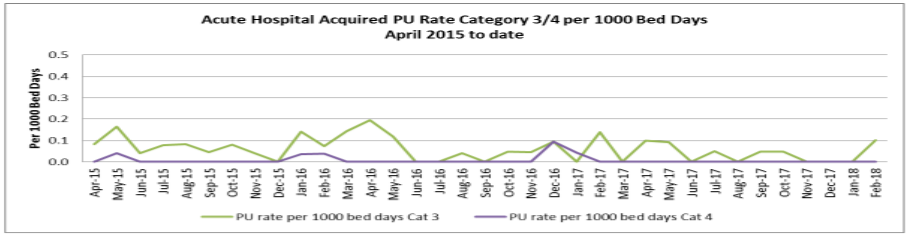
| Indicator Description | Target | Month Comparison | | | YTD Comparison | | | Rolling 12 month Avg | Trend |
|---|---|---|---|---|---|---|---|---|---|
| | | Feb-17 | Feb-18 | Var | 2016/17 | 2017/18 | Var | | |
| **Total patient safety incidents reported** | M | 1235 | 1083 | -12.3% | 14804 | 12091 | -18.3% | 1112 | |
| **Total falls** | M | 155 | 105 | -32.3% | 1677 | 1475 | -12.0% | 136 | |
| All patient falls per 1000 Beddays | 5.5 | 6.4 | 4.6 | -1.8 | 6.2 | 5.7 | -0.45 | 5.4 | |
| All patient falls with harm per 1000 Beddays | | 2.0 | 1.1 | -0.9 | 1.9 | 1.4 | -0.49 | 1.4 | |
| **Total grade 2 to 4 pressure ulcers per 1000 Beddays** | M | 2.9 | 2.3 | -20.7% | 2.2 | 1.9 | -12.3% | 2.0 | |
| **Safety Thermometer overall score** | 92.0% | 92.5% | 92.0% | -0.5% | 93.6% | 92.4% | -1.1% | 92.4% | |
| **VTE Assessment compliance** | 95.0% | 97.0% | 94.7% | -2.2% | 96.9% | 95.8% | -1.1% | 95.9% | |
| Number of MRSA Cases | 0 | 0 | 0 | 0 | 0 | 3 | 3 | 0 | |
| Number of Cdiff cases | 4 | 2 | 1 | -1 | 41 | 31 | -10 | 3 | |
| Number of MSSA cases | M | 0 | 0 | 0 | 11 | 9 | -2 | 1 | |

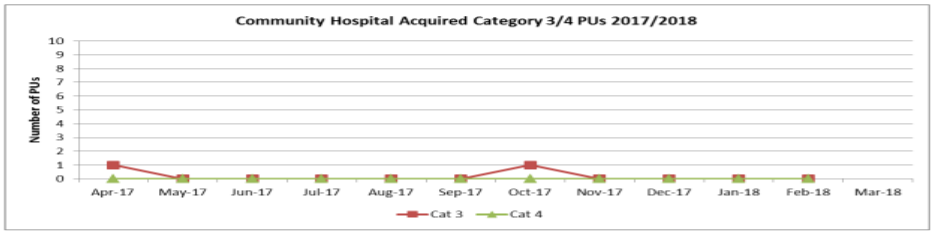
- The percentage of no harm/near miss incidents is 80% of all patient safety incidents which is an indicator of a good reporting culture (national figure 73%).
- The number of patient falls reported in February has decreased from January and is below our target of 5.5 falls per 1000 bed days. We are currently on target to achieve this if March falls remain low. Increased number of wards are now using the trial assessment form which is being altered based on feedback and will then be taken to the falls group for final approval.
- One Clostridium Difficile Infection was reported in February. We are currently at 33 for the year against a limit of 38 to date. The total limit for 17/18 is 41.

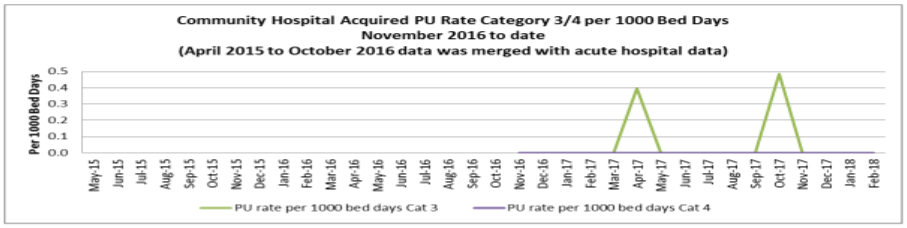
# PRESSURE ULCERS Grade 3 and 4

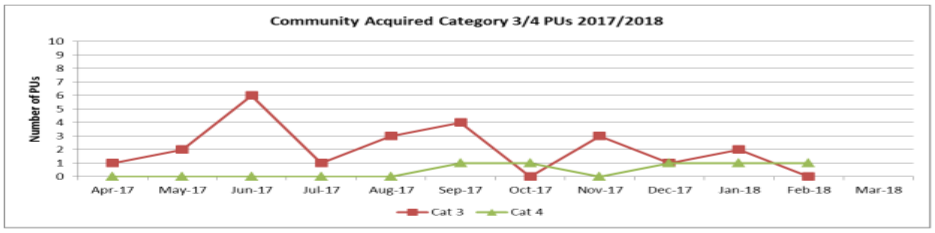
Quality and Safety

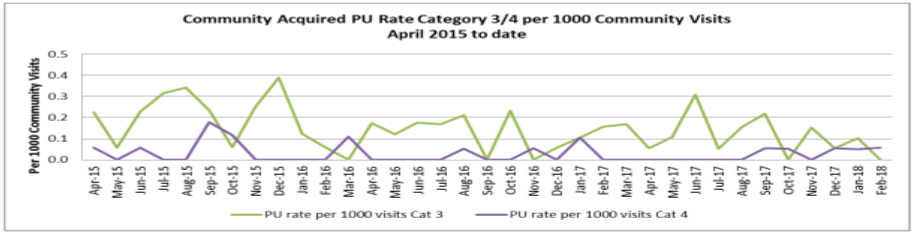


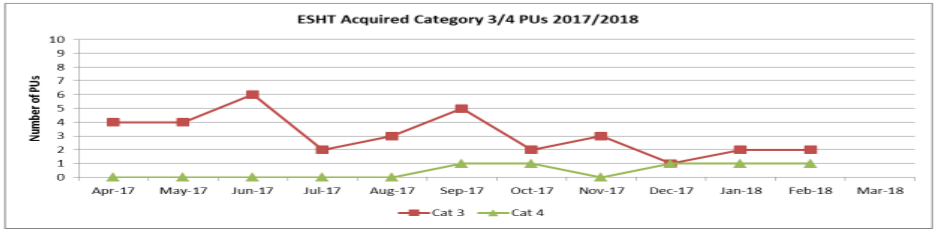



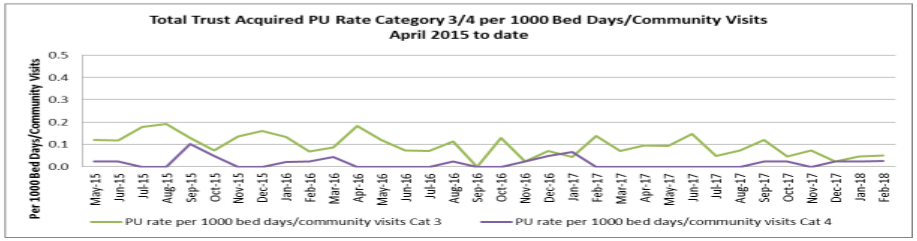




Total ESHT acquired = 48 (January 58)
Acute hospital acquired: cat 2 = 27: cat 3 = 2 - one on Benson and one H4*: cat 4 = 0
Community acquired cat 2 = 18: cat 3 = 0: cat 4= 1 – DN Hastings, patient in a care home
Community hospital acquired cat 2 = 0: cat 3 = 0: cat 4 = 0
(H4* The patient was not on the DN caseload prior to admission and so was non-ESHT acquired, an RCA is being undertaken)
February - RCA overdue for grade 3 / 4 - DAS: 2 (1 waiting update, 1 for submission), Medicine:2 (1 waiting update, 1 for submission, OOH: 4 (1 waiting update, 3 for submission)

# Serious Incidents (SI) reported in February

| Indicator Description | Target | Month Comparison | | | YTD Comparison | | | Rolling 12 month Avg | Trend |
|---|---|---|---|---|---|---|---|---|---|
| | | Feb-17 | Feb-18 | Var | 2016/17 | 2017/18 | Var | | |
| Number of Serious Incidents reported | M | 6 | 3 | -3 | 52 | 42 | -10 | 4 |  |
| Never Events | 0 | 0 | 0 | 0 | 1 | 4 | 3 | 0 |  |

There were 3 serious incidents reported during February 2018 which were:

- 1 x decontamination concern to one instrument (one patient)
- 1 x fall to fracture
- 1 x deteriorating patient from self administration of insulin

**Serious and Amber (Moderate) Incident Management and Duty of candour**

As of the end of February there were 18 open Serious Incidents in the system. 11 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 is at 88% informed verbally, 90% followed up in writing and 90% findings shared with patient or family upon completed investigation. There are 76 Amber (moderate harm) investigations open in the system and of these 59 are either overdue for submission/requiring further work or awaiting to be shared with the patient/family or Division. This is being worked through by the ADN's following further requests by the Associate Director of Governance and the Director of Nursing.

# PATIENT EXPERIENCE

East Sussex Healthcare NHS
NHS Trust

| Indicator Description | Target | Month Comparison | | | YTD Comparison | | | Rolling 12 month Avg | Trend |
|---|---|---|---|---|---|---|---|---|---|
| | | Feb-17 | Feb-18 | Var | 2016/17 | 2017/18 | Var | | |
| **Inpatient FFT response rate** | 45.0% | 31.8% | 40.3% | 8.5% | 19.9% | 40.0% | 20.1% | 39.3% |  |
| Inpatient FFT score | 96.0% | 97.4% | 97.8% | 0.4% | 97.3% | 97.2% | -0.1% | 97.1% |  |
| A&E FFT response rate | 22.0% | 6.4% | 4.5% | -1.9% | 7.7% | 8.7% | 1.1% | 8.6% |  |
| A&E FFT score | 88.0% | 81.9% | 94.1% | 12.1% | 86.8% | 89.6% | 2.8% | 89.4% |  |
| Outpatient FFT Score | M | 95.9% | 97.1% | 1.2% | 95.7% | 96.1% | 0.4% | 96.1% |  |
| Maternity FFT response rate | 45.0% | 39.2% | 30.6% | -8.7% | 32.3% | 32.3% | 0.0% | 32.9% |  |
| Maternity FFT score | 96.0% | 95.6% | 100.0% | 4.4% | 94.5% | 98.4% | 3.9% | 98.3% |  |

Patient Experience feedback continues to be an important quality measure in terms of score and response rate. The A&E rates continue to remain low and are worse than the previous year. This was discussed at the Urgent Care Integrated Performance Review and the departments have been asked to work on improving this by embedding the request for feedback in the culture.

The highest scored questions answered as part of the Patient Experience Survey were;

- Were you given enough privacy and dignity when being examined or treated on the ward or department?
- If sharing a ward with others, were curtains or screens used for personal needs/examinations/treatments and discussions?
- Did you receive enough help to wash and dress?

The Lowest scoring questions answered as part of the Patient Experience Survey were;

- Were you informed as to why you had to repeat clinical information when asked by a nurse or doctor?
- Were you ever bothered by noise at night?
- Were you provided with a “Welcome to the Ward” booklet?

The National Inpatient Survey result has been published and the lowest score for the trust is patient experience with discharge information and processes. Lack of treatment and patient information on discharge and the way it is carried out. This will be picked up in the Discharge Improvement Group.

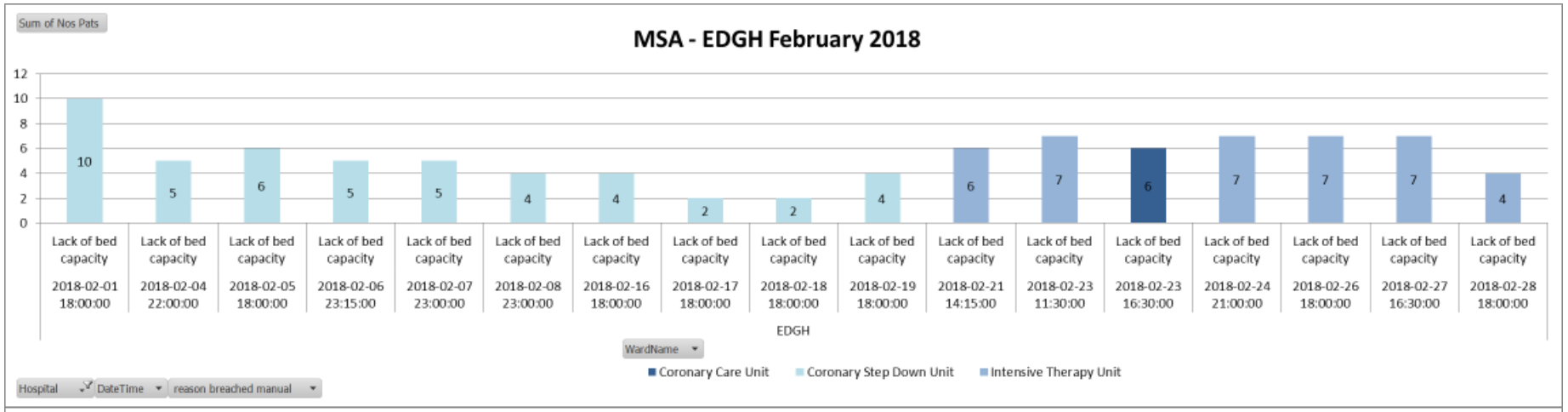
NHS Choices

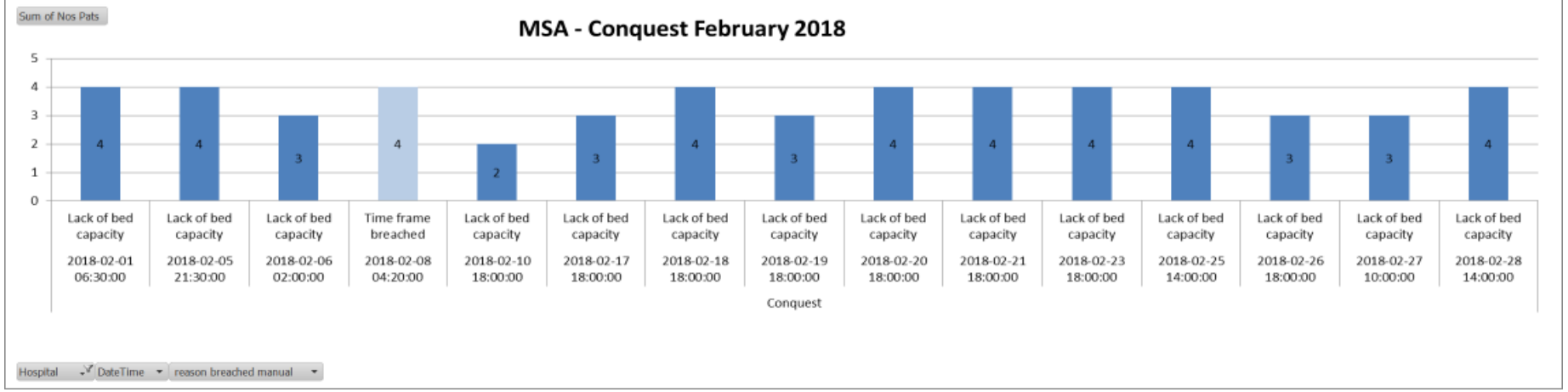
- Overall rating at EDGH = 4 Stars (182 ratings)
- Overall rating at Conquest = 4.5 Stars (187 ratings)

Plaudits – 120 thank you cards and 50 formal compliments

# MIXED SEX ACCOMMODATION

East Sussex Healthcare NHS
NHS Trust




A new system has been implemented in February. All patients who are placed in a mixed sex bay are recorded on a real time system by the site team. Using the categories provided by the KSS NHI team certain categories are reported to Unify (nonjustified). Patients in mixed bays in Hyperacute beds are recorded but not reported, Infection control patients who are cohorted are recorded but nor reported. Both of these categories are clinically justified.

Unify February - 144 pts affected, 33 breaches.

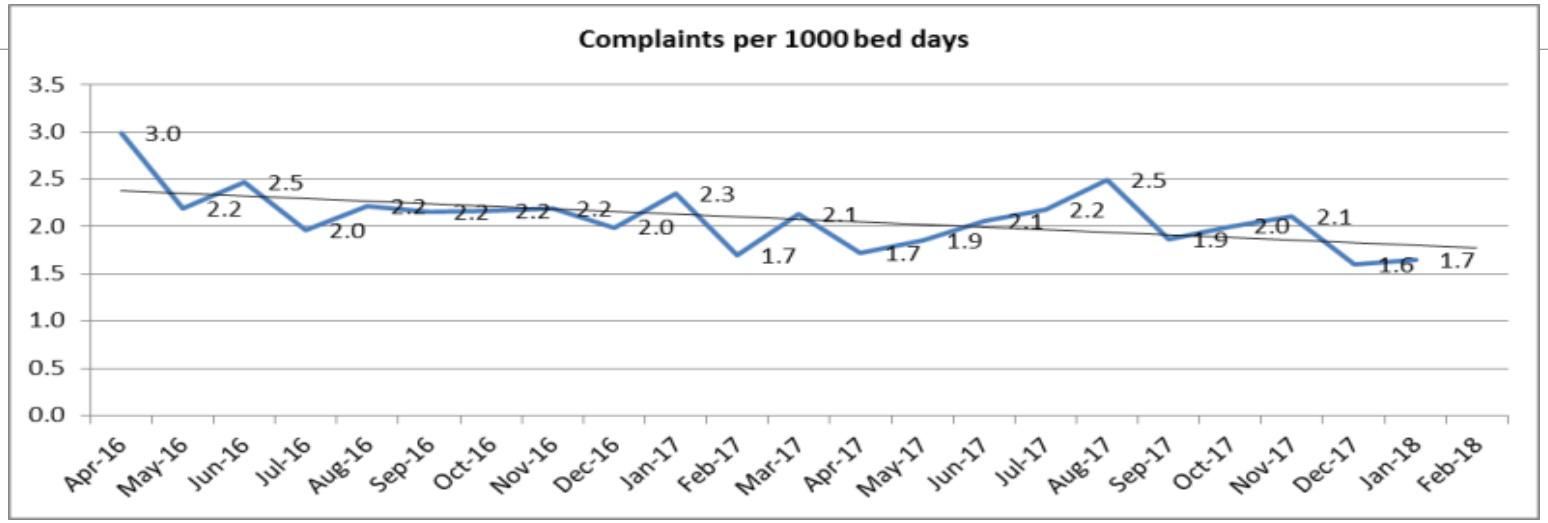
Of these 33, 29 were wardable patients in HDU / ITU but there was no bed capacity in the trust.

Of the 33, 19 occurred when trust was in  OPEL 4 status.

All steps were taken to move patients to single sex accommodation as soon as possible.

# Complaints

East Sussex Healthcare NHS
NHS Trust




46 new complaints were received in February and at the end of the month there was one overdue complaint. The average per month year to date is 47. Complaints by bed days within each Division from April 2017 up to and including December 2017 are as follows:

- Medicine – 1.1 per 1000 bed days (14 complaints per month)
- DAS – 2.2 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 – 4.5 per 1000 bed days (7 complaints per month)
- Urgent Care - Average 7 reported per month.

The main themes in February from complaints is communication, attitude, lack of diagnosis, problems /complications communication and attitude but also the lack of information available to patients.

Two new case were referred to the Parliamentary and Health Service Ombudsman (PHSO) during February.

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 inpatient ward and emergency department nurse establishment review is complete with the Director of Nursing's recommendations being presented to the Finance and Investment Committee in March 2018. The outcome will be presented to the Trust Board at their public meeting in April 2018.

- Winter pressures continue to negatively impact ward staffing levels on a daily basis. The additional escalation areas open at EDGH place an increased demand on the established ward staffing as TWS is unable to fulfil all RN requests submitted and the escalation areas must be safely staffed.

- Staff moves are happening on a shift by shift basis to mitigate risk. Twice daily staffing meetings are in place at both acute sites, with the CQ meeting including a review of the Bexhill Irvine Unit and Rye Memorial Hospital staffing. These meetings are attended by divisional representatives, the site team and supported by TWS . Together all wards and he emergency departments are systematically reviewed by the clinicians present to agree which moves are made and the communication of these decisions to ward staff.

- "Safe Care" programme implementation is complete as originally designed. However, the ongoing embedding of processes to achieve a business as usual approach is being further developed.

- The POD committee has received the Trust response to the House of Commons Health Committee report on the Nursing workforce and accepted the recommendations and actions.

- Revised Health roster compliance meetings commence on 5th April 2018 led by the Director of Nursing and corporate nursing team. They will focus on improving compliance with rostering KPIs and supporting wards with rostering good practice.

# Safer Staffing



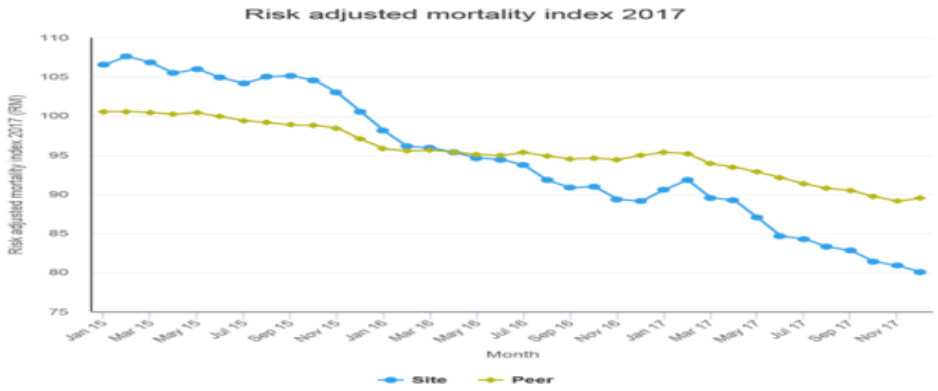
| Site Name | Day | | Night | |
|---|---|---|---|---|
| | Average fill rate - registered nurses/midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses/midwives (%) | Average fill rate - care staff (%) |
| BEXHILL HOSPITAL | 82.90% | 100.50% | 88.60% | 113.60% |
| CONQUEST HOSPITAL | 82.10% | 111.60% | 82.90% | 113.30% |
| EASTBOURNE DISTRICT GENERAL HOSPITAL | 86.60% | 110.20% | 87.50% | 122.10% |
| TOTAL | 84.30% | 110.10% | 85.20% | 117.70% |

- 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;
    - Rostering of HCAs to fill RN shifts
    - Additional staff required for patients needing enhanced observation/those at risk.
- 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 demand, fill rate and outstanding shifts continues and is supplemented with a daily report on staff moves and Safe Care compliance following the staffing meetings at each site.
- Divisional actions to optimise staffing and optimise rosters will be led by the Associate Directors of Nursing in each division. KPIs and reports are being shared to support this.
- More detailed reporting has been received at the People and Organisational Development (POD) Committee including breakdown of fill rates and impact by ward.

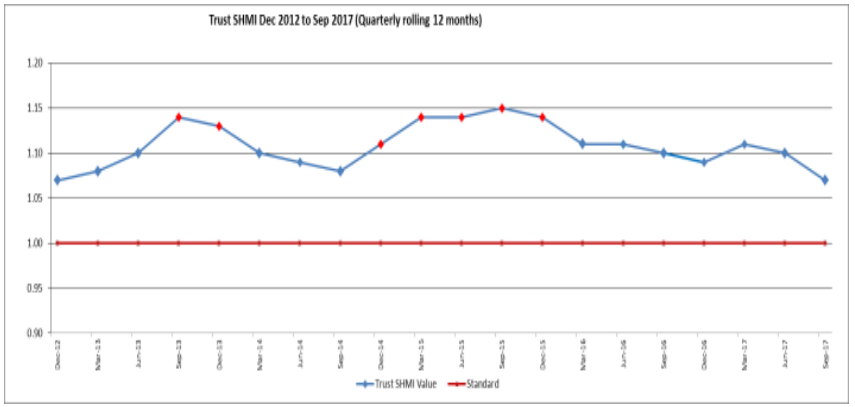
# Mortality Metrics

East Sussex Healthcare NHS
NHS Trust

**RAMI 17 (Rolling 12 months)**




**SHMI (Rolling 12 months)**




SHMI for the period October 2016 to September 2017 is the latest published and is 1.07. The Trust remains within the EXPECTED range.

RAMI 17 January 2017 to December 2017 (rolling 12 months) is 80 compared to 89 for the same period last year (January 2016 to December 2016). December 2016 to November 2017 was 81 (RAMI 17).

RAMI 17 shows an December position of 87 against a peer value of 107. The November position was 76 against a peer value of 82.

Crude mortality shows January 2017 to December 2017 at 1.79% compared to 1.84% for January 2016 to December 2016 (a 2.48% reduction)

The percentage of deaths reviewed within 3 months was 63% in November 2017, compared to 58% in October 2017.

| Main causes of death during February 2018 (Mortality Database) | |
|---|---|
| Pneumonia | 49 |
| Sepsis/Septicaemia | 24 |
| Cancer | 23 |
| Myocardial Infarction (MI) | 10 |
| Heart Failure | 8 |
| Chronic Obstructive Pulmonary Disease (COPD) | 7 |

**Septicaemia CCS Group (Rolling 12 months)**

Access & Delivery

# ACCESS AND DELIVERY

East Sussex Healthcare NHS
NHS Trust

# URGENT CARE

| Indicator Description | Target | Month Comparison | | | YTD Comparison | | | Rolling 12 month Avg | Trend |
|---|---|---|---|---|---|---|---|---|---|
| | | Feb-17 | Feb-18 | Var | 2016/17 | 2017/18 | Var | | |
| **Four hour standard** | 95.0% | 76.0% | 86.8% | 10.8% | 80.3% | 87.7% | 7.4% | 87.1% | |
| 12 Hour DTAs | 0 | 0 | 0 | 0 | 3 | 0 | -3 | 0 | |
| Unplanned re-attendance to Emergency Department | 5.0% | 2.7% | 2.5% | -0.1% | 3.0% | 2.8% | -0.2% | 2.8% | |
| % Patients waiting less than 15 minutes for assessment in ED | M | 81.7% | 78.7% | -3.0% | 90.4% | 82.7% | -7.7% | 82.4% | |
| % Patients waiting less than 60 minutes for treatment in ED | M | 48.5% | 52.6% | 4.1% | 41.1% | 46.3% | 5.2% | 46.1% | |
| % Patients waiting less than 120 minutes for treatment in ED | M | 76.9% | 83.0% | 6.1% | 68.3% | 75.9% | 7.6% | 75.7% | |
| % Patients that left without being seen in ED | M | 1.0% | 1.7% | 0.7% | 1.5% | 1.7% | 0.2% | 1.7% | |
| % Patients admitted from ED (Conversion rate) | M | 27.8% | 32.7% | 5.0% | 25.5% | 28.9% | 3.4% | 28.8% | |
| Number of ambulatory care admissions with zero length of stay | M | 451 | 607 | 156 | 5833 | 8232 | 2399 | 735 | |
| % of ambulatory care admissions with zero length of stay | M | 35.8% | 44.5% | 8.7% | 37.6% | 45.3% | 7.7% | 44.8% | |
| **Emergency Department attendances** | M | 7951 | 8652 | 8.8% | 101095 | 108276 | 7.1% | 9810 | |
| Ambulance conveyances | M | 2886 | 2945 | 2.0% | 33927 | 35344 | 4.2% | 3208 | |
| Admissions via A&E | M | 27.8% | 32.7% | 5.0% | 25.5% | 28.9% | 3.4% | 28.8% | |

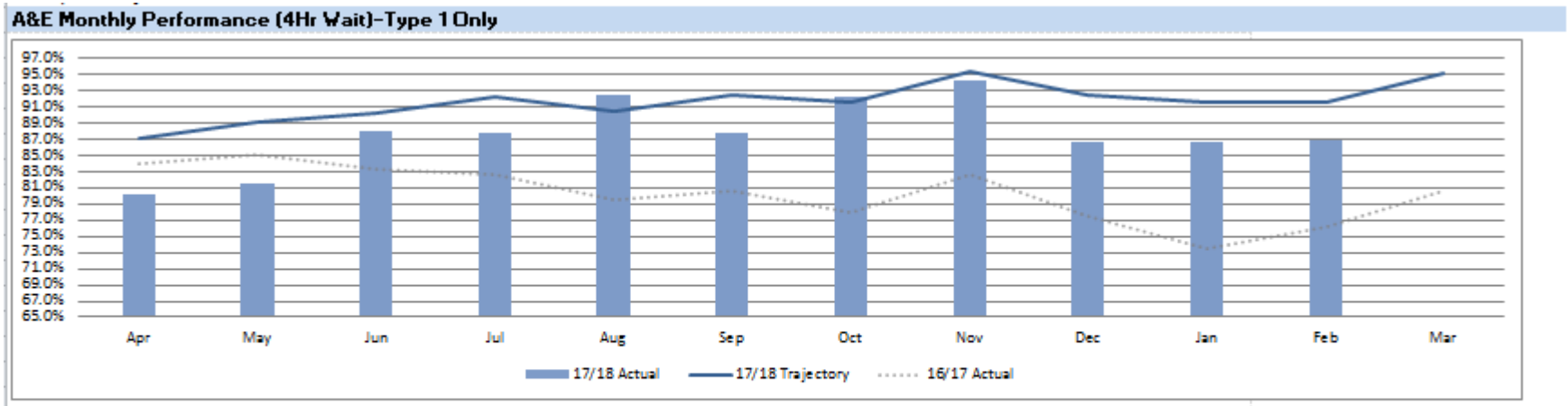
The Trusts' 4 hour performance was 86.8% (and 10% improvement on the previous year).

The system, which includes the walk in centres and the acutes is performing above 90%

Patients being managed through the ambulatory unit and AMU with a 0 day LOS has increased by 35%

Activity continues to increase on the previous year, with 8.7% on attendances and 20% increased in non-elective spells

# A&E Trajectory




| | 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% | 94.1% | 86.7% | 86.7% | 86.8% | |
| 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% |

- EDGH – 84.4.4%
- Conquest – 89.4%

- Minors performance for February is 97.1%
- Attendances in February increased by 8.8% on the previous year.
- Ambulance conveyances increased by 2% on February 2017.

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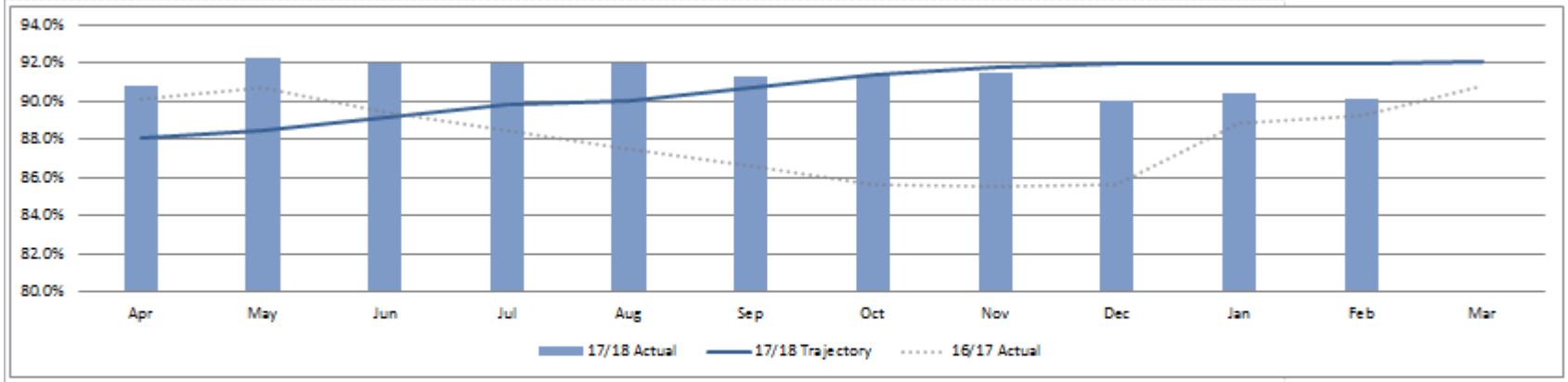
# RTT

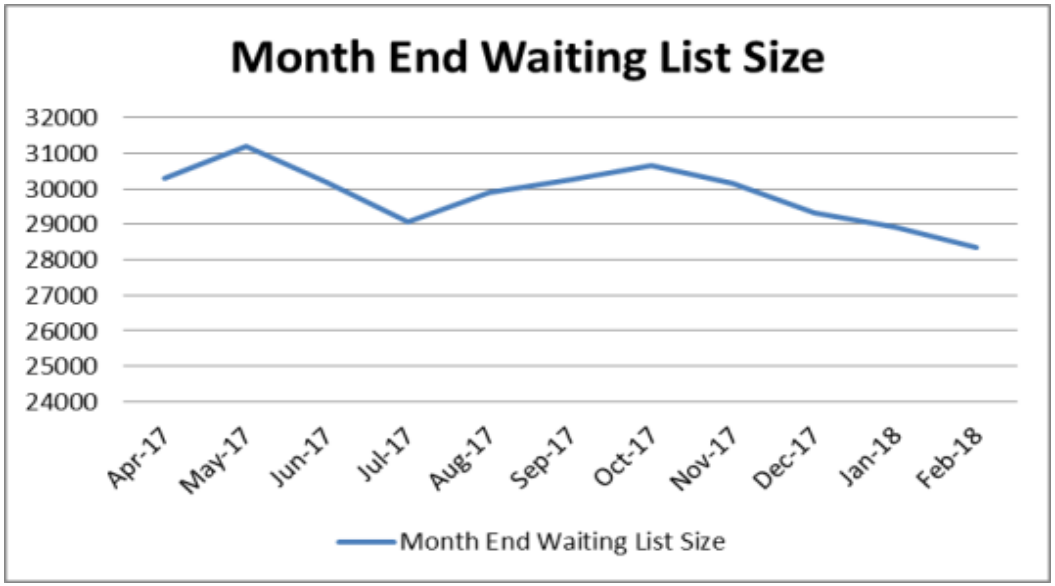
| Indicator Description | Target | Month Comparison | | | YTD Comparison | | | Rolling 12 month Avg | Trend |
|---|---|---|---|---|---|---|---|---|---|
| | | Feb-17 | Feb-18 | Var | 2016/17 | 2017/18 | Var | | |
| **RTT Incomplete standard** | 92.0% | 89.3% | 90.2% | 0.9% | 88.0% | 91.3% | 3.3% | 91.3% | |
| RTT Backlog (Number of patients waiting over 18 weeks) | M | 3131 | 2777 | -354 | 3131 | 2777 | -354 | 2643 | |
| RTT 52 week waiters | 0 | 0 | 0 | 0 | 1 | 2 | 1 | 0 | |
| RTT 35 week waiters | M | 326 | 165 | -49.4% | 326 | 165 | -49.4% | 207 | |
| **Diagnostic standard (% patients waiting more than 6 weeks)** | 1.0% | 1.2% | 1.9% | 0.7% | 2.0% | 2.4% | 0.5% | 2.4% | |

**Referral to Treatment Incomplete (under 18 weeks)**




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 17/18 Trajectory | 88.1% | 88.5% | 89.2% | 89.8% | 90.0% | 90.7% | 91.4% | 91.8% | 92.0% | 92.0% | 92.0% | 92.1% |
| 17/18 Actual | 90.8% | 92.3% | 92.0% | 92.0% | 92.0% | 91.3% | 91.4% | 91.5% | 90.0% | 90.4% | 90.2% | |
| 16/17 Actual | 90.2% | 90.7% | 89.5% | 88.5% | 87.5% | 86.6% | 85.7% | 85.6% | 85.6% | 88.9% | 89.3% | 90.8% |

- **The Trust performance for the February was 90.2%.**
- **Elective activity has been maintained through winter, prioritising cancer, urgent and long waiting patients.**
- **Focusing on out-patient and theatre productivity to better manage demand and capacity without additional costs.**
- **Agreement (at no cost to Trust) to re-direct long-waiters to other provider.**
- **18 week team supporting ophthalmology out-patients**




- **The waiting list continues to drop as is currently at 28,355 from a peak in May 2017 of 31,1197.**

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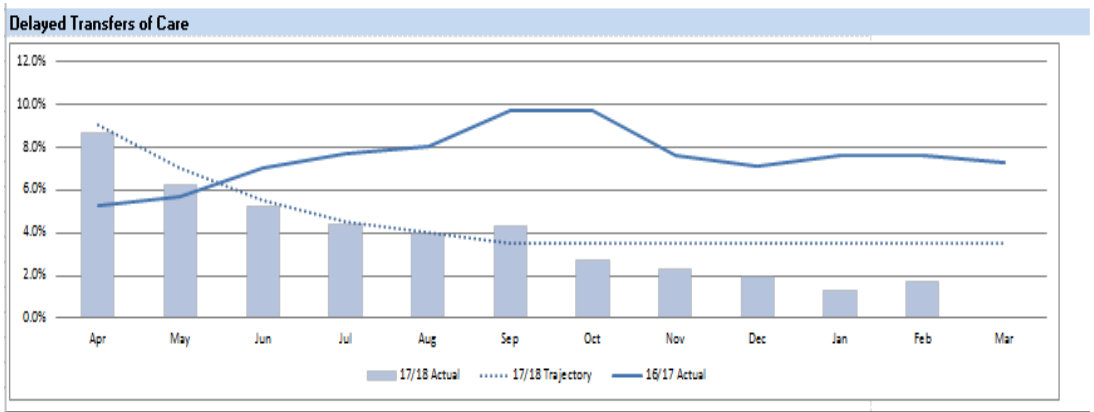
# CANCELLATIONS AND DTC

| Indicator Description | Target | Month Comparison | | | YTD Comparison | | | Rolling 12 month Avg | Trend |
|---|---|---|---|---|---|---|---|---|---|
| | | Feb-17 | Feb-18 | Var | 2016/17 | 2017/18 | Var | | |
| **Delayed transfer of care national standard** | 3.5% | 7.6% | 1.7% | -5.9% | 7.5% | 3.9% | -3.7% | 4.2% | |
| **Cancellations** | | | | | | | | | |
| Urgent operations cancelled for a second time | 0 | 1 | 0 | -1 | 7 | 1 | -6 | 0 | |
| Proportion of last minute cancellations not rebooked within 28 days | 0.0% | 2.7% | | | 1.4% | 0.7% | -0.7% | 99.3% | |




| | 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% | 2.0% | 1.3% | 1.7% | |
| 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 increased marginally in February. This is the fourth 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.**
- **Despite the increase in activity, non-elective bed days have reduced by 5.1% and length of stay by 1.5 days supporting the continued elective flow and sustained 4 hour performance**
- **Elective LOS has increased by 0.2 days, this is being investigated and is a focus moving forwards**

# Diagnostics

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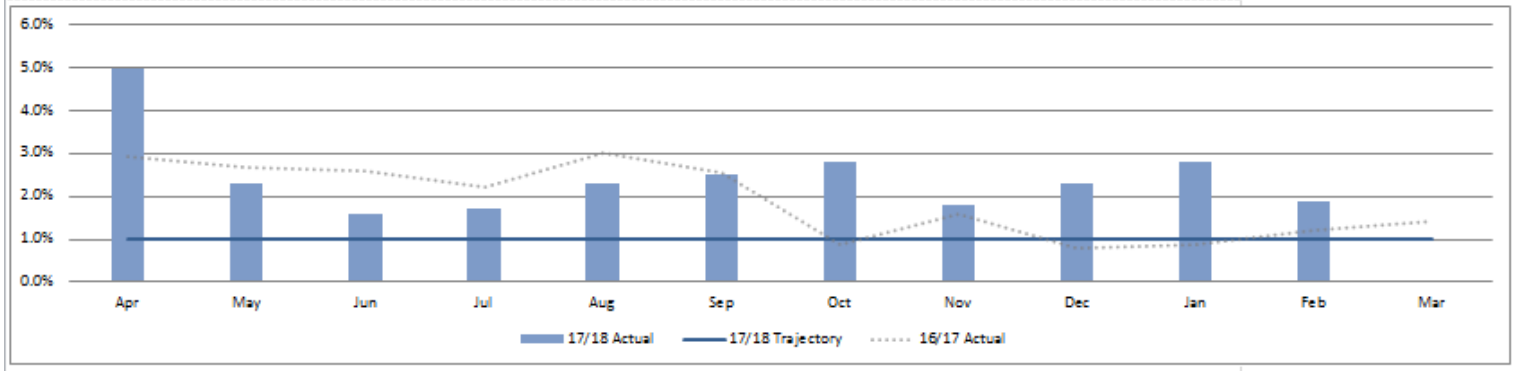
| Indicator Description | Target | Month Comparison | | | YTD Comparison | | | Rolling 12 month Avg | Trend |
|---|---|---|---|---|---|---|---|---|---|
| | | Feb-17 | Feb-18 | Var | 2016/17 | 2017/18 | Var | | |
| Diagnostic standard (% patients waiting more than 6 weeks) | 1.0% | 1.2% | 1.9% | 0.7% | 2.0% | 2.5% | 0.5% | 2.4% | |

Diagnostic waiting times (over 6 weeks)




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 17/18 Trajectory | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% |
| 17/18 Actual | 5.0% | 2.3% | 1.6% | 1.7% | 2.3% | 2.5% | 2.8% | 1.8% | 2.3% | 2.8% | 1.9% | |
| 16/17 Actual | 2.9% | 2.7% | 2.6% | 2.2% | 3.0% | 2.6% | 0.9% | 1.6% | 0.8% | 0.9% | 1.2% | 1.4% |

**Diagnostics remains a challenge for the organisation. Performance in February improved to 1.9% but still requires further work to achieve the <1% target.**

**Key areas for improvement are radiology (CT/MRI and ultrasound) and endoscopy.**

**The agreed intensive review of radiology, supported by external expert has begun and is currently focussing on capacity & demand with the intention to then review service re-design to reduce waits for all patients for CT & MRI scans.**

**Delays in endoscopy relate to patients who require their procedure under sedation, within the theatre environment. Clinical appropriateness is being reviewed, scheduling of patients and additional capacity.**

The breaches were:

| | |
|---|---|
| Imaging | 96 |
| Physiology | 7 |
| Endoscopy | 26 |

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# CANCER STANDARDS

| Indicator Description | Target | Month Comparison | | | YTD Comparison | | | Rolling 12 month Avg | Trend |
|---|---|---|---|---|---|---|---|---|---|
| | | Jan-17 | Jan-18 | Var | 2016/17 | 2017/18 | Var | | |
| **Cancer 2WW Standard** | 93.0% | 97.1% | 95.8% | -1.3% | 97.2% | 96.1% | -1.1% | 96.3% | |
| **Cancer 62 day urgent referral standard** | 85.0% | 78.6% | 65.5% | -13.1% | 76.5% | 75.6% | -0.8% | 75.7% | |
| Cancer 2WW Standard (breast symptoms) | 93.0% | 95.5% | 94.4% | -1.1% | 96.8% | 95.8% | -1.1% | 96.1% | |
| Cancer 31 day standard | 96.0% | 99.5% | 95.6% | -3.9% | 98.8% | 97.2% | -1.6% | 97.2% | |
| Cancer 31 day subsequent drug treatment | 98.0% | 100.0% | 100.0% | 0.0% | 100.0% | 100.0% | 0.0% | 100.0% | |
| Cancer 31 day subsequent surgery | 94.0% | 100.0% | 100.0% | 0.0% | 98.6% | 98.3% | -0.3% | 97.8% | |
| Cancer 62 day screening standard | 90.0% | 92.6% | 66.7% | -25.9% | 88.0% | 74.8% | -13.2% | 76.0% | |

- **The cancer data is reported a month in arrears.**
- **For January the trust fell short of the target for the 31 day standard, the 62 Day urgent referral standard and the 62 Day screening**
- **2WW referrals have increased by 5.9% on the previous year (Feb data)**

# Cancer 62 Days

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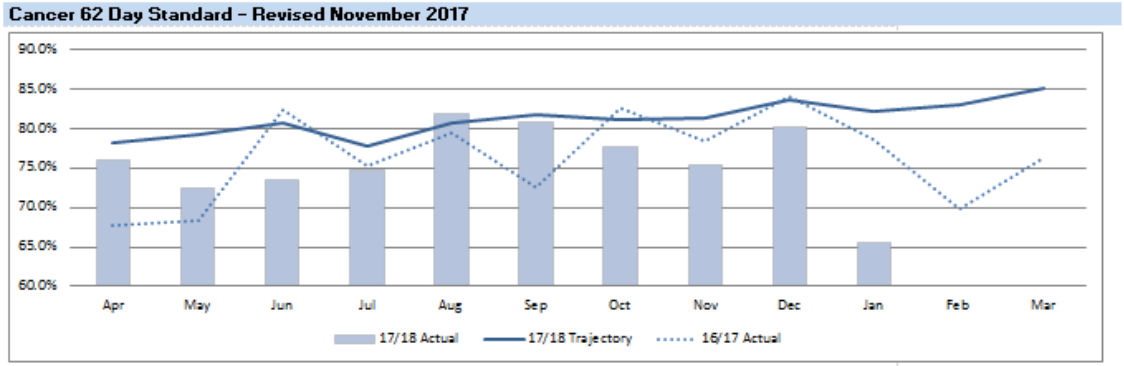


| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 17/18 Trajectory | 78.2% | 79.2% | 80.6% | 77.8% | 80.6% | 81.7% | 81.0% | 81.2% | 83.6% | 82.1% | 83.0% | 85.0% |
| 17/18 Actual | 76.0% | 72.4% | 73.4% | 74.7% | 81.9% | 80.8% | 77.6% | 75.4% | 80.2% | 65.5% | | |
| 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 January:**

- **Project Manager assigned, reviewing existing and recovery plans**
- **Interdependency with Radiology re-design.**
- **Detailed breach analysis being completed**
- **Development of reporting tools to prevent breaches.**
- **Revised Escalation Plan for implementation, in line with timed pathways**

# Cancer Summary

| January 2018 Summary | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Standard | Seen/Treated | | | On Target | | | Breaches | | | Compliance | | | Target |
| | Conq. | EDGH | All | Conq. | EDGH | All | Conq. | EDGH | All | Conq. | EDGH | All | |
| Cancer 2WW | 537 | 791 | 1,328 | 508 | 764 | 1,272 | 29 | 27 | 56 | 94.6 % | 96.6 % | 95.8 % | 93 % |
| Symptomatic Breast 2WW | 53 | 72 | 125 | 49 | 69 | 118 | 4 | 3 | 7 | 92.5 % | 95.8 % | 94.4 % | 93 % |
| DDT to First Treatment 31 Days | 60 | 120 | 180 | 60 | 112 | 172 | 0 | 8 | 8 | 100 % | 93.3 % | 95.6 % | 96 % |
| ECAD to Subs Surgery 31 Days | 7 | 3 | 10 | 7 | 3 | 10 | 0 | 0 | 0 | 100 % | 100 % | 100 % | 94 % |
| ECAD to Subs Chemo 31 Days | 10 | 12 | 22 | 10 | 12 | 22 | 0 | 0 | 0 | 100 % | 100 % | 100 % | 98 % |
| ECAD to Subs Other 31 Days | 2 | 7 | 9 | 2 | 7 | 9 | 0 | 0 | 0 | 100 % | 100 % | 100 % | |
| 2WW Ref to First Treatment 62 Days | 45.5 | 86.5 | 132.0 | 27.0 | 59.5 | 86.5 | 18.5 | 27.0 | 45.5 | 59.3 % | 68.8 % | 65.5 % | 85 % |
| Screening Ref to First Treatment 62 Days | 0.5 | 2.5 | 3.0 | 0.5 | 1.5 | 2.0 | 0.0 | 1.0 | 1.0 | 100 % | 60.0 % | 66.7 % | 90 % |
| Upgrade to First Treatment 62 Days | 6.5 | 5.0 | 11.5 | 4.0 | 4.5 | 8.5 | 2.5 | 0.5 | 3.0 | 61.5 % | 90.0 % | 73.9 % | |

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# Cancer Standards – 31 days (target 96%)

| January 2018 DDT to First Treatment 31 Days | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Site | Seen/Treated | | | On Target | | | Breaches | | | Compliance | | | Target |
| | Conq. | EDGH | All | Conq. | EDGH | All | Conq. | EDGH | All | Conq. | EDGH | All | |
| Breast Cancer | 6 | 18 | 24 | 6 | 17 | 23 | 0 | 1 | 1 | 100 % | 94.4 % | 95.8 % | 96 % |
| Colorectal | 9 | 9 | 18 | 9 | 8 | 17 | 0 | 1 | 1 | 100 % | 88.9 % | 94.4 % | 96 % |
| Gynaecology | 0 | 2 | 2 | 0 | 2 | 2 | 0 | 0 | 0 | | 100 % | 100 % | 96 % |
| Haematology | 2 | 8 | 10 | 2 | 8 | 10 | 0 | 0 | 0 | 100 % | 100 % | 100 % | 96 % |
| Head & Neck | 0 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | | 100 % | 100 % | 96 % |
| Lung | 14 | 10 | 24 | 14 | 10 | 24 | 0 | 0 | 0 | 100 % | 100 % | 100 % | 96 % |
| Other | 2 | 0 | 2 | 2 | 0 | 2 | 0 | 0 | 0 | 100 % | | 100 % | 96 % |
| Skin | 9 | 19 | 28 | 9 | 15 | 24 | 0 | 4 | 4 | 100 % | 78.9 % | 85.7 % | 96 % |
| Upper GI | 8 | 5 | 13 | 8 | 5 | 13 | 0 | 0 | 0 | 100 % | 100 % | 100 % | 96 % |
| Urology | 10 | 48 | 58 | 10 | 46 | 56 | 0 | 2 | 2 | 100 % | 95.8 % | 96.6 % | 96 % |
| Total | 60 | 120 | 180 | 60 | 112 | 172 | 0 | 8 | 8 | 100 % | 93.3 % | 95.6 % | 96 % |

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# Cancer Standards – 62 days (target 85%)

| January 2018 2WW Ref to First Treatment 62 Days | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Site | Seen/Treated | | | On Target | | | Breaches | | | Compliance | | | Target |
| | Conq. | EDGH | All | Conq. | EDGH | All | Conq. | EDGH | All | Conq. | EDGH | All | |
| Breast Cancer | 3.5 | 9.0 | 12.5 | 3.0 | 9.0 | 12.0 | 0.5 | 0.0 | 0.5 | 85.7 % | 100 % | 96.0 % | 85 % |
| Colorectal | 8.0 | 7.0 | 15.0 | 5.0 | 4.0 | 9.0 | 3.0 | 3.0 | 6.0 | 62.5 % | 57.1 % | 60.0 % | 85 % |
| Gynaecology | 0.0 | 3.0 | 3.0 | 0.0 | 1.5 | 1.5 | 0.0 | 1.5 | 1.5 | | 50.0 % | 50.0 % | 85 % |
| Haematology | 2.0 | 3.0 | 5.0 | 0.0 | 1.0 | 1.0 | 2.0 | 2.0 | 4.0 | 0.0 % | 33.3 % | 20.0 % | 85 % |
| Head & Neck | 2.0 | 1.5 | 3.5 | 0.5 | 1.5 | 2.0 | 1.5 | 0.0 | 1.5 | 25.0 % | 100 % | 57.1 % | 85 % |
| Lung | 5.5 | 4.0 | 9.5 | 1.0 | 2.0 | 3.0 | 4.5 | 2.0 | 6.5 | 18.2 % | 50.0 % | 31.6 % | 85 % |
| Sarcoma | 0.0 | 0.5 | 0.5 | 0.0 | 0.5 | 0.5 | 0.0 | 0.0 | 0.0 | | 100 % | 100 % | 85 % |
| Skin | 9.5 | 15.0 | 24.5 | 8.5 | 15.0 | 23.5 | 1.0 | 0.0 | 1.0 | 89.5 % | 100 % | 95.9 % | 85 % |
| Upper GI | 6.0 | 5.5 | 11.5 | 4.0 | 3.0 | 7.0 | 2.0 | 2.5 | 4.5 | 66.7 % | 54.5 % | 60.9 % | 85 % |
| Urology | 9.0 | 38.0 | 47.0 | 5.0 | 22.0 | 27.0 | 4.0 | 16.0 | 20.0 | 55.6 % | 57.9 % | 57.4 % | 85 % |
| Total | 45.5 | 86.5 | 132.0 | 27.0 | 59.5 | 86.5 | 18.5 | 27.0 | 45.5 | 59.3 % | 68.8 % | 65.5 % | 85 % |

# Community Nursing and Therapy Services

East Sussex Healthcare NHS Trust

| Indicator Description | Target | Month Comparison | | | YTD Comparison | | | Rolling 12 month Avg | Trend |
|---|---|---|---|---|---|---|---|---|---|
| | | Feb-17 | Feb-18 | Var | 2016/17 | 2017/18 | Var | | |
| **Community Nursing** | | | | | | | | | |
| Community nursing referrals | M | 4270 | 3991 | -279 | 45001 | 45341 | 340 | 4155 |  |
| Community nursing total contacts | M | 34058 | 33029 | -1029 | 377496 | 388794 | 11298 | 35559 |  |
| Community Nursing face-to-face contacts | M | 18442 | 17931 | -511 | 212477 | 217141 | 4664 | 19866 |  |
| Community nursing ALOS | M | 20.5 | 4.1 | -16 | 23.5 | 14.3 | -9.2 | 15 |  |
| **Waiting Times** | | | | | | | | | |
| % SALT patients waiting less than 13 weeks | M | 100.0% | 100.0% | 0.0% | 100.0% | 100.0% | 0.0% | 100.0% |  |
| Total SALT patients waiting | M | 133 | 159 | 26 | 1721 | 1545 | -176 | 140 |  |
| % Podiatry patients waiting less than 13 weeks | M | 100.0% | 100.0% | 0.0% | 100.0% | 100.0% | 0.0% | 100.0% |  |
| Total podiatry patients waiting | M | 284 | 236 | -48 | 7227 | 2747 | -4480 | 261 |  |
| % Dietetics patients waiting less than 13 weeks | M | 98.7% | 100.0% | 1.3% | 99.8% | 98.4% | -1.5% | 98.5% |  |
| Total dietetics patients waiting | M | 74 | 53 | -21 | 661 | 665 | 4 | 61 |  |
| % MSK patients waiting less than 13 weeks | M | 81.0% | 96.5% | 15.5% | 98.8% | 78.7% | -20.2% | 81.3% |  |
| Total MSK patients waiting | M | 434 | 1018 | 584 | 11632 | 9431 | -2201 | 955 |  |

- **Community nursing continue to receive high referrals which is impacting the nursing teams, although there has been a slight reduction on the same period last year**
- **A review of services is being undertaken to understand what activities lay outside of contract or could be delivered in a different way to reduce the pressure on the teams**
- **Therapy services are all meeting their access standards in seeing patients in less than 13 weeks from referral**
- **Community bed length of stay has reduced by 5 days, increasing flow into these beds from acute and from home avoiding hospital admissions**

# Admission Avoidance Teams

East Sussex Healthcare NHS
NHS Trust

| Indicator Description | Target | Month Comparison | | | YTD Comparison | | | Rolling 12 month Avg | Trend |
|---|---|---|---|---|---|---|---|---|---|
| | | Jan-17 | Jan-18 | Var | 2016/17 | 2017/18 | Var | | |
| **HIT** | | | | | | | | | |
| Number of Referrals | M | 480 | 714 | 48.8% | 3977 | 5804 | 45.9% | 569 | |
| Number of Contacts | M | 480 | 1135 | 136.5% | 4066 | 8171 | 101.0% | 766 | |
| | | | | | | | | | |
| **Frailty** | | | | | | | | | |
| Number of Referrals | M | 39 | 85 | 117.9% | 51 | 884 | 1633.3% | 85 | |
| Number of Contacts | M | 25 | 456 | 1724.0% | 33 | 5316 | 16009.1% | 519 | |
| Overall response rate | M | | 88.2% | | | 55.7% | | 54.6% | |
| | | | | | | | | | |

**Hospital Intervention Team:**

- Significant increase in referrals both monthly and YTD comparison, % of patient discharged reduced in month due to an increasing number of patients being referred who are not medically fit or requiring analgesia to enable assessment. Access to intermediate care beds and other appropriate services is also leading to admissions.

**Frailty Practitioners:**

- The frailty practitioners have been working within the community and acute sites, activity above includes the community referrals only
- Increase in waiting times for community referrals due to mobilisation of acute frailty model from December. The pilot will report in April.

**Crisis Response:**

- 330 new referrals seen
- 82% Prevention of Admission and 18% Discharge to Assess
- 68% of pts seen within 2 hours
- 92% of patient had ‘home’ destination 27% of patients were re admitted to hospital within 30 days

Leadership & Culture

# LEADERSHIP & CULTURE

East Sussex Healthcare NHS Trust

# CONTENT

# TRUST OVERVIEW

| TRUST | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WORKFORCE CAPACITY | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Trend line |
| Budgeted fte | 6,470.1 | 6,470.1 | 6,966.1 | 6,887.8 | 6,904.3 | 6,827.9 | 6,824.5 | 6,893.0 | 6,852.0 | 6,879.3 | 6,873.2 | 6,859.5 | |
| Total fte usage | 6,572.2 | 6,702.2 | 6,674.2 | 6,607.7 | 6,679.0 | 6,663.4 | 6,672.3 | 6,695.4 | 6,756.7 | 6,813.8 | 6,846.7 | 6,888.7 | |
| Variance | 102.1 | 232.1 | -291.9 | -280.2 | -225.3 | -164.4 | -152.3 | -197.6 | -95.3 | -65.5 | -26.5 | 29.2 | |
| Permanent vacancies | 435.2 | 389.2 | 810.7 | 785.0 | 788.6 | 706.8 | 706.4 | 745.9 | 647.0 | 622.0 | 609.9 | 577.7 | |
| Fill rate | 93.1% | 93.8% | 88.3% | 88.3% | 88.3% | 89.4% | 89.4% | 89.0% | 90.4% | 90.8% | 91.0% | 91.4% | |
| Bank fte usage (as % total fte usage) | 7.3% | 8.3% | 8.8% | 8.0% | 8.9% | 8.9% | 9.3% | 9.3% | 9.3% | 9.3% | 9.7% | 9.7% | |
| Agency fte usage (as % total fte usage) | 3.9% | 3.9% | 3.2% | 2.9% | 2.7% | 2.4% | 2.2% | 2.2% | 1.8% | 2.1% | 1.8% | 2.0% | |
| Turnover rate | 10.0% | 10.3% | 11.0% | 11.1% | 11.0% | 11.2% | 11.2% | 11.6% | 11.3% | 11.3% | 11.3% | 11.2% | |
| Stability rate | 92.7% | 93.0% | 92.3% | 92.1% | 92.0% | 91.4% | 91.7% | 91.1% | 91.6% | 91.5% | 92.1% | 92.2% | |
| SICKNESS ABSENCE | | | | | | | | | | | | | |
| Annual sickness rate | 4.4% | 4.3% | 4.2% | 4.2% | 4.2% | 4.2% | 4.3% | 4.3% | 4.3% | 4.3% | 4.4% | 4.4% | |
| Monthly sickness rate (%) | 4.4% | 4.0% | 3.4% | 3.5% | 3.8% | 4.4% | 4.2% | 4.3% | 4.8% | 5.0% | 5.3% | 5.6% | |
| Monthly long term sickness (28 days+) | 32.9% | 31.8% | 42.6% | 37.7% | 42.7% | 38.2% | 40.5% | 36.6% | 41.4% | 38.4% | 41.0% | 34.6% | |
| Short term sickness (<28 days) | 67.1% | 68.2% | 57.4% | 62.3% | 57.3% | 61.8% | 59.5% | 63.4% | 58.6% | 61.6% | 59.0% | 65.4% | |
| MANDATORY TRAINING & APPRAISALS | | | | | | | | | | | | | |
| Appraisal rate | 79.1% | 78.9% | 79.3% | 81.7% | 81.0% | 81.5% | 81.6% | 82.2% | 82.3% | 81.4% | 81.3% | 81.8% | |
| Fire | 84.4% | 84.5% | 83.3% | 84.4% | 84.2% | 85.5% | 85.9% | 85.5% | 85.8% | 86.0% | 85.8% | 86.4% | |
| Moving & Handling | 89.0% | 89.5% | 88.7% | 89.2% | 89.7% | 90.2% | 90.2% | 89.7% | 89.1% | 89.3% | 89.4% | 90.4% | |
| Induction | 95.4% | 96.0% | 95.8% | 95.1% | 95.5% | 95.0% | 95.0% | 94.3% | 91.9% | 93.5% | 92.5% | 95.1% | |
| Infec Control | 87.3% | 87.6% | 86.9% | 87.6% | 88.1% | 89.0% | 89.6% | 89.3% | 88.8% | 88.8% | 88.7% | 89.8% | |
| Info Gov | 84.2% | 87.2% | 83.7% | 84.3% | 84.4% | 85.8% | 85.3% | 85.7% | 85.0% | 85.8% | 84.6% | 86.8% | |
| Health & Safety | 88.5% | 87.6% | 87.6% | 88.1% | 88.8% | 89.6% | 88.8% | 88.1% | 87.9% | 88.8% | 87.9% | 88.0% | |
| MCA | 95.5% | 95.7% | 96.0% | 96.0% | 96.2% | 96.5% | 96.0% | 95.8% | 94.8% | 94.8% | 95.1% | 95.0% | |
| DoLs | 97.7% | 97.9% | 98.1% | 98.0% | 97.8% | 98.0% | 97.6% | 97.5% | 95.5% | 95.5% | 95.8% | 95.1% | |
| Safeguarding Vulnerable Adults | 87.2% | 87.5% | 88.2% | 88.6% | 89.6% | 90.3% | 90.1% | 88.9% | 88.0% | 87.8% | 87.4% | 86.2% | |
| Safeguarding Children Level 2 | 86.3% | 86.4% | 86.8% | 87.1% | 87.2% | 87.4% | 86.4% | 86.1% | 85.9% | 86.0% | 85.7% | 85.0% | |

***Source data**: ESR dated 1st Feb '17 to 31st Jan '18 & Finance Ledger*

# MONTHLY HEADLINES

**HEADLINES – JANUARY 2018**

- Actual workforce utilisation 6,888.7 fte (+29.2 fte above the budgeted establishment)
- Total Trust workforce expenditure to date budget £229,459k actual £237,280k (+£7,821k)
- Jan '18 monthly budget £22,733k against monthly actual expenditure £24,723k (+£1,990k)
  - Substantive expenditure £20,955k
  - Temporary staff expenditure £3,767k (15.2% of total pay expenditure) as follows:
    - Bank expenditure £2,807k
    - Agency expenditure £929k
    - Overtime £31k
- Vacancies in January compared to December reduced by -32.2 fte to 577.7 fte (8.6%)
- Annual turnover slightly down by 0.1% to 11.2%, which represents 647.6 fte leavers in the last year
- Annual sickness rate unchanged at 4.4%. Monthly sickness increased +0.3% against December to 5.6% attributed to cold, cough flu.
- Mandatory Training rate and Appraisal rates:
  - Mandatory Training increased by +0.6% to 88.8%. Compliance increased in most subjects with the exception of Mental Capacity Act, Deprivation of Liberties training, Safeguarding Vulnerable Adults and Safeguarding Children Level 2 where compliance was slightly down.
  - Appraisal compliance increased by +0.5% at 81.8%

# WORKFORCE UTILISATION BY DIVISION - JANUARY

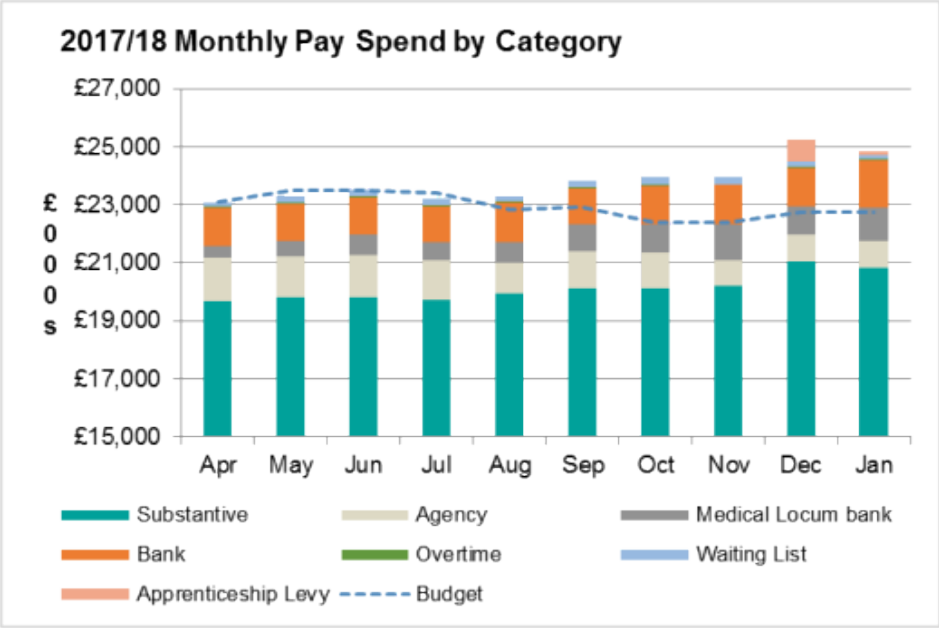
- The cumulative utilisation shows Medicine, Diagnostics, Anaesthetics, & Surgery with Estates & Facilities as the top 3 areas utilising both bank and agency resources

| RESOURCE RATIO | | | MONTHLY | | |
|---|---|---|---|---|---|
| DIVISION | BUDGET FTE | SUBSTANTIVE | BANK | AGENCY | TOTAL |
| Diagnostics Anaesthetics & Surgery | 1,827.4 | 1,626.7 | 149.2 | 41.5 | 1,817.5 |
| Medicine | 1,350.8 | 1,169.0 | 245.9 | 23.9 | 1,438.8 |
| Out of Hospital Care | 1,046.5 | 944.6 | 46.7 | 22.7 | 1,014.0 |
| Womens Childrens & Sexual Health | 687.5 | 617.3 | 29.1 | 5.5 | 651.9 |
| Estates & Facilities | 651.6 | 514.3 | 85.2 | 28.2 | 627.6 |
| Urgent Care | 230.3 | 199.9 | 46.6 | 10.2 | 256.7 |
| Corporate | 1,065.5 | 959.3 | 66.5 | 6.8 | 1,082.3 |
| **TRUST** | **6,859.5** | **6,031.1** | **669.1** | **138.8** | **6,888.7** |

*Source Data: Finance Ledger Month 10*

# WORKFORCE EXPENDITURE

| Actuals in Month (£000s) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Category | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Trend line |
| Budget | £23,106 | £23,504 | £23,497 | £23,400 | £22,825 | £22,912 | £22,390 | £22,366 | £22,726 | £22,733 | |
| **Substantive** | **£19,648** | **£19,785** | **£19,789** | **£19,725** | **£19,931** | **£20,126** | **£20,096** | **£20,189** | **£21,050** | **£20,802** | |
| Agency | £1,522 | £1,444 | £1,473 | £1,342 | £1,043 | £1,269 | £1,269 | £889 | £907 | £929 | |
| Medical Locum bank | £396 | £498 | £696 | £609 | £745 | £909 | £968 | £1,249 | £976 | £1,145 | |
| Bank | £1,315 | £1,317 | £1,299 | £1,267 | £1,332 | £1,268 | £1,321 | £1,347 | £1,329 | £1,663 | |
| Overtime | £42 | £25 | £33 | £38 | £39 | £45 | £44 | £32 | £31 | £31 | |
| Waiting List | £151 | £218 | £237 | £222 | £184 | £210 | £235 | £238 | £195 | £153 | |
| Apprenticeship Levy | | | | | | | | | £744 | £123 | |
| **Total Temp Expenditure** | **£3,426** | **£3,502** | **£3,738** | **£3,478** | **£3,343** | **£3,701** | **£3,837** | **£3,755** | **£4,182** | **£4,044** | |
| **Total Spend** | **£23,074** | **£23,287** | **£23,527** | **£23,203** | **£23,274** | **£23,827** | **£23,933** | **£23,944** | **£24,488** | **£24,723** | |




**Trend Overview**

- Workforce Expenditure tracking above budget since August 2017
- Although agency expenditure has reduced since April, total temporary workforce has not reduced due to locum and bank increases
- Increase in medical locum expenditure includes some switch from agency through 2017

**January**

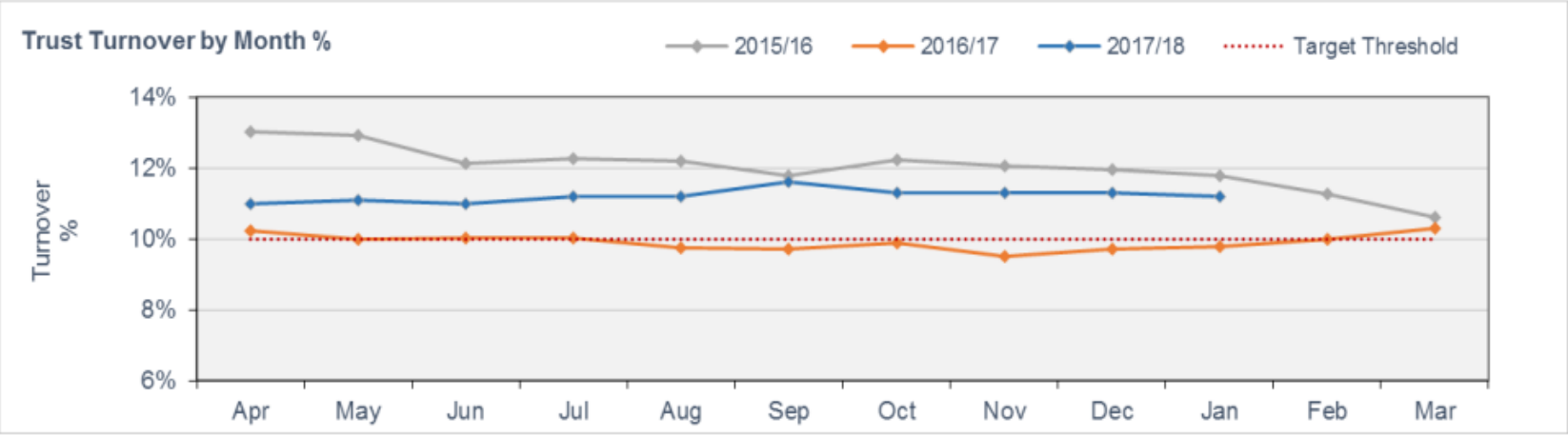
- Additional locums in Urgent Care and Gastroenterology
- Locum and bank payments in January higher partly due to payment of enhancements for Christmas/New Year period, as well as cover for increased monthly sickness

*Source: Finance Ledger Months 1-10*

# TURNOVER TREND – STAFF GROUP

- Turnover rate of 11.2% in January equates to 647.6fte leavers.
- Turnover remains consistent since October with January seeing a small reduction

| TRUST TURNOVER BY STAFF GROUP (%) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Year on Year | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Trend line |
| Additional Clinical Services | 11.9% | 12.6% | 12.5% | 12.4% | 12.8% | 13.7% | 13.9% | 14.5% | 13.8% | 13.5% | |
| Administrative and Clerical | 11.4% | 10.9% | 11.0% | 11.1% | 11.2% | 11.5% | 11.3% | 10.8% | 11.1% | 11.4% | |
| Allied Health Professionals | 9.6% | 10.9% | 10.8% | 11.5% | 11.2% | 11.3% | 11.0% | 11.6% | 12.7% | 12.7% | |
| Estates and Ancillary | 10.0% | 10.2% | 9.4% | 10.2% | 10.7% | 11.0% | 11.5% | 11.4% | 10.4% | 10.7% | |
| Healthcare Scientists | 12.6% | 13.4% | 12.7% | 9.9% | 9.5% | 12.0% | 11.8% | 12.4% | 11.0% | 9.7% | |
| Medical & Dental | 14.4% | 13.2% | 12.8% | 13.0% | 12.1% | 11.4% | 9.7% | 9.4% | 10.0% | 9.1% | |
| Nursing & Midwifery Registered | 10.0% | 10.0% | 10.5% | 10.8% | 10.6% | 11.1% | 10.3% | 10.2% | 10.4% | 10.2% | |
| Prof Scientific and Tech | 12.8% | 11.2% | 10.4% | 10.2% | 10.2% | 6.7% | 8.2% | 8.8% | 8.8% | 8.3% | |
| **TOTAL TRUST TURNOVER** | **11.0%** | **11.1%** | **11.0%** | **11.2%** | **11.2%** | **11.6%** | **11.3%** | **11.3%** | **11.3%** | **11.2%** | |




***Source data**: ESR dated 1st April '17 to 31st Dec '17*

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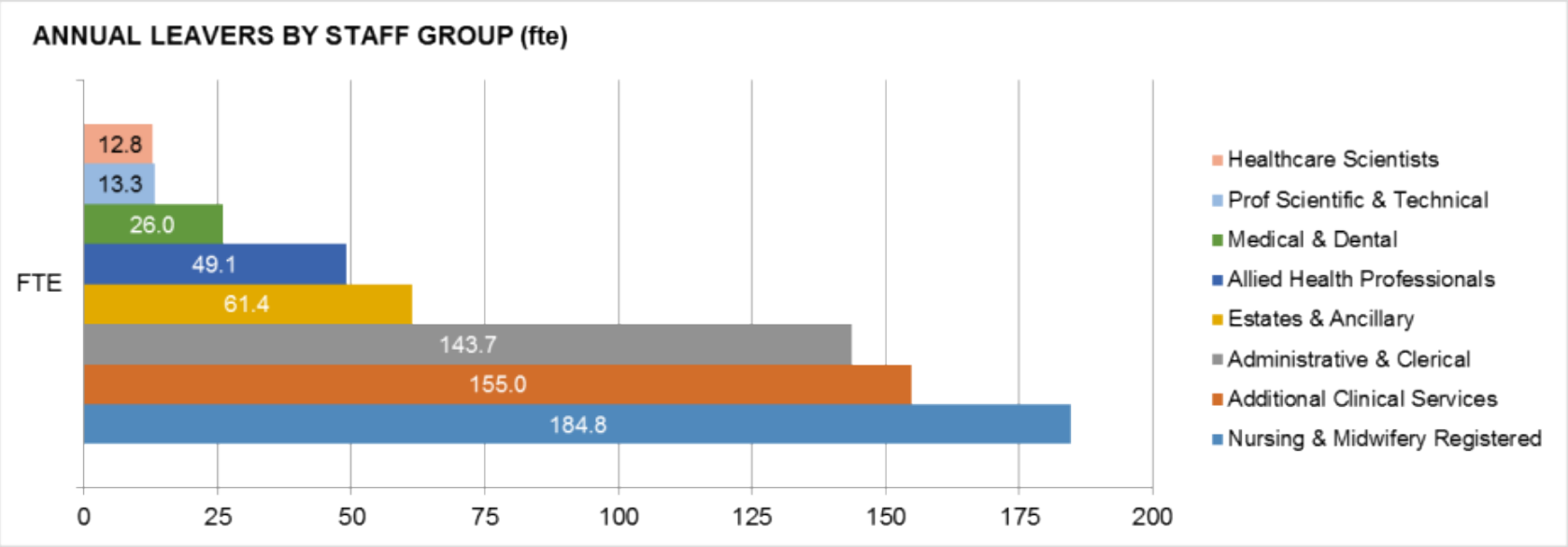
# LEAVERS & STABILITY – STAFF GROUP

| STAFF GROUPS | STABILITY > 1YR |
|---|---|
| Medical & Dental | 92.2% |
| Prof Scientific & Technical | 99.5% |
| Administrative & Clerical | 93.1% |
| Nursing & Midwifery Registered | 92.1% |
| Estates & Ancillary | 91.6% |
| Additional Clinical Services | 90.3% |
| Healthcare Scientists | 91.1% |
| Allied Health Professionals | 88.6% |
| **TRUST** | **91.9%** |

**Overview**

- The Stability Rate measures the number of staff across 12 months who have more than 1 year's service with ESHT
- ESHT stability consistently remains >90% for all groups with the exception of Allied Health Professionals where specific professions rotate externally i.e. Physiotherapy
- Latest available comparisons show stability for NHS organisations at 90.7% and for Kent, Surrey & Sussex Trusts at 87.7% (Nov 2017)

*Source: ESR January 2018; NHS Digital iView.*

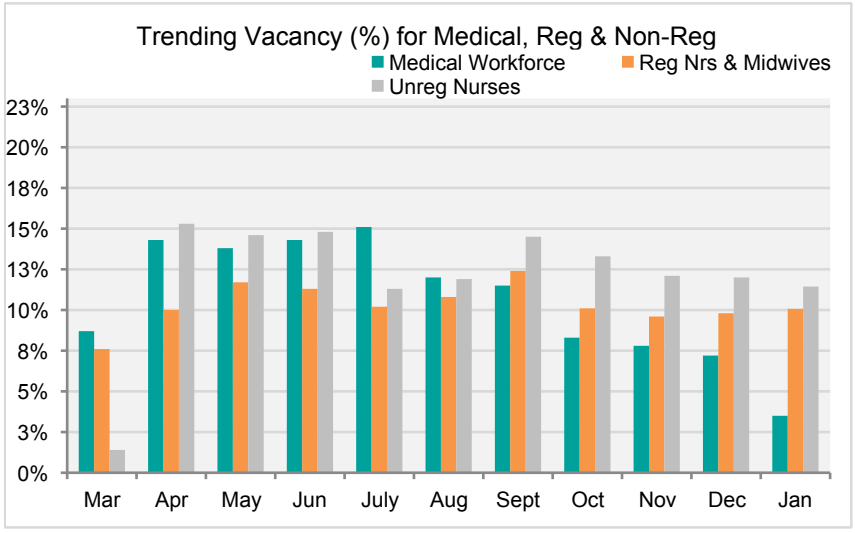


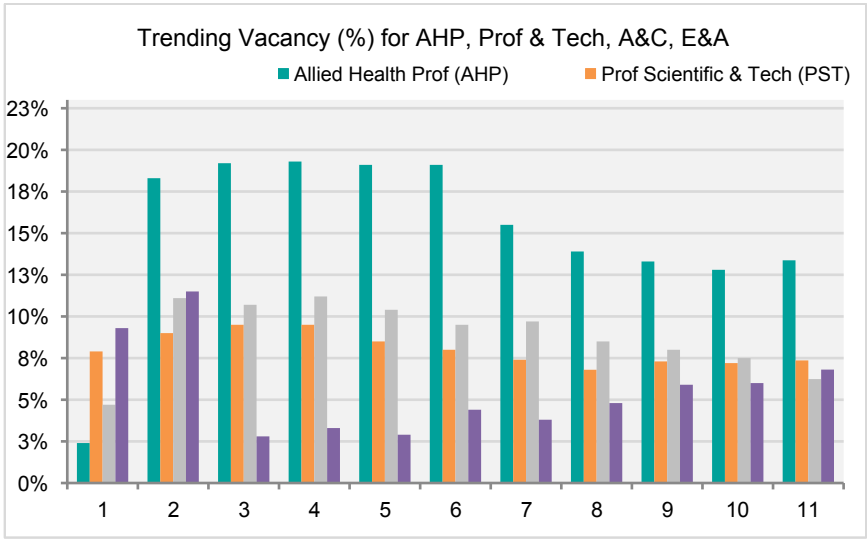

***Source data**: ESR dated 1st April '17 to 31st Dec '17*

# RECRUITMENT – TRENDING NET VACANCIES BY STAFF GROUP (%)

- All staff groups have seen a trending reduction in net vacancies due to creative recruitment strategies that include social media campaigns driving a hike in site activity rates
- MEDACS due to be the primary recruitment source for Medical 'hard to fill' posts
- Apprenticeships continue to be promoted with good uptake, supporting the 'grow your own' Trust strategy

| MAR 2017 TO JAN 2018 | Mar | Apr | May | Jun | July | Aug | Sept | Oct | Nov | Dec | Jan | Trend line |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical Workforce | 8.7% | 14.3% | 13.8% | 14.3% | 15.1% | 12.0% | 11.5% | 8.3% | 7.8% | 7.2% | 3.5% | |
| Reg Nrs & Midwives | 7.6% | 10.0% | 11.7% | 11.3% | 10.2% | 10.8% | 12.4% | 10.1% | 9.6% | 9.8% | 10.1% | |
| Unreg Nurses | 1.4% | 15.3% | 14.6% | 14.8% | 11.3% | 11.9% | 14.5% | 13.3% | 12.1% | 12.0% | 11.4% | |
| Allied Health Prof (AHP) | 2.4% | 18.3% | 19.2% | 19.3% | 19.1% | 19.1% | 15.5% | 13.9% | 13.3% | 12.8% | 13.4% | |
| Prof Scientific & Tech (PST) | 7.9% | 9.0% | 9.5% | 9.5% | 8.5% | 8.0% | 7.4% | 6.8% | 7.3% | 7.2% | 7.4% | |
| Admin & Clerical | 4.7% | 11.1% | 10.7% | 11.2% | 10.4% | 9.5% | 9.7% | 8.5% | 8.0% | 7.5% | 6.2% | |
| Estates & Ancillary (E&A) | 9.3% | 11.5% | 2.8% | 3.3% | 2.9% | 4.4% | 3.8% | 4.8% | 5.9% | 6.0% | 6.8% | |
| **TRUST** | **6.2%** | **12.0%** | **11.7%** | **11.7%** | **10.6%** | **10.6%** | **11.0%** | **9.6%** | **9.2%** | **9.0%** | **8.6%** | |



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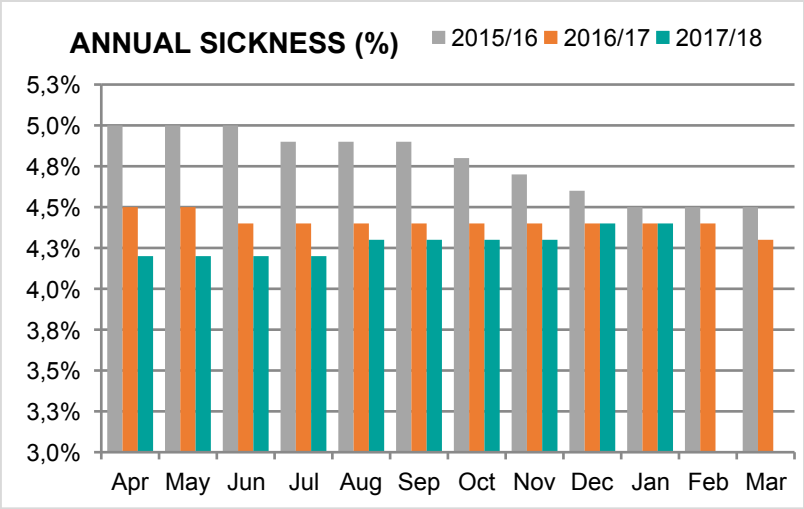
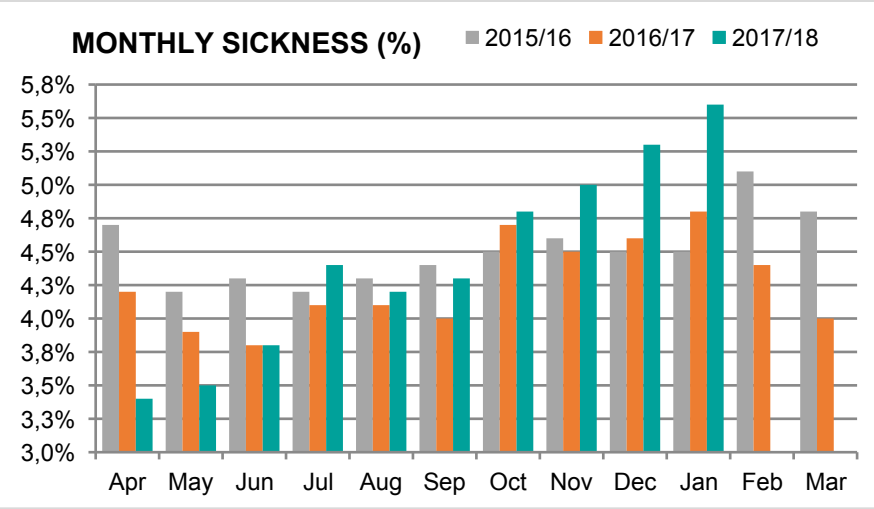
# ABSENCE MANAGEMENT – SICKNESS RATES

- The monthly sickness rate has increased by +0.3% to 5.6% whilst the annual sickness rate remains unchanged at 4.4%
- The staff groups with the highest monthly sickness rates are Estates & Ancillary staff at 8.2% (increase of +0.4% since December) and Additional Clinical Services staff (unregistered nurses & therapy helpers) an increase of +1.3% to 7.0%
- Further insight shows that the increase in short-term sick reasons are directly attributed to cold, cough flu

| ANNUAL (%) | 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% | 4.4% | | |

| MONTHLY (%) | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 4.7% | 4.2% | 4.3% | 4.2% | 4.3% | 4.4% | 4.5% | 4.6% | 4.5% | 4.5% | 5.1% | 4.8% |
| 2016/17 | 4.2% | 3.9% | 3.8% | 4.1% | 4.1% | 4.0% | 4.7% | 4.5% | 4.6% | 4.8% | 4.4% | 4.0% |
| 2017/18 | 3.4% | 3.5% | 3.8% | 4.4% | 4.2% | 4.3% | 4.8% | 5.0% | 5.3% | 5.6% | | |




***Source data**: ESR dated 1st Apr '15 to 31st Jan '18*

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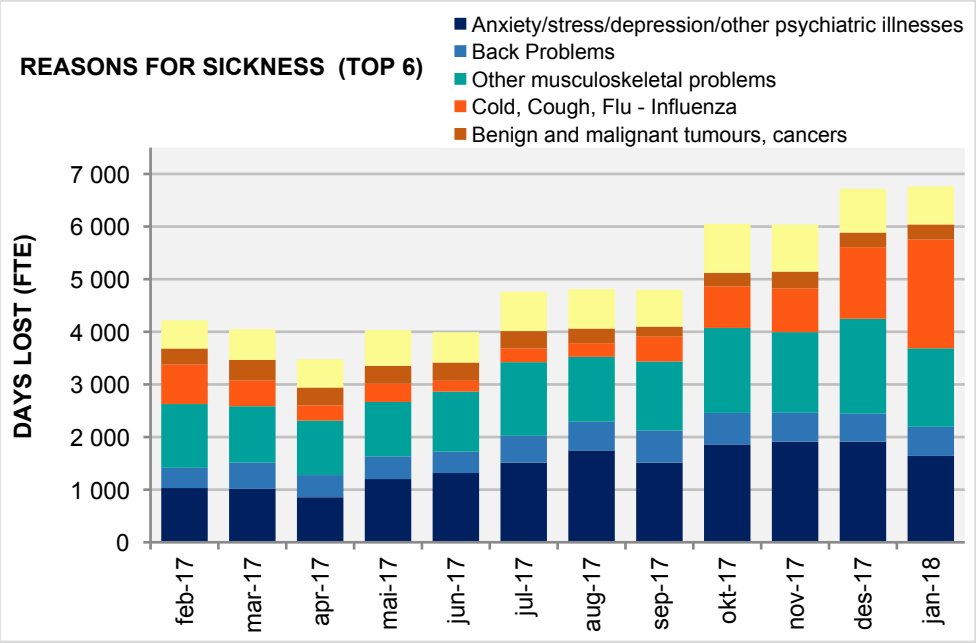
# ABSENCE MANAGEMENT – SICKNESS REASONS

- The increase in monthly sickness is due to a rise in Cold/Cough/Flu which is up by 710 fte days lost in month to 2,070 fte days lost, whilst anxiety/stress and other musculoskeletal problems, usually the top two reasons, are down this month.

| TOP 6 | Fte Days Lost by Month | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Reason for sickness | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Trend line |
| Anxiety/stress/depression/other psychiatric illnesses | 1,030.7 | 1,015.3 | 856.2 | 1,201.7 | 1,316.3 | 1,513.2 | 1,745.7 | 1,514.0 | 1,859.6 | 1,912.3 | 1,912.1 | 1,641.5 | |
| Back Problems | 384.7 | 497.7 | 421.0 | 431.4 | 406.5 | 510.4 | 546.3 | 611.0 | 599.0 | 548.2 | 532.2 | 553.9 | |
| Other musculoskeletal problems | 1,211.3 | 1,072.6 | 1,034.9 | 1,033.6 | 1,141.3 | 1,399.0 | 1,231.5 | 1,309.9 | 1,614.7 | 1,532.5 | 1,803.4 | 1,490.5 | |
| Cold, Cough, Flu - Influenza | 748.7 | 487.5 | 288.9 | 347.8 | 205.4 | 258.6 | 260.2 | 472.3 | 789.5 | 829.0 | 1,360.5 | 2,070.4 | |
| Benign and malignant tumours, cancers | 307.0 | 391.5 | 339.8 | 338.4 | 346.3 | 332.6 | 278.0 | 191.8 | 258.2 | 322.3 | 277.9 | 283.7 | |
| Gastrointestinal problems | 534.1 | 583.2 | 540.2 | 680.4 | 576.5 | 747.9 | 747.5 | 699.8 | 930.7 | 895.1 | 831.8 | 723.1 | |




| Jan 2018 Top 10 in descending order (%) | | |
|---|---|---|
| 1 | Cold, Cough, Flu - Influenza | 19.3% |
| 2 | Anxiety/stress/depression/psychiatric | 15.3% |
| 3 | Other musculoskeletal problems | 13.9% |
| 4 | Reason not specified | 10.8% |
| 5 | Chest & respiratory problems | 8.6% |
| 6 | Gastrointestinal problems | 6.7% |
| 7 | Back Problems | 5.2% |
| 8 | Injury, fracture | 3.2% |
| 9 | Ear, nose, throat (ENT) | 3.1% |
| 10 | Benign and malignant tumours, cancers | 2.6% |
| **TOP 10 REASONS** | | 88.7% |

***Source data**: ESR dated 1st Dec '16 to 31st Dec '17*

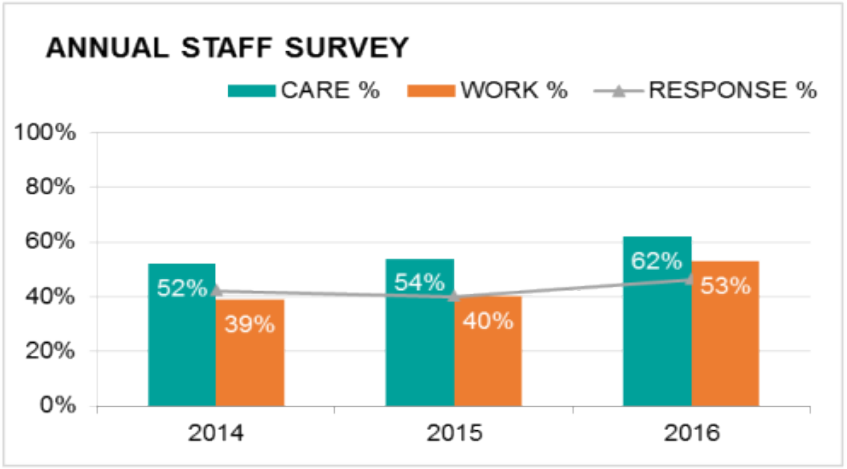
# WELLBEING & ENGAGEMENT

**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 2018 Health & Well-being events planned to raise awareness of support (physical & psychological)
- Schwartz rounds are on plan for 2018 (monthly)

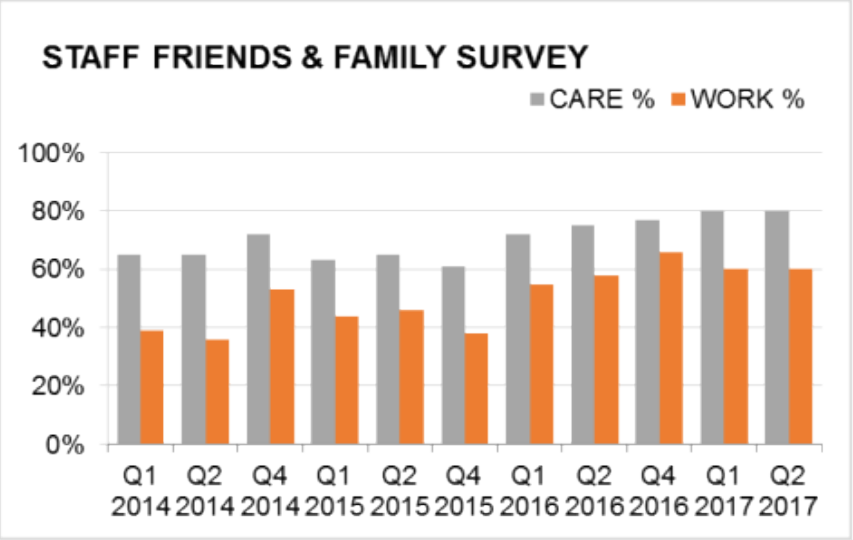
**STAFF ENGAGEMENT**

- 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 underway




| 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% |



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# TRAINING & APPRAISAL COMPLIANCE BY DIVISION

**MANDATORY TRAINING**

- The overall compliance rate for mandatory training has increased by +0.6% to 88.8%
- Small reduction seen in compliance for Mental Capacity Act and Safeguarding training currently under investigation to understand the drivers
- Mental Capacity Act will be moving to a 3 yearly renewal from April onwards (currently once only training)

**APPRAISAL OVERVIEW**

- The Trust appraisal rate has increased by +0.5% to 81.8%

| DIVISION | APPRAISAL |
|---|---|
| Urgent Care | 84.0% |
| Medicine | 81.9% |
| Out of Hospital | 80.2% |
| Diag/Anaes/Surg | 86.5% |
| Womens, S/Health | 85.0% |
| Estates & Facilites | 76.3% |
| Corporate | 81.4% |
| **TRUST** | **81.8%** |

| | | | | | | | | | SAFEGUARDING | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| DIVISION | FIRE SAFETY | MANUAL HANDLING | INDUCTION | INFECTION CONTROL | INFO GOV | HEALTH & SAFETY | MENTAL CAP ACT | DEPRIV OF LIBERTIES | VULN ADULTS | CHILDREN (LEVEL 2) | CHILDREN (LEVEL 3) |
| Urgent Care | 87.1% | 90.6% | 97.2% | 92.1% | 87.1% | 94.1% | 92.5% | 84.3% | 85.0% | 87.3% | 88.4% |
| Medicine | 85.8% | 89.3% | 91.9% | 86.9% | 84.2% | 87.1% | 92.0% | 88.9% | 84.7% | 84.1% | n/a |
| Out of Hospital | 86.5% | 90.0% | 98.4% | 92.7% | 82.9% | 86.2% | 97.6% | 99.5% | 85.6% | 82.6% | n/a |
| Diag/Anaes/Surg | 84.0% | 88.2% | 93.7% | 85.8% | 87.0% | 87.4% | 95.9% | 94.7% | 86.4% | 85.3% | n/a |
| Womens, S/Health | 87.1% | 90.3% | 93.5% | 89.3% | 85.6% | 88.4% | 94.9% | 94.3% | 89.5% | 88.4% | 88.7% |
| Estates & Facilites | 83.7% | 91.5% | 100.0% | 96.9% | 91.0% | 84.7% | n/a | n/a | n/a | n/a | n/a |
| Corporate | 91.5% | 94.8% | 96.4% | 93.1% | 92.0% | 91.8% | 96.7% | 96.8% | 87.2% | 86.3% | 90.5% |
| **TRUST** | **86.4%** | **90.4%** | **95.1%** | **89.8%** | **86.8%** | **88.0%** | **95.0%** | **95.1%** | **86.2%** | **85.0%** | **88.8%** |

**Training & Appraisal Parameters:** +85% **Green**, 75% to 85% **Amber**, < 75% **Red**

***Source data**: ESR*

February 2018

# FINANCE

**Jonathan Reid, Director of Finance – March 2018**

# Financial Position

# Financial Summary – February 2018

| Key metrics | Plan YTD | Actual YTD | Variance YTD | Plan Out-turn | Forecast Out-turn | Variance Out-turn |
|---|---|---|---|---|---|---|
| Agreed control total (exc STF) (£'m) | (35.4) | (53.9) | (18.5) | (36.4) | (57.4) | (21.0) |
| Agreed control total (inc STF) (£'m) | (26.6) | (52.6) | (26.0) | (26.5) | (56.1) | (29.6) |

| Better Payments practice code | Month Volume | Month Value | YTD Volume | YTD Value |
|---|---|---|---|---|
| Trade invoices | 32.7% | 38.2% | 16.9% | 25.3% |
| NHS invoices | 38.2% | 73.0% | 26.7% | 82.6% |

| 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 | 4 |
| 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 | • The Trust reported £53.9m deficit YTD and therefore has not received STF.<br>• Actual deficit YTD is £18.5m adverse to the original plan, but is on track to deliver the revised forecast deficit of £57.4m, subject to confirmation of year end agreements and technical elements.<br>• £8.6m is linked to NHS patient income below plan (including prior year credit notes and CCG mediation).<br>• Other pay costs are £8.2m above plan YTD due to under delivery of CIP £4.7m, £1m apprenticeship levy, continued agency and waiting list premium costs, operational pressures, and service developments funded through additional income, including Primary care Streaming and the new AEC.<br>• Other non pay costs are £3.5m above plan offset by £0.6m additional non patient income. |
| Efficiencies | • The forecast delivery for the efficiency programme is £23.5m against the £28.7m plan £5.2m away from plan. |
| Balance Sheet | • Receivables and Payables remain high, in advance of a significant cash scheme . |
| 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 – February 2018

| I&E Summary (£'m) | In Month | | | YTD | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance | Plan | Actual | Variance |
| NHS Patient Income | 25.4 | 23.0 | (2.3) | 291.4 | 284.7 | (6.6) | 318.4 | 309.8 | (8.6) |
| Tariff-Excluded Drugs & Devices | 2.8 | 2.6 | (0.2) | 30.7 | 31.0 | 0.2 | 33.5 | 34.3 | 0.8 |
| Private Patient / ICR | 0.3 | 0.4 | 0.1 | 3.6 | 2.7 | (0.9) | 4.0 | 3.0 | (0.9) |
| Other Non Clinical Income | 2.8 | 3.1 | 0.3 | 31.4 | 33.3 | 1.9 | 34.2 | 35.9 | 1.7 |
| **Total Income** | **31.3** | **29.2** | **(2.1)** | **357.1** | **351.7** | **(5.4)** | **390.0** | **383.0** | **(7.0)** |
| Pay - Substantive | (22.2) | (20.7) | 1.5 | (245.6) | (224.2) | 21.3 | (267.7) | (243.2) | 24.5 |
| Pay - Bank | (0.5) | (1.6) | (1.1) | (5.5) | (23.2) | (17.7) | (6.0) | (25.2) | (19.2) |
| Pay - Agency | (0.1) | (0.8) | (0.8) | (1.1) | (12.9) | (11.8) | (1.2) | (14.5) | (13.3) |
| **Total Pay** | **(22.7)** | **(23.1)** | **(0.4)** | **(252.2)** | **(260.4)** | **(8.2)** | **(274.9)** | **(282.8)** | **(8.0)** |
| Drugs | (3.3) | (3.4) | (0.1) | (36.8) | (38.9) | (2.1) | (40.2) | (42.6) | (2.5) |
| Supplies and services - Clinical | (2.6) | (2.3) | 0.3 | (29.7) | (31.7) | (2.0) | (31.9) | (34.9) | (3.0) |
| Supplies and services - General | (0.3) | (0.4) | (0.1) | (3.7) | (4.0) | (0.2) | (4.0) | (4.3) | (0.2) |
| Purchase of healthcare (non NHS bodies) | (0.3) | (0.5) | (0.1) | (3.5) | (4.8) | (1.3) | (3.8) | (5.3) | (1.4) |
| Consultancy costs | (0.0) | (0.1) | (0.1) | (0.3) | (0.7) | (0.4) | (0.3) | (0.7) | (0.4) |
| Clinical Negligence | (1.2) | (1.2) | (0.0) | (13.4) | (13.4) | (0.0) | (14.6) | (14.6) | (0.0) |
| Premises | (1.2) | (1.7) | (0.5) | (13.1) | (13.5) | (0.4) | (14.3) | (13.9) | 0.4 |
| Depreciation | (1.1) | (1.1) | 0.0 | (11.7) | (11.7) | 0.1 | (12.8) | (11.7) | 1.1 |
| Other | (1.8) | (2.0) | (0.2) | (20.5) | (20.4) | 0.1 | (21.5) | (21.9) | (0.5) |
| **Total Non Pay** | **(11.9)** | **(12.7)** | **(0.8)** | **(132.8)** | **(138.9)** | **(6.2)** | **(143.4)** | **(150.0)** | **(6.6)** |
| **Total Operating Costs** | **(34.6)** | **(35.8)** | **(1.2)** | **(385.0)** | **(399.3)** | **(14.4)** | **(418.3)** | **(432.8)** | **(14.6)** |
| **Surplus/-Deficit from Operations** | **(3.3)** | **(6.6)** | **(3.3)** | **(27.8)** | **(47.6)** | **(19.8)** | **(28.2)** | **(49.8)** | **(21.6)** |
| Financing Costs: Interest, PDC, Etc | (0.7) | (0.4) | 0.3 | (7.5) | (6.5) | 1.0 | (8.2) | (7.6) | 0.6 |
| **Total Non Operating Costs** | **(0.7)** | **(0.4)** | **0.3** | **(7.5)** | **(6.5)** | **1.0** | **(8.2)** | **(7.6)** | **0.6** |
| **Total Costs** | **(35.3)** | **(36.2)** | **(0.9)** | **(392.5)** | **(405.8)** | **(13.4)** | **(426.5)** | **(440.4)** | **(14.0)** |
| **Net Surplus/-Deficit** | **(4.0)** | **(7.0)** | **(2.9)** | **(35.4)** | **(54.1)** | **(18.7)** | **(36.4)** | **(57.4)** | **(21.0)** |
| Donated Asset/Impairment Adjustment | - | 0.1 | 0.1 | - | 0.2 | 0.2 | - | - | - |
| **Operational Surplus/-Deficit** | **(4.0)** | **(6.9)** | **(2.9)** | **(35.4)** | **(53.9)** | **(18.5)** | **(36.4)** | **(57.4)** | **(21.0)** |
| Sustainability & Transformation Fund | 1.2 | - | (1.2) | 8.8 | 1.3 | (7.5) | 9.9 | 1.3 | **(8.6)** |
| **Net Surplus/-Deficit** | **(2.9)** | **(6.9)** | **(4.0)** | **(26.6)** | **(52.6)** | **(26.0)** | **(26.5)** | **(56.1)** | **(29.6)** |

## Highlights

- Contract income forecast (£8.6m) reflects the negative impact of mediation and under delivery of CIP on elective activity.
- Pay is overspent in £8.2m YTD, £4.7m of this overspend is driven by CIPs not delivering the anticipated benefits in. In addition to continued agency and waiting list spend.
- YTD Non pay overspends are predominantly in drugs and Medica (radiology reporting) costs and £4.9m on CIP under delivery.
- 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) – February 2018

| Divisional Summary (£'m) | In Month | | | YTD | | | Forecast | | | Notes |
|---|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance | Plan | Actual | Variance | |
| **Urgent Care:** | | | | | | | | | | Contract Income YTD Increase compare to plan 2.4% activity & 10.1% £. CIP YTD above plan by £0.2m . Ongoing use of temp staff to cover vacant posts and sickness absence. |
| Contract Income | 1.6 | 1.7 | 0.1 | 19.2 | 21.2 | 2.0 | 21.0 | 24.1 | 3.1 | |
| Other Income | 0.1 | 0.0 | (0.1) | 0.5 | 0.2 | (0.2) | 0.6 | 0.3 | (0.3) | |
| Pay | (0.9) | (1.1) | (0.2) | (10.3) | (11.7) | (1.4) | (11.2) | (12.8) | (1.6) | |
| Non Pay | (0.0) | (0.1) | (0.1) | (0.4) | (0.8) | (0.4) | (0.5) | (0.8) | (0.3) | |
| **Total** | **0.7** | **0.5** | **(0.2)** | **9.0** | **8.9** | **(0.1)** | **9.8** | **10.7** | **0.9** | |
| **Medicine:** | | | | | | | | | | Contract Income YTD Increase compared to plan 0.7% activity & 4.9% £. CIP YTD under delivery £0.9m. Ongoing use of temp staff to cover vacant posts at premium rate. Ongoing issue relating to Endoscopy Leasehire (plans to capital purchase 18/19) and Cardiology Stock- Non Pay. |
| Contract Income | 6.9 | 7.9 | 1.0 | 80.6 | 84.6 | 4.0 | 88.2 | 90.3 | 2.1 | |
| Other Income | 0.1 | 0.1 | 0.0 | 2.4 | 2.6 | 0.2 | 2.5 | 2.8 | 0.3 | |
| Pay | (4.6) | (4.9) | (0.2) | (52.4) | (54.6) | (2.2) | (57.0) | (60.0) | (3.0) | |
| Non Pay | (0.7) | (0.7) | (0.1) | (7.7) | (8.9) | (1.2) | (8.4) | (9.6) | (1.3) | |
| **Total** | **1.7** | **2.4** | **0.7** | **22.9** | **23.7** | **0.8** | **25.2** | **23.4** | **(1.8)** | |
| **DAS:** | | | | | | | | | | Under delivery of CIP YTD of £4.6m and forecast CIP of £5.0m variance. Spend of £1.8m on waiting list payments, and continued agency usage to cover vacancies. Elective activity is below planned levels. |
| Contract Income | 8.8 | 8.5 | (0.3) | 102.6 | 94.1 | (8.5) | 112.1 | 102.9 | (9.2) | |
| Other Income | 0.5 | 0.5 | 0.0 | 5.1 | 4.7 | (0.4) | 5.6 | 5.0 | (0.5) | |
| Pay | (7.2) | (7.2) | 0.0 | (79.8) | (81.1) | (1.3) | (87.0) | (88.7) | (1.6) | |
| Non Pay | (2.5) | (2.7) | (0.2) | (27.8) | (30.2) | (2.4) | (29.9) | (33.4) | (3.5) | |
| **Total** | **(0.5)** | **(0.9)** | **(0.4)** | **0.1** | **(12.5)** | **(12.5)** | **0.7** | **(14.1)** | **(14.8)** | |
| **WAC** | | | | | | | | | | Continued medical agency costs £1m YTD above budget, CIP under delivery forecast at £0.8m below plan offset by vacancies. |
| Contract Income | 3.7 | 4.2 | 0.5 | 42.4 | 43.1 | 0.7 | 46.3 | 46.2 | (0.1) | |
| Other Income | 0.0 | (0.3) | (0.3) | 0.3 | 0.6 | 0.3 | 0.3 | 0.6 | 0.3 | |
| Pay | (2.4) | (2.6) | (0.1) | (27.1) | (28.4) | (1.2) | (29.6) | (30.8) | (1.3) | |
| Non Pay | (0.3) | (0.3) | (0.1) | (2.9) | (3.4) | (0.4) | (3.2) | (3.5) | (0.4) | |
| **Total** | **1.0** | **1.0** | **0.0** | **12.6** | **11.9** | **(0.7)** | **13.8** | **12.4** | **(1.4)** | |

# Workforce Pay Costs – February 2018

| Staff Category £'m | FTE Plan | FTE Actual | In Month | | | YTD | | |
|---|---|---|---|---|---|---|---|---|
| | | | Plan | Actual | Variance | Plan | Actual | Variance |
| Nursing | 3,130 | 3,073 | 9.5 | 9.3 | (0.1) | 105.7 | 104.7 | (1.0) |
| Medical | 652 | 667 | 5.4 | 5.6 | 0.2 | 59.1 | 63.4 | 4.3 |
| Administrative & Clerical | 1,254 | 1,223 | 2.8 | 2.8 | 0.0 | 31.7 | 31.6 | (0.1) |
| Prof & Tech | 524 | 528 | 1.7 | 1.6 | (0.1) | 18.3 | 19.4 | 1.1 |
| Professions Allied to Medicine | 515 | 444 | 1.7 | 1.5 | (0.2) | 18.8 | 16.2 | (2.6) |
| Ancillary | 718 | 668 | 1.4 | 1.4 | (0.1) | 15.6 | 15.6 | 0.0 |
| Senior Manager (Other) | 123 | 105 | 0.7 | 0.7 | (0.1) | 8.0 | 7.0 | (1.0) |
| Executive | 8 | 10 | 0.1 | 0.1 | (0.0) | 1.3 | 1.3 | 0.0 |
| Other Employees | ( 4 ) | - | 0.2 | 0.1 | (0.1) | 0.7 | 1.1 | 0.4 |
| Vacancy Factor | ( 60 ) | - | (0.8) | 0.0 | 0.8 | (7.1) | 0.0 | 7.1 |
| **Grand Total** | **6,860** | **6,716** | **22.7** | **23.1** | **0.4** | **252.2** | **260.4** | **8.2** |

| | Month 16/17 (£) | Month 17/18 (£) | Month Variance | YTD 16/17 | YTD 17/18 | YTD Variance |
|---|---|---|---|---|---|---|
| Agency | 1.8 | 0.9 | 0.8 | 21.4 | 12.9 | 8.5 |
| Bank | 1.0 | 1.7 | - 0.7 | 10.8 | 14.3 | - 3.5 |
| Locum | 0.4 | 1.1 | - 0.8 | 5.4 | 9.0 | - 3.6 |
| Waiting List | 0.1 | 0.2 | - 0.0 | 1.0 | 2.2 | - 1.1 |
| **Total Pay** | **3.2** | **3.9** | **- 0.6** | **38.7** | **38.3** | **0.3** |

## Comparison to previous financial year

- Overall temporary staffing costs YTD of £38.3m, which is a £0.3m reduction compared to the previous year.
- There has been a successful drive to reduce agency and increase recruitment to internal bank/ locum.
- Spend on waiting list payments has increased compared to previous financial year with a reduction on external outsourcing and to meet increase demand in some specialties.

## Highlights

- Month 11 pay costs show a reduction from previous month this is mainly due to bank holiday enhancements paid in mth 10 and February being a shorter month .
- Nursing spend is £1.0m underspent YTD, due to underspends predominately in ESBT, Health visiting and corporate, (some of these are offset by an overspend on the vacancy factor line.)
- Ward based nursing is £2.2m overspent, due to special observations and agency nursing used above templates to cover sickness and operational capacity pressures.
- YTD Medical staff £4.3m overspend is driven by the use of high cost temporary staff, and £1.7m waiting list ad hoc payments.
- £7.1m vacancy factor line includes CIP targets allocated to divisions.
- Agency spend is within the NHSi ceiling and ongoing progress negotiating rates to reduce costs.

# Financial Risks & Mitigating Actions – February 2018

| Risks | Mitigations |
|---|---|
| The Trust has a £28.7m savings requirement, currently forecasting adverse delivery. 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. |

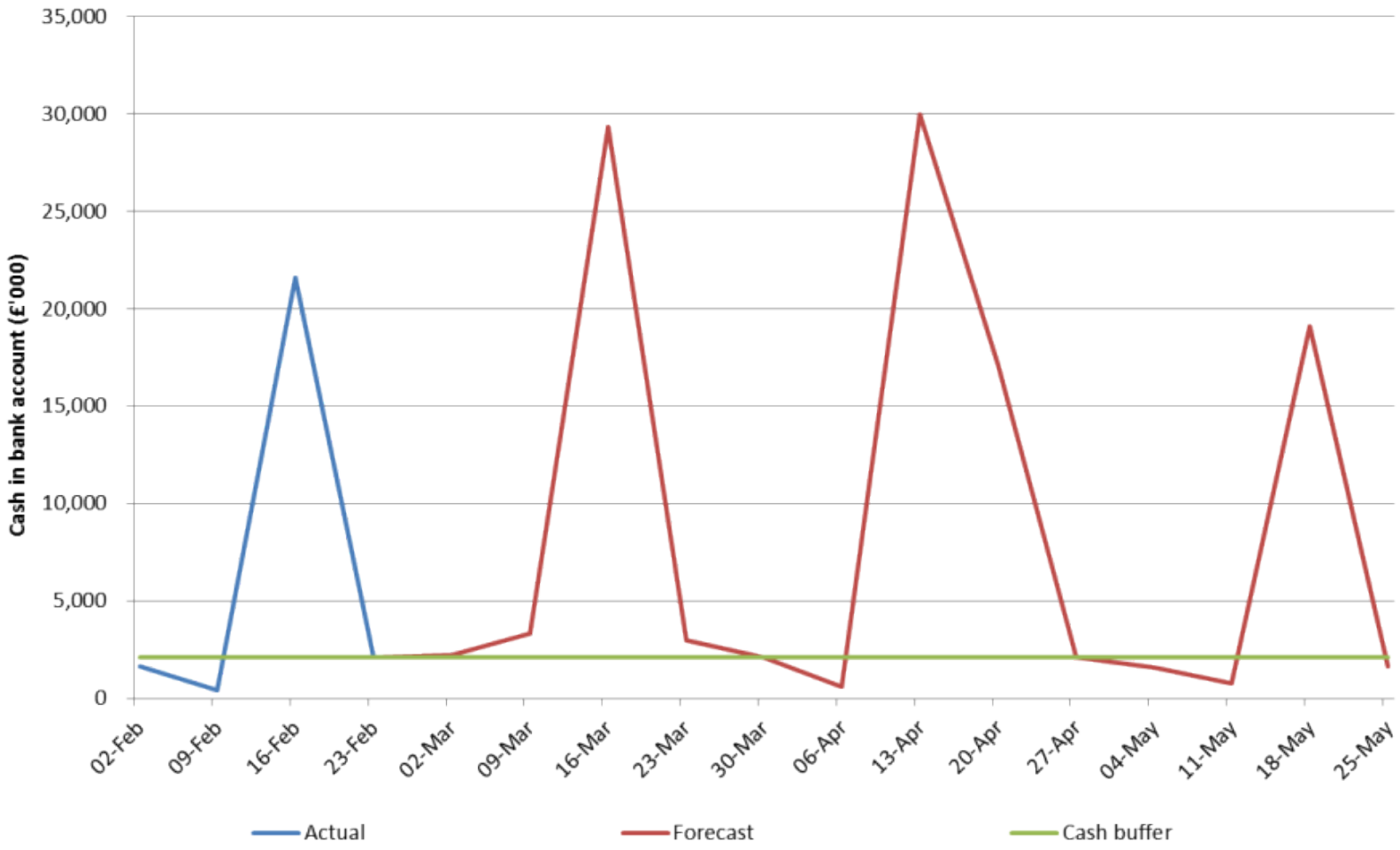
# Liquidity

## Commentary

### Short term cash flow forecast for period ending 25 May 2018.

- Cash remains positive throughout the planning period, however the Trust consistently breaches it's minimum cash balance.
- The Trust received a cash draw-down of £20.5m in March
- Numerical and graphical representations as shown later in this report.
- The cash flow forecast is consistent with the I&E forecast.
- The Trust's debtor and creditor positions are set out later in this document.
- Details of borrowings are contained on page 7
- Draft Board minute for 18/19 deficit funding enclosed
- Future iterations will build on the information contained within and will include;
  - A reconciliation between this cashflow and the next
  - More detailed documentation of the assumptions contained within the cashflow
  - Details of loan covenants

# Short-Term Cashflow Chart (13 weeks)



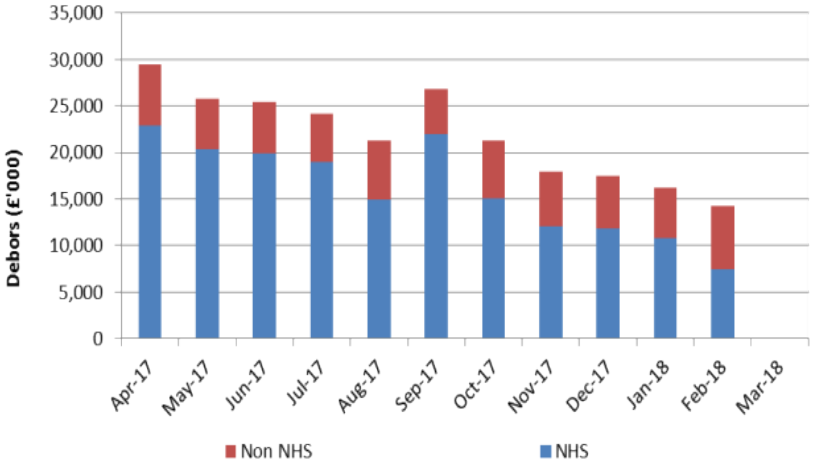
# Short-Term Cashflow Chart (13 weeks)

| Week ending (Friday) | 26-Jan | 02-Feb | 09-Feb | 16-Feb | 23-Feb | 02-Mar | 09-Mar | 16-Mar | 23-Mar | 30-Mar | 06-Apr | 13-Apr | 20-Apr | 27-Apr |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| | Actual | Forecast | Forecast | Forecast | Forecast | Forecast | Forecast | Forecast | Forecast | Forecast | Forecast | Forecast | Forecast | Forecast |
| **Receipts** | | | | | | | | | | | | | | |
| WGA income | 404 | 316 | 692 | 26,373 | 692 | 700 | 2,313 | 24,346 | 700 | 860 | 300 | 28,411 | 300 | 300 |
| Other Income | 357 | 442 | 196 | 336 | 393 | 418 | 393 | 455 | 393 | 335 | 369 | 434 | 434 | 434 |
| Other Income | - | 258 | - | 3 | 302 | 750 | - | - | 300 | 1 | - | - | 300 | - |
| External Financing | - | - | 790 | 5,590 | - | 210 | - | 20,488 | - | - | - | - | 3,833 | - |
| **TOTAL RECEIPTS** | 761 | 1,017 | 1,678 | 32,302 | 1,388 | 2,078 | 2,706 | 45,289 | 1,393 | 1,196 | 669 | 28,845 | 4,867 | 734 |
| **Payments** | | | | | | | | | | | | | | |
| Pay | (12,696) | (316) | (326) | (6,335) | (16,426) | (280) | (280) | (280) | (22,116) | (280) | (280) | (280) | (9,480) | (12,716) |
| Non-pay | (3,118) | (3,438) | (2,482) | (4,634) | (3,652) | (2,732) | (2,676) | (16,652) | (3,150) | (1,338) | (1,150) | (2,150) | (3,645) | (2,150) |
| Capital expenditure | (37) | (133) | (120) | (118) | - | - | - | - | - | - | - | - | - | - |
| PDC dividend | - | - | - | - | - | - | - | (1,235) | - | - | - | - | - | - |
| Other Payments | (2) | (2) | (3) | (3) | (567) | (808) | - | (816) | (246) | (8) | - | - | (96) | - |
| **TOTAL PAYMENTS** | (15,853) | (3,888) | (2,931) | (11,089) | (20,645) | (3,820) | (2,956) | (18,983) | (25,512) | (1,626) | (1,430) | (2,430) | (13,221) | (14,866) |
| **Net cash inflow/(outflow** | (15,092) | (2,871) | (1,253) | 21,213 | (19,257) | (1,742) | (250) | 26,305 | (24,119) | (429) | (761) | 26,415 | (8,354) | (14,132) |
| **Balance b/f** | 19,596 | 4,504 | 1,632 | 380 | 21,593 | 2,335 | 593 | 343 | 26,648 | 2,529 | 2,100 | 1,339 | 27,754 | 19,400 |
| **BALANCE C/F** | 4,504 | 1,632 | 380 | 21,593 | 2,335 | 593 | 343 | 26,648 | 2,529 | 2,100 | 1,339 | 27,754 | 19,400 | 5,267 |

Note – the above classifications do not directly match the I&E subjective classifications, for example Non-pay above includes agency staff expenditure and VAT thereon

# Debtors

Debtors have consistently reduced throughout the year with the exception of September; this was caused by a catch up in invoicing coupled with a slight reduction in receipts. The Trust anticipates further improvements in the run up to the year-end. The value of Non-NHS debt has remained fairly constant. The finance team are now focussed on ensuring all invoices are raised as early as possible.




## Debtors over £500k

| CUSTOMER NAME | Note | Balance £'000 | Days 0 - 30 | 31 to 60 | 61 - 90 | 91 - 120 | 120 - 180 | 180+ |
|---|---|---|---|---|---|---|---|---|
| SUSSEX MSK PARTNERSHIP 2 LTD | 1 | 5,610.75 | 1,138.98 | 1,167.48 | 1,112.42 | 237.51 | 1,400.90 | 553.46 |
| BRIGHTON & SUSSEX UNI HOSPITAL | | 2,053.06 | 740.63 | (15.02) | 41.85 | 4.07 | 468.17 | 813.37 |
| HIGH WEALD LEWES HAVENS CCG | | 1,549.90 | (341.89) | 39.08 | 0.37 | 0.00 | 574.07 | 278.27 |
| EAST SUSSEX COUNTY COUNCIL | | 1,079.70 | 1,023.82 | 30.48 | 19.66 | 5.74 | 0.00 | 0.00 |
| SUSSEX PARTNERSHIP NHS FT | | 668.31 | 367.03 | 120.92 | 25.50 | 150.08 | 0.00 | 4.78 |

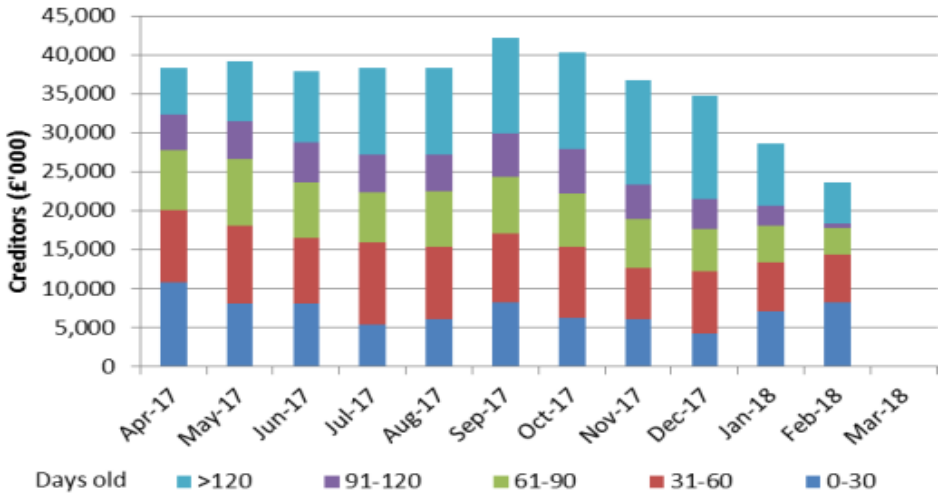
Notes

1. Relates to SMSK - on going contractual disputes surrounding application of local prices and 16/17 reconciliation

# Divisional Performance (2) – February 2018

| Divisional Summary (£'m) | In Month | | | YTD | | | Forecast | | | Notes |
|---|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance | Plan | Actual | Variance | |
| **Out of Hospital:** | | | | | | | | | | Underspend on ESBT and therapy vacancies offset by under delivery on CIP and staff to cover the iMSK service. Drugs continues to overspend (£0.9m YTD). Other income shows loss of contracts in Pharmacy Manufacturing Unit, offset by biosimilar income above plan. |
| Contract Income | 3.3 | 3.0 | (0.2) | 36.2 | 35.4 | (0.8) | 39.4 | 39.3 | (0.2) | |
| Other Income | 0.5 | 0.7 | 0.2 | 5.1 | 4.7 | (0.4) | 5.5 | 4.9 | (0.7) | |
| Pay | (2.8) | (3.0) | (0.2) | (31.9) | (32.1) | (0.2) | (34.7) | (35.0) | (0.3) | |
| Non Pay | (1.0) | (1.3) | (0.3) | (12.7) | (13.2) | (0.6) | (13.6) | (14.2) | (0.5) | |
| **Total** | **(0.1)** | **(0.6)** | **(0.6)** | **(3.3)** | **(5.3)** | **(2.0)** | **(3.4)** | **(5.0)** | **(1.7)** | |
| **Estates & Facilities:** | | | | | | | | | | E&F £0.4k over in Feb due to Energy & Utilities £200k, Laundry temporary staff charge from Salisbury £86k, Backdated SCT maintenance invoices £80k. These contribute to the movement away from forecast. Unidentified CIP target £190k over but increase in capitalisation of Design team |
| 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) | 8.2 | 7.5 | (0.6) | 8.9 | 8.2 | (0.7) | |
| Pay | (1.3) | (1.1) | 0.2 | (15.1) | (15.0) | 0.0 | (16.4) | (16.6) | (0.2) | |
| Non Pay | (1.3) | (1.9) | (0.6) | (14.9) | (14.8) | 0.2 | (16.2) | (16.0) | 0.3 | |
| **Total** | **(1.9)** | **(2.3)** | **(0.4)** | **(21.8)** | **(22.3)** | **(0.4)** | **(23.7)** | **(24.3)** | **(0.6)** | |
| **Corporate Services:** | | | | | | | | | | Corporate is overspend due to additional £2m CIP target allocated, Apprenticeship Levy of £128 ytd. 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 | 1.6 | 0.4 | 13.6 | 14.3 | 0.7 | 14.8 | 15.1 | 0.4 | |
| Pay | (2.9) | (3.4) | (0.5) | (34.5) | (37.4) | (2.8) | (37.4) | (40.9) | (3.5) | |
| Non Pay | (2.0) | (2.5) | (0.5) | (24.4) | (26.4) | (2.0) | (26.4) | (29.3) | (2.8) | |
| **Total** | **(3.8)** | **(4.4)** | **(0.6)** | **(45.3)** | **(49.5)** | **(4.2)** | **(49.1)** | **(55.0)** | **(6.0)** | |
| **Other:** | | | | | | | | | | Contract income includes mediation deal with CCG £10.2m by year end. STF is £8.6m below plan as not met criteria. Other income reflects ICR benefit and income received relating to the previous financial year. |
| Contract Income (TEDDs) | 2.8 | 2.6 | (0.2) | 30.7 | 31.0 | 0.2 | 33.5 | 34.3 | 0.8 | |
| Contract Income (Other) | 1.1 | (2.2) | (3.3) | 10.3 | 6.3 | (4.0) | 11.5 | 7.0 | (4.5) | |
| STF | 1.2 | 0.0 | (1.2) | 8.8 | 1.3 | (7.5) | 9.9 | 1.3 | (8.6) | |
| Other Income | 0.1 | 0.2 | 0.2 | (0.1) | 1.5 | 1.6 | (0.1) | 2.0 | 2.0 | |
| Pay | (0.5) | 0.2 | 0.7 | (1.1) | (0.2) | 0.9 | (1.6) | 1.9 | 3.5 | |
| Non Pay TEDDs) | (2.8) | (2.6) | 0.2 | (30.7) | (31.0) | (0.3) | (33.5) | (34.3) | (0.8) | |
| Non Pay (Other) | (2.0) | (0.8) | 1.1 | (18.6) | (16.5) | 2.1 | (19.8) | (16.4) | 3.4 | |
| **Total** | **(0.1)** | **(2.6)** | **(2.5)** | **(0.7)** | **(7.6)** | **(6.9)** | **(0.0)** | **(4.2)** | **(4.2)** | |

# Creditors




Total creditors are £23.6m, this is a reduction from the peak in September of £42.2m.
The Trust anticipates further reduction during March (21 Mar £17.1m) as debts are collected and loans received. The creditors over 120 days remains of significant concern and is being actively targeted.

The majority of the Trust's high value creditors are now on an agreed payment plan. Work continues to ensure that critical suppliers are engaged with and proactively managed to try and ensure continuity of supply.

Notes

1. No formal payment plan but periodic reciprocal payments and receipts reduces balance.

## Top ten creditors by value

| Creditor Name | £ | Note | Payment plan in place? |
|---|---|---|---|
| NHS SUPPLY CHAIN | 3,510,074.94 | | Yes |
| NHS PROPERTY SERVICES LTD | 1,391,093.09 | 1 | N/A |
| MEDTRONIC LTD | 899,180.31 | | Yes |
| BRIGHTON AND SUSSEX UNIV HOSPS NHS TR | 865,056.14 | 1 | N/A |
| NHS SUPPLY CHAIN (MAIDSTONE) | 809,284.56 | 1 | Yes |
| ALLIANCE HEALTHCARE (DISTRIBUTION) LTD | 563,331.75 | | Yes |
| INHEALTH LIMITED | 472,753.05 | | Yes |
| RICHARD WOLF UK LTD | 400,696.22 | | Yes |
| NHS BLOOD AND TRANSPLANT (NHSBT) | 398,144.91 | | Yes |
| PAUL HARTMANN LTD | 329,905.43 | | Yes |

# Loans

| | Date drawn | Value £'000s | Description | Term (years) | Interest rate | Annual interest charge £'000s | Months remaining |
|---|---|---|---|---|---|---|---|
| **Prior years** | | | | | | | |
| | Dec-08 | 222 | Capital Loan - Decontamination centre | 10 | 3.5% | 9 | 13 |
| | Dec-09 | 1,216 | Capital Loan - Endoscopy Development | 20 | 4.0% | 49 | 140 |
| | Jun-10 | 1,250 | Capital Loan - Endoscopy Development | 20 | 3.9% | 0 | 145 |
| | Mar-15 | 321 | Capital Loan - Health Records | 10 | 1.4% | 5 | 84 |
| | Mar-15 | 331 | Capital Loan - Health Records | 10 | 1.4% | 0 | 84 |
| | | 31,300 | Revolving Working Capital Loan | 5 | 3.5% | 1,096 | |
| | | 35,218 | Interim Loan Agreement | 3 | 1.5% | 530 | |
| | Dec-16 | 1,619 | Interim Loan Agreement - December 2016 | 3 | 6.0% | 97 | 21 |
| | Jan-17 | 8,925 | Exceptional Loan Agreement - January 2017 | 3 | 6.0% | 537 | 22 |
| | Feb-17 | 8,000 | Loan Agreement - February 2017 | 3 | 6.0% | 482 | 23 |
| | Mar-17 | 4,600 | Loan - March 2017 | 3 | 6.0% | 278 | 24 |
| **Prior years total** | | **89,665** | | | | **3,083** | |
| **Current year** | | | | | | | |
| | Apr-17 | 3,214 | Loan - April 2017 | 3 | 6.0% | 193 | 25 |
| | May-17 | 2,558 | Loan - May 2017 | 3 | 6.0% | 154 | 26 |
| | Jun-17 | 5,477 | Loan - June 2017 | 3 | 6.0% | 331 | 27 |
| | Jul-17 | 2,536 | Loan - July 2017 | 3 | 6.0% | 153 | 28 |
| | Aug-17 | 3,107 | Loan - August 2017 | 3 | 3.5% | 109 | 29 |
| | Aug-17 | 5,722 | Loan - September 2017 | 3 | 3.5% | 202 | 30 |
| | | 1,369 | Loan - November 2017 | 3 | 3.5% | 48 | |
| | Dec-17 | 3,640 | Loan - December 2017 | 3 | 3.5% | 128 | 33 |
| | Jan-18 | 11,247 | Loan - January 2018 | 3 | 3.5% | 394 | 34 |
| | Feb-18 | 800 | Capital Loan - February 2018 | 20 | 1.6% | 13 | 239 |
| | Feb-18 | 4,790 | Loan - February 2018 | 3 | 3.5% | 168 | 35 |
| **Current year total** | | **44,460** | | | | **1,125** | |
| **TOTAL** | | **134,125** | | | | **4,208** | |

The Trust has been drawing down loan funding from Department of Health to support the cash gap left by reporting losses over the last few years. February included deficit funding as well as a capital loan.

# Capital Programme

# Capital Programme at M11

- **YTD Review of 2017/18 Capital Programme as at 28th February 2018**
- The Trust's capital resource limit (CRL )for 2017/18 is £15.3m. This is determined by the Trust's level of depreciation plus received PDC loan relating to successful bids as shown in the table below:

| | CRL £ |
|---|---|
| *Opening Capital Resource Limit (CRL)* | 11,694 |
| *A&E/GP Streaming (PDC)* | 1,685 |
| *Ambulatory Care (PDC)* | 790 |
| *Ambulatory Care (Loan)* | 800 |
| *Wifi (PDC)* | 210 |
| *Cyber Security (PDC)* | 98 |
| ***CLOSING CAPITAL RESOURCE LIMIT (CRL)*** | **15,277** |

# Month 11 Spend and Forecast

- At the close of month11 the cumulative capital expenditure amounted to £11.0m (£10.4m on owned assets and £0.6m relating to donated assets).
- The forecast of capital commitments relating to purchase orders, intangibles and minor capital transfers equates to £15.2m, the remaining commitment available being £0.1m.
- The CRG hold regular discussions, review the position and consider requests for capital expenditure.

# Capital Programme Month 11

| ESHT | 2017/18 PLAN £'000 | 2017/18 ACTUAL YTD £'000 | 2017/18 Committed Expenditure (PO's raised since 01/04/2017) |
|---|---|---|---|
| Brought Forward | 10 | 522 | 301 |
| Estates - Brought Forward | 4,300 | 1,915 | 3,001 |
| Estates - Backlog Maintenance | 1,924 | 740 | 861 |
| Estates - Central | 1,685 | 2,183 | 2,130 |
| Estates - Clinical | 366 | 180 | 625 |
| Estates - Statutory | 380 | 90 | 189 |
| IT - Core | 2,024 | 377 | 1,011 |
| IT - EDM | 437 | 288 | 85 |
| IT - Other | 192 | 161 | 431 |
| IT - T4S (formerly GS1) | 196 | 109 | 0 |
| Medical Equipment | 2,000 | 1,416 | 2,447 |
| Minor Capital | 1,200 | 2,202 | 2,500 |
| Unplanned Urgents | 500 | 237 | 396 |
| | **15,214** | **10,419** | **13,977** |
| Friends | 1,000 | 588 | 427 |
| Less Donated Income | (1,000) | (588) | (427) |
| **TOTAL** | **15,214** | **10,419** | **13,977** |
| | | *Design Fees* | 695 |
| | | *Capitalisation of Staff* | 500 |
| | | *Estimated Commitment* | **15,172** |
| | | ***Uncommitted*** | **(105)** |

Sustainability and Strategy

# SUSTAINABILITY

# Timetable for delivery of 2018/19 Business Plan

East Sussex Healthcare NHS Trust

| | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|
| Actions completed or *in progress or outstanding* | • Business planning timetable and documentation agreed<br>• Business planning launched to Divisions | • Corporate planning assumptions agreed<br>• Workshops to support divisions rolled out<br>• Trust Provider intentions for 2018/19 submitted to Commissioners | • ***Divisions start work to identify 2017/18 non-recurrent/ FYE/ Cost pressures within current budget baselines & validation of draft 1 planning assumptions*** | • Deadline for first drafts of 2018/19 divisional plans and expenditure forecasts<br>• ***2018/19 Planning Group established*** | • ***Confirm & Challenge meetings started with Divisions***<br>• Divisions validation of draft 2 planning assumptions | • Divisions present draft business plans at IPRs<br>• Capital planning workshops commenced<br>• Business planning update at Leadership briefings<br>• ***Ongoing commissioner contract discussions*** | • ***Prioritisation of divisional schemes***<br>• ***Finalise 2017/18 forecast outturn position***<br>• ***Submission of finalised plans to NHSI***<br>• ***Final commissioner contract to be agreed***<br>• ***Commence development of Trust Integrated Business Plan*** | • ***Finalisation of divisional budgets, including CIPs***<br>• ***Divisions to sign off budgets*** | • ***Presentation of final business plans at Trust Board Seminar by divisional leads*** |
| Timeline for issuing activity , income , workforce, and expenditure budget planning assumptions to divisions for validation | | Draft 1 issued (based on M5) | | | Draft 2 issued (based on M6) | Draft 3 issued (based on M9) | ***Draft 4*** | ***Final Budget issued*** | |
| Committee updates | | | Trust Board update | | Trust Board and F&I update | Extraordinary F&I update<br>F&I update | ***F&I update***<br>***Trust Board update*** | ***Final Trust Business plan for Trust Board and F&I*** | |

**Timelines will be continually updated as agreed with regulators*

## Strategy, Innovation and Planning

The SIP team are supporting the development of integrated business plans for each of the divisions that incorporate activity, income, workforce and expenditure. The Trust Board and finance and Investment Committee is advised of progress.

The focus of the 18/19 programme is to drive the efficiency programmes that have been diagnosed through the Lord Carter, Model Hospital and GIRFT programmes. The review of structural opportunity will run alongside this.

Activity

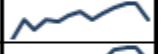
# ACTIVITY

# Activity Headlines

The increase in activity has continued into February. Whilst overall numbers are lower than January, based on working days the daily number of attendances has increased from 283 in February 2017 to 309 in February 2018, up from 305 in January 2018. Conveyences and t the % of patients being admitted following an A&E attendance remain roughly on a par with the previous month

Elective inpatient and day case activity remains lower than previous years and down against the agreed plan although elective inpatient activity has increased against January 2018

East Sussex Healthcare NHS
NHS Trust

| Indicator Description | Target | Month Comparison | | | YTD Comparison | | | Rolling 12 month Avg | Trend |
|---|---|---|---|---|---|---|---|---|---|
| | | Feb-17 | Feb-18 | Var | 2016/17 | 2017/18 | Var | | |
| **Emergency Department attendances** | M | 7951 | 8652 | 8.8% | 101095 | 108276 | 7.1% | 9810 |  |
| Ambulance conveyances | M | 2886 | 2945 | 2.0% | 33927 | 35344 | 4.2% | 3208 |  |
| Admissions via A&E | M | 27.8% | 32.7% | 5.0% | 25.5% | 28.9% | 3.4% | 28.8% |  |
| **Primary Referrals** | M | 8701 | 7583 | -12.8% | 98518 | 91392 | -7.2% | 8472 |  |
| Consultant to Consultant referrals | M | 1429 | 1799 | 25.9% | 16677 | 19532 | 17.1% | 1778 |  |
| 2WW Referrals | M | 1567 | 1659 | 5.9% | 17857 | 18155 | 1.7% | 1670 |  |
| **Elective spells** | M | 644 | 591 | -8.2% | 7287 | 6592 | -9.5% | 609 |  |
| Day Cases | M | 3831 | 3695 | -3.5% | 43694 | 43022 | -1.5% | 3955 |  |
| Elective Beddays | M | 1891 | 1871 | -1.1% | 20899 | 17947 | -14.1% | 1674 |  |
| **Total Non-Elective Spells** | M | 3493 | 4087 | 17.0% | 41631 | 46091 | 10.7% | 4181 |  |
| Number of Emergency spells | M | 2924 | 3524 | 20.5% | 34822 | 39364 | 13.0% | 3565 |  |
| Number of Maternity spells (ante and post partem) | M | 311 | 308 | -1.0% | 3669 | 3629 | -1.1% | 332 |  |
| Number of other non-elective spells (Births/Transfers from other hospitals) | M | 258 | 255 | -1.2% | 3140 | 3098 | -1.3% | 284 |  |
| Non-Elective beddays | M | 22383 | 21239 | -5.1% | 251505 | 240431 | -4.4% | 21970 |  |
| **LOS** | | | | | | | | | |
| Elective Average Length of Stay | M | 2.9 | 3.2 | 0.2 | 2.9 | 2.7 | -0.1 | 2.7 |  |
| Non-Elective Average Length of Stay | M | 6.4 | 4.9 | -1.5 | 6.0 | 5.2 | -0.7 | 5.3 |  |
| Inpatient Average Length of Stay at intermediate care units | M | 35.4 | 30.4 | -5.0 | 30.1 | 28.2 | -1.9 | 29.0 |  |
| **Outpatients** | | | | | | | | | |
| First outpatient attendances | M | 10568 | 9529 | -1039 | 130140 | 117980 | -12160 | 10000 |  |
| Follow-up outpatient attendances | M | 23353 | 22906 | -447 | 283997 | 292929 | 8932 | 24601 |  |
| First outpatient DNA rate | M | 8.1% | 7.6% | -0.5% | 9.0% | 8.3% | -0.7% | 8.4% |  |
| New to follow up ratio | M | 2.2 | 2.4 | 0.2 | 2.2 | 2.5 | 0.3 | 2.5 |  |

| Indicator Description | Target | Month Comparison | | | YTD Comparison | | | Rolling 12 month Avg | Trend |
|---|---|---|---|---|---|---|---|---|---|
| | | Feb-17 | Feb-18 | Var | 2016/17 | 2017/18 | Var | | |
| **Community Nursing** | | | | | | | | | |
| Community nursing referrals | M | 4270 | 3991 | -279 | 45001 | 45341 | 340 | 4155 |  |
| Community nursing total contacts | M | 34058 | 33029 | -1029 | 377496 | 388794 | 11298 | 35559 |  |
| Community Nursing face-to-face contacts | M | 18442 | 17931 | -511 | 212477 | 217141 | 4664 | 19866 |  |
| Community nursing ALOS | M | 20.5 | 4.1 | -16 | 23.5 | 14.3 | -9.2 | 15 |  |
| **Waiting Times** | | | | | | | | | |
| % SALT patients waiting less than 13 weeks | M | 100.0% | 100.0% | 0.0% | 100.0% | 100.0% | 0.0% | 100.0% |  |
| Total SALT patients waiting | M | 133 | 159 | 26 | 1721 | 1545 | -176 | 140 |  |
| % Podiatry patients waiting less than 13 weeks | M | 100.0% | 100.0% | 0.0% | 100.0% | 100.0% | 0.0% | 100.0% |  |
| Total podiatry patients waiting | M | 284 | 236 | -48 | 7227 | 2747 | -4480 | 261 |  |
| % Dietetics patients waiting less than 13 weeks | M | 98.7% | 100.0% | 1.3% | 99.8% | 98.4% | -1.5% | 98.5% |  |
| Total dietetics patients waiting | M | 74 | 53 | -21 | 661 | 665 | 4 | 61 |  |
| % MSK patients waiting less than 13 weeks | M | 81.0% | 96.5% | 15.5% | 98.8% | 78.7% | -20.2% | 81.3% |  |
| Total MSK patients waiting | M | 434 | 1018 | 584 | 11632 | 9431 | -2201 | 955 |  |

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

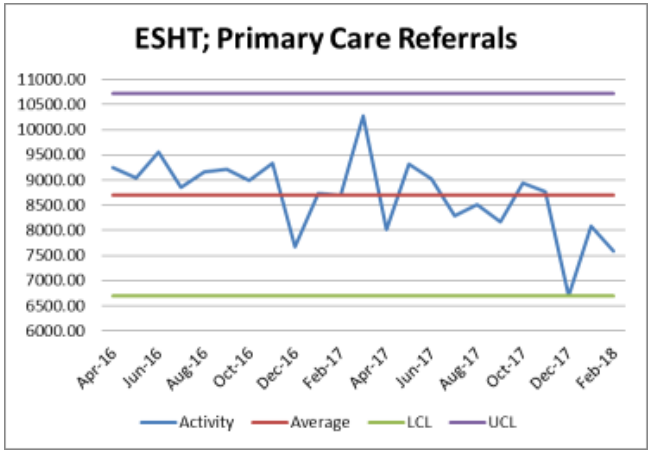
Activity to date is shown in the table below against last year's outturn and against the plan year to date.

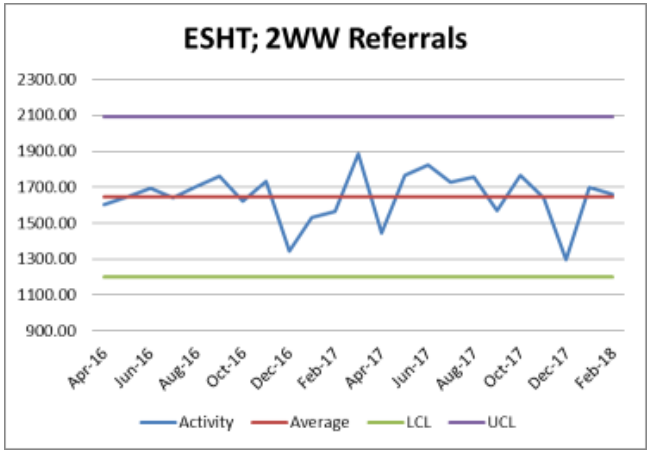
| | Actual 17/18 | Actual 16/17 | Plan 17/18 | Variance to last year | Variance to plan |
|---|---|---|---|---|---|
| Daycase | 43,019 | 43,694 | 47,761 | -1.5% | -9.9% |
| Inpatient | 6,611 | 7,287 | 8,006 | -9.3% | -17.4% |
| Elective (Total DC/IP) | 49,630 | 50,981 | 55,767 | -2.7% | -11.0% |
| Non Elective | 43,135 | 39,231 | 39,231 | 10.0% | 10.0% |
| First OP | 108,329 | 97,342 | 119,746 | 11.3% | -9.5% |
| Follow Up OP | 269,215 | 211,413 | 263,998 | 27.3% | 2.0% |

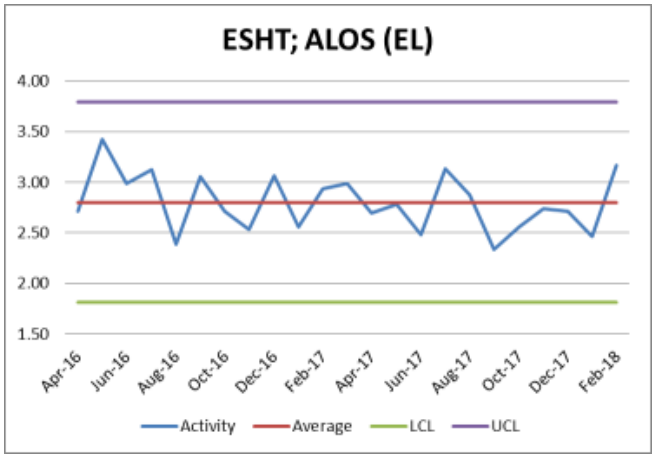
*excludes well babies and neonatals*

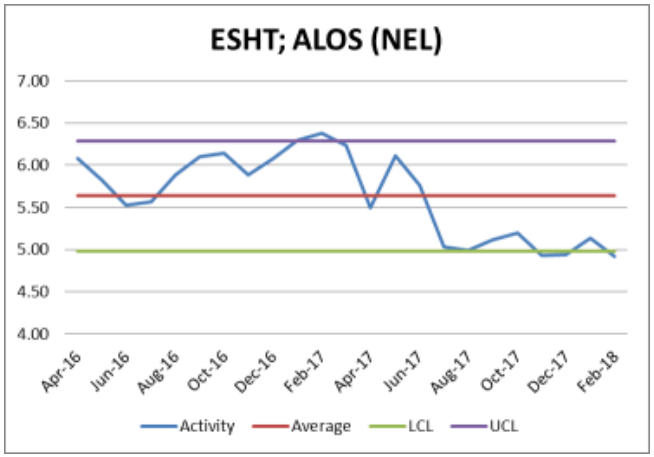
| | Year End Plan | Year end forecast | Variance to Year end forecast | |
|---|---|---|---|---|
| Daycase | 52,406 | 46,980 | -10.4% | Worsening |
| Inpatient | 8,934 | 7,221 | -19.2% | Worsening |
| Elective (Total DC/IP) | 61,340 | 54,201 | -11.8% | Worsening |
| Non Elective | 43,038 | 47,160 | 9.6% | Improving |
| First OP | 132,402 | 118,304 | -10.5% | Worsening |
| Follow Up OP | 288,907 | 294,009 | 1.9% | Improving |

East Sussex Healthcare NHS
NHS Trust




Primary care referrals has have dropped again in February. When taken with the increase in consultant to consultant referrals (pathway change) the variance reduces to a reduction of 3.7% overall

The referrals for two week waits is back in line with previous levels. This represents an 6% increase up from February 2017 against February 2018 and a 1.7% increase year on year.

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.

| Referrals | Month Comparison | | | YTD Comparison | | | Rolling 12 month Avg | Trend |
|---|---|---|---|---|---|---|---|---|
| | Feb-17 | Feb-18 | Var | 2016/17 | 2017/18 | Var | | |
| **Primary referrals** | 8701 | 7583 | -12.8% | 98518 | 91392 | -7.2% | 8472 | |
| Consultant to Consultant referrals | 1429 | 1799 | 25.9% | 16677 | 19532 | 17.1% | 1778 | |


WHAT
MATTERS
TO YOU
MATTERS
TO US
ALL

# Financial Planning for 2018-19 – Board Review April 2018

| Meeting information: | | | |
|---|---|---|---|
| Date of Meeting: | 17th April 2018 | Agenda Item: | 11 |
| 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?<br><br>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

The Board, through Seminar and Committee, has been working to develop a financial plan for 2018-19 which is ambitious, but achievable. As the detailed business planning and budget-setting has progressed, the planning assumptions have been refined and refreshed. An initial financial plan has been developed for review and consideration by the Board. This plan sets a 2018/19 target deficit of £47.8m, although changes to income uncollectible in year under contract rules mean that the exit run-rate will be £43.3m, compared to the forecast deficit in 2017/18 of £57.4m. The Finance Committee has indicated that the Trust needs to continue to seek a further improvement on this plan, and the attached paper sets out the actions in train to develop a further refresh of this provisional plan. Nationally, a further submission of plans is expected at the end of April 2018.

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

Finance and Investment Committee have reviewed the components of the plan as they have developed from December 2017 through to April 2018. The Board has considered the plan in the Board Seminar and then the Board meeting on 10 April.

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

Following extensive review at the Board Seminar and then the Board meeting on 10 April, the Board is asked to note the indicative financial plan for 2018/19, and the intention to further improve the planned deficit. The Board is also asked to note the required actions to ensure deliverability of the financial plan in 2018/19.

East Sussex Healthcare NHS Trust

# INDICATIVE REFRESHED FINANCIAL PLAN 2018/19

## EAST SUSSEX HEALTHCARE NHS TRUST

10 APRIL 2018

Jonathan Reid
Director of Finance
East Sussex Healthcare NHS Trust

## Summary

- The 2017/18 outturn was disappointing. The Trust set an ambitious plan, but a number of key challenges have led to an forecast outturn (excluding STF) of £57.4m deficit.

- The Trust has made a small improvement to the underlying position, calculated by KPMG at £57m deficit in 2016/17 and estimated at £53.6m in 2017/18. However, the Trust Board is seeking to significantly improve on this outturn and move towards financial sustainability.

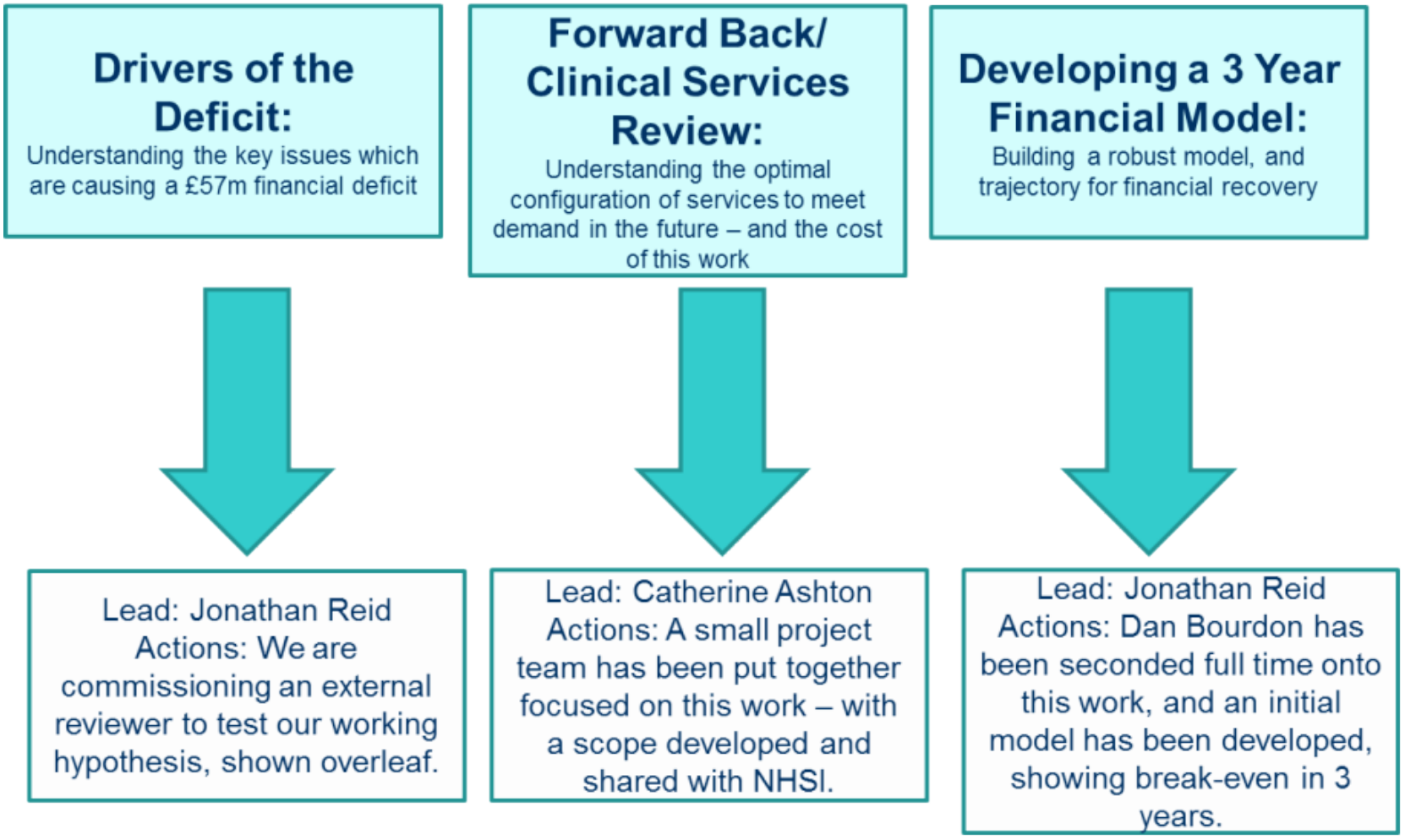
- The Trust remains in Financial Special Measures and is receiving significant support from NHS Improvement. The Trust will remain in FSM until it develops a robust plan for moving out of deficit, and delivers on several quarters of an NHSI-agreed ambitious plan for 2018/19.

- The Trust has three key workstreams in place to understand the route map to sustainability, described in this paper – understanding the drivers of the deficit, modelling the optimum delivery of services, and developing a 3-5 financial model which maps from current state to future state. This work will be presented to the Board in June 2018. The current plan is aligned with emerging findings, and is focused on delivering early efficiency and productivity gains indicated by the Model Hospital.

- The Trust has set an initial financial plan for a £47.8m deficit in 2018/19. The Finance and Investment Committee have indicated that continued work must take place to seek opportunities to improve the indicative financial plan beyond the £47.8m deficit plan. Therefore, the plan for approval by the Board today is indicative, and subject to further review and agreement by the Board and NHS Improvement.

# Moving to Sustainability

There are a number of key pieces of work in train to progress our financial sustainability plan, all due for completion in June 2018 – the current plan is aligned with the emerging findings from this work:



# Our Current Hypothesis

There are four key components in our financial hypothesis. The priority in the short term must be operational efficiency, although work continues in each of the core areas. We have a specification to secure external support to test this hypothesis in more detail:

**Unrecovered Income £15m:**
Based on SLR, benchmarking and comparisons.

We have identified £7m of unrecovered income and notified the CCGs for payment in 2019/20.

**STF/ PSF £15m:**
If we can meet our control total, we are eligible for £15m STF funding..

Our forward trajectory needs to be ambitious to ensure we can meet control totals in the future.

**Service Configuration £10-15m:**
What is the optimal configuration of services for E. Sussex?

Our Specialty Review process will review each specialty and agree the appropriate configuration.

**Operational Efficiency £15-20m:**
What is the optimal configuration of services for E. Sussex?

We must deliver annual efficiency of 3-4% just to meet growth in costs/ changes in tariff….

This work is based on Model Hospital, which suggests significant opportunities.

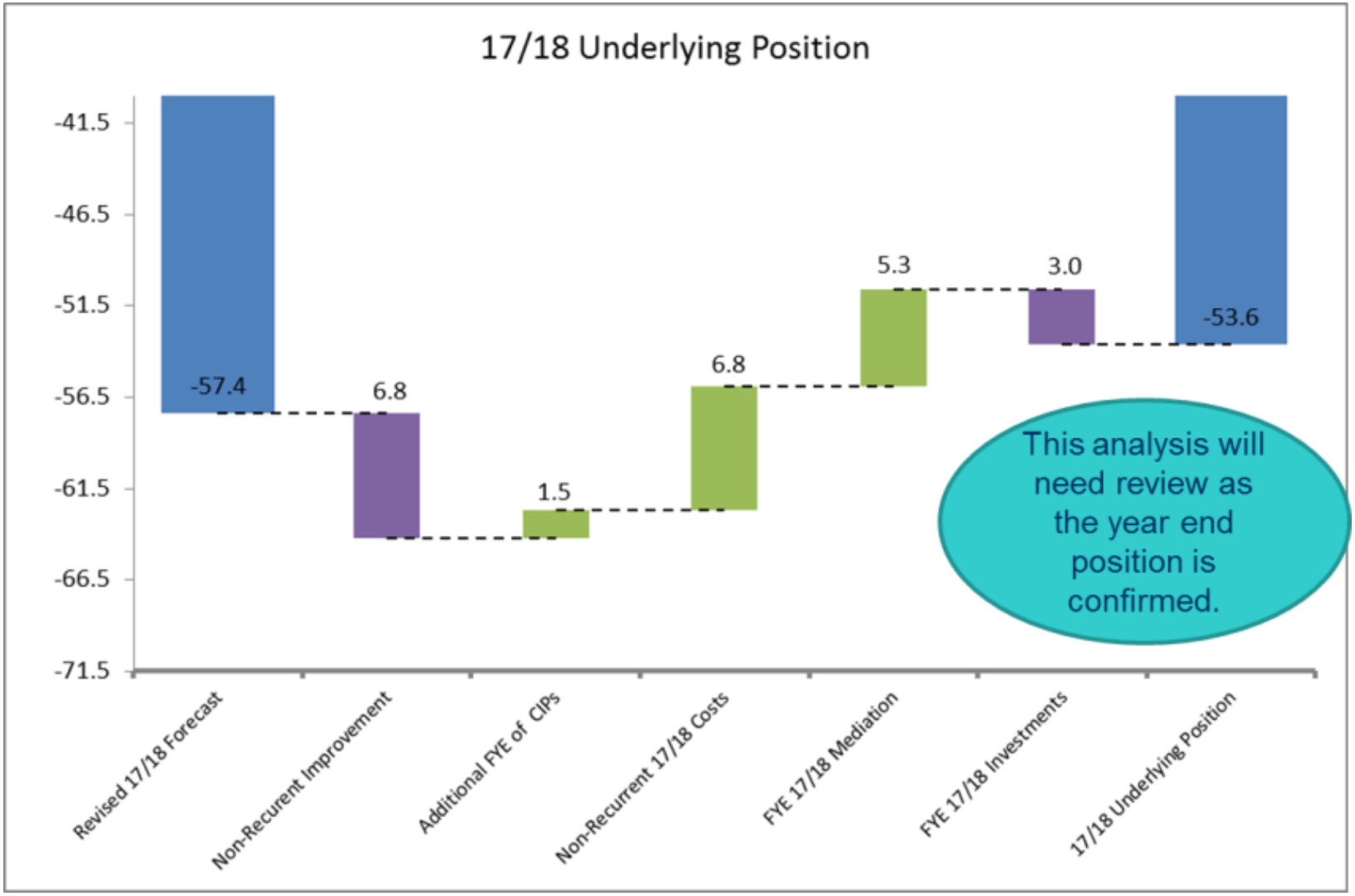
## Building Blocks for Financial Sustainability

- Right-size planned care
- Reduce bedded care capacity
- Exit peripheral sites
- Right-size urgent care
- Align community activity, income and cost
- Understand activity and bill accurately
- Secure STF funding

**Each of these components (except STF) is reflected in the draft financial plan for 2018/19, and in forward financial plans.**

**In the early years of the plan, grip and control and operational efficiency will be the basis for financial improvement.**

# Understanding the 17/18 Underlying Position



# Key Issues for the 2018/19 Financial Plan

- The 2018/19 plan is represented overleaf, removing contingency – except for a £2m risk reserve. The current planned deficit is £47.8m. The Finance Committee has indicated that it is seeking a significant improvement on this deficit, which will require a step change in CIP delivery.

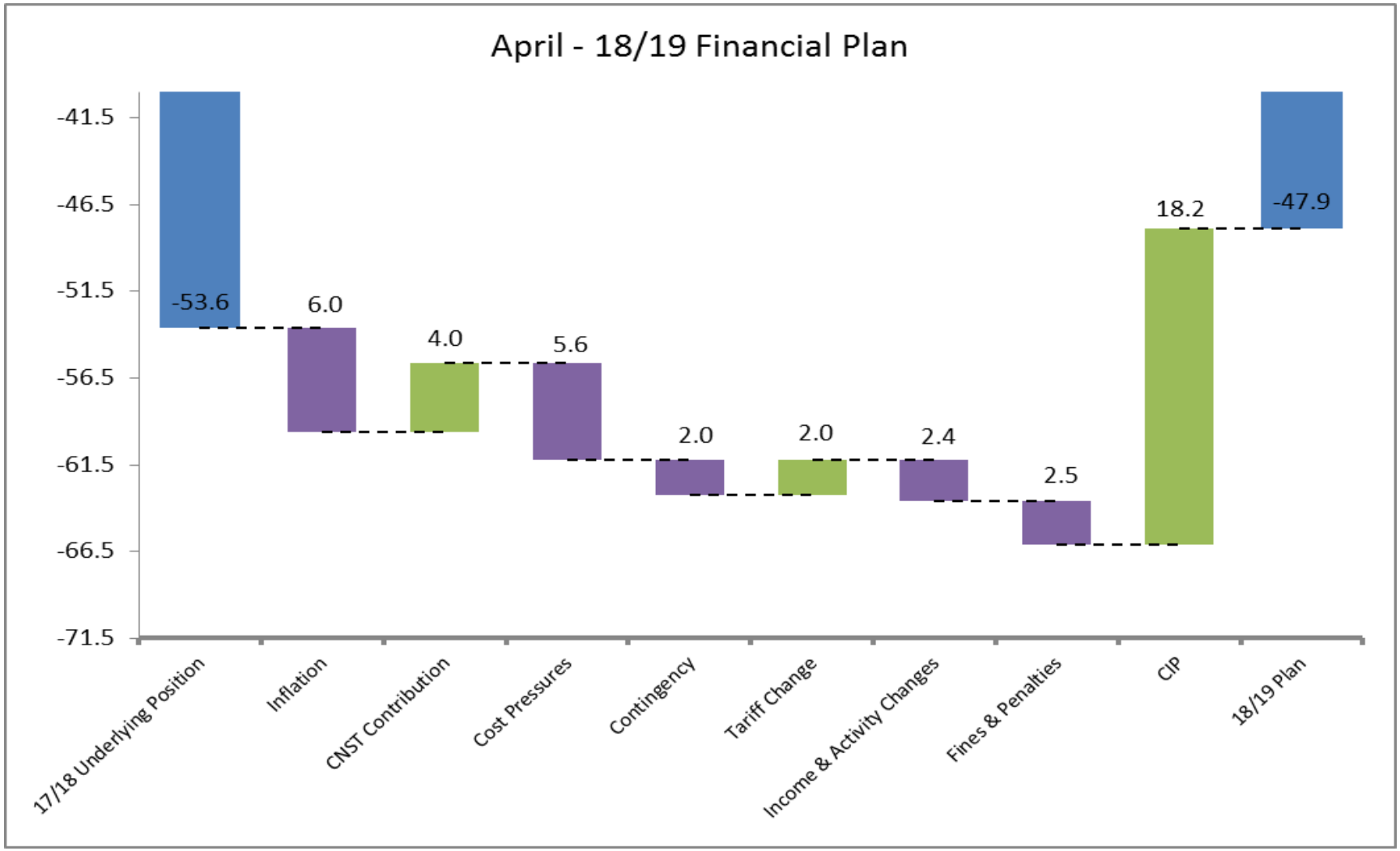
- The Trust set an ambition of £23.5m CIPs (6%) for 2018/19, focusing on cost. A minimum of £18.2m is required to deliver £47.8m. Delivery of £23.5m CIP would improve the position by £5.2m. Current green CIPS are c£13m, likely to rise to £15m by end April – a plan is in development to identify the full CIP pipeline, currently valued at £28m.

- The Trust required contract value for East Sussex CCGs associated with the plan is £268.7m. The CCGs are 'offering' £264.3m – with the difference of £4.4m as QIPP schemes. The CCG is unable to sign the 2018/19 contract, even at this offer price, as it is unaffordable. The Trust and CCG are working with NHSI/E to agree next steps.

- Current risks to delivery are £16.5m, with opportunities of £11.2m. Risks include the £4.4m CCG QIPP, and the £3m shortfall in CIP to £18m, both of which will likely reduce during April – leaving the Trust to focus on the opportunities.

- The key challenge is strengthening the CIP plans for the year. Additional support is being provided through PA consulting, both on Corporate and Clinical Unit CIPs to develop as many detailed plans as possible. Other key areas for improvement (and risk) are in respect of the contract with the CCGs, which reduces and reinvests penalties, avoids unsubstantiated QIPP. The Trust is also reviewing all cost pressures and is seeking to understand the potential benefits from growth.

# April 2018/19 Indicative Financial Plan



# April 2018 Financial Plan

| | Apr-18<br>DRAFT 18/19<br>£000 | |
|---|---|---|
| Revised Forecast out turn | (57,480) | |
| Adjust for non recurrent items | 3,845 | |
| Underlying Deficit - 2017/18 | (53,635) | |
| | | **Status of Planning Assumption** |
| *Inflation* | | |
| Pay Inflation | (2,860) | Confirmed through budget-setting |
| Non-Pay Inflation | (2,604) | Confirmed through budget-setting |
| Pharmacy Inflation | (500) | Confirmed through budget-setting |
| | | |
| *Cost Pressures* | | |
| CNST/ NHS Resolution Change in Pricing | 4,000 | Confirmed through budget-setting |
| Cost Pressures, including increased interest | (4,309) | Under review - currently £6.1m, but options to reduce |
| Financial Improvement Costs | (1,300) | Anticipated costs of support in-year |
| | | |
| *Reserves* | | |
| in-Year Management of Risk | (2,000) | RESERVE FOR RISK |
| | | |
| *Activity and Income Changes* | | |
| Tariff Change | 2,003 | Based on draft contract |
| New CCG Challenges - MRET | (1,400) | Confirmed with CCG, based on draft contract |
| Income Margin on Growth/Community | 377 | Under review with specialties |
| Net Service Change and Decomissioning | (1,350) | Confirmed through budget-setting |
| Fines and Penalties - 50% of current performance | (2,500) | Under negotiation with CCG |
| | | |
| *CIP Plans* | *18,225* | MINIMUM REQUIRED TO REACH £47.8m |
| | | |
| **Initial Financial Plan 2018/19** | **(47,853)** | |

## Delivering Cost Improvements

Developing and delivering CIPS is key to strengthening our financial plan. Since October 2017, the Trust has been working with a new approach, developed and supported by Mark Hackett. This involves weekly confirm and challenge sessions with the Clinical Units and Corporate Teams, supported by a strengthened PSO and external assistance where required.

NHS Improvement, through the Operational Productivity Directorate, have provided the Trust with additional support during April with a team of staff embedded within Clinical Units to assist in moving schemes to green and building the pipeline, and a further joint review of corporate services opportunities in train to ensure delivery of the 7% corporate CIP. This work finishes at the end of April, and further support from PA Consulting (or an alternative provider) is likely to be required. The Executive Team will review delivery by PA and work with NHSI to develop an appropriate approach, to be reviewed by the Finance and Investment Committee.

**As at 10 April, however, only £12.3m of the CIP schemes are green, with a total pipeline of £28m. The Clinical Units and Corporate Teams have agreed a trajectory – to the end of May – aimed at securing green status for all schemes in the pipeline. This will need careful monitoring and support, and is kept under weekly review by the Financial Improvement Oversight Group, and as appropriate by the Financial Improvement and Sustainability Committee.**

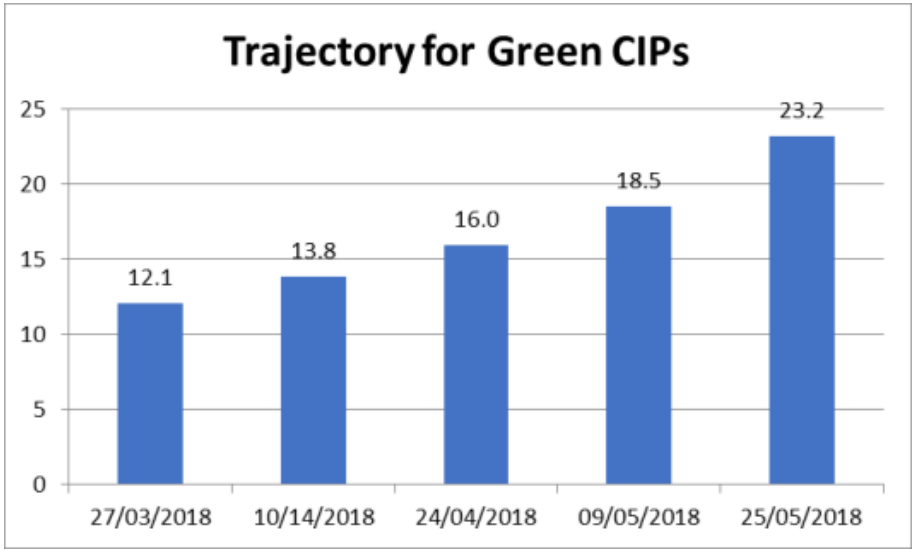
# 2018/19 CIP Progress

| Division | 2018/19 CIP Target £m (7%) | Awaiting QIA £m | Awaiting FISC £m | FISC Signed £m | Total Green Schemes £m | Amber Schemes £m | Red Schemes £m | Amber/ Red Schemes £m | Total Identified £m | Further Opps £m | Total £m |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |
| Corporate Services | 3.4 | 0.1 | 0.2 | 0.8 | 1.1 | 0.2 | 1.8 | 2.0 | 3.1 | 0.0 | **3.1** |
| Trust-wide Budgets | 1.4 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | **0.0** |
| Estates & Facilities | 2.3 | 0.1 | 0.2 | 0.2 | 0.5 | 0.0 | 0.3 | 0.3 | 0.8 | | **0.8** |
| Medicine | 4.8 | 0.0 | 0.1 | 3.6 | 3.7 | 1.7 | 1.8 | 3.5 | 7.2 | 1.7 | **8.9** |
| Out of Hospital Care/Pharmacy | 3.3 | 0.0 | 0.0 | 1.0 | 1.0 | 0.0 | 0.0 | 0.0 | 1.0 | 1.2 | **2.2** |
| Surgery, Anaesthetics & Diagnostics | 8.4 | 0.0 | 0.0 | 4.0 | 4.1 | 0.3 | 3.7 | 4.0 | 8.1 | | **8.1** |
| Emergency Care | 0.9 | 0.3 | 0.0 | 0.3 | 0.6 | 0.0 | 0.0 | 0.0 | 0.6 | | **0.6** |
| Women's, Children's & Sexual Health | 2.4 | 0.1 | 0.0 | 0.6 | 0.7 | 0.2 | 1.7 | 1.9 | 2.6 | 1.6 | **4.2** |
| Patient Flow | | | | 0.5 | 0.5 | | | 0.0 | 0.5 | | **0.5** |
| Procurement | | | | | 0.0 | | 0.4 | 0.4 | 0.4 | | **0.4** |
| Workforce | | | | | 0.0 | | 0.5 | 0.5 | 0.5 | | **0.5** |
| **Total** | **27.0** | **0.6** | **0.4** | **11.2** | **12.2** | **2.4** | **10.2** | **12.5** | **24.8** | **4.5** | **29.3** |
| | | | | | | | | | | | |
| **Financial Plan Target (6%)** | **23.5** | | | | | | | | | | |

- The Trust has identified £24.8m of schemes with a further £4.5m of opportunities
- £12.2m of the £24.8m are ‘green’
- Work is progressing to move the £12.5m amber and red schemes into green.
- The Divisions have been asked to agreed a timeframe for when schemes will be expected to be green.

# 2018/19 CIP Trajectory

| | 10/04/2018 | | 24/04/2018 | | 09/05/2018 | | 25/05/2018 | | Income | | Later Date | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Division | No. | £ | No. | £ | No. | £ | No. | £ | No. | £ | No. | £ | No. | £ |
| Corporate | 21 | 408,243 | 13 | 1,858,950 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 35 | 2,267,193 |
| DAS | 4 | 133,344 | 12 | 40,000 | 31 | 776,517 | 2 | 3,028,000 | 0 | 0 | 2 | 0 | 51 | 3,977,861 |
| ED | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 0 |
| MED | 4 | 278,400 | 4 | 25,000 | 12 | 1,782,823 | 0 | 0 | 2 | 1,394,000 | 0 | 0 | 22 | 3,480,223 |
| OOH | 0 | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 0 |
| WAC | 2 | 0 | 5 | 221,000 | 0 | 0 | 1 | 1,679,000 | 0 | 0 | 0 | 0 | 8 | 1,900,000 |
| Procurement | 1 | 392,208 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 392,208 |
| Workforce | 1 | 500,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 500,000 |
| **Total** | **38** | **1,712,195** | **39** | **2,144,950** | **44** | **2,559,340** | **3** | **4,707,000** | **2** | **1,394,000** | **2** | **0** | **128** | **12,517,485** |




The latest trajectory shows that between now and end of May 2018 the Trust will increase green schemes by £11m from £12.1m this week to £23.2m.

In order to deliver the revised CIP plan of £18.2m the Trust needs to have green schemes exceeding this value to provide some headroom to ensure the planned value is delivered.

# Next Steps

The indicative financial plan sets an ambitious target. However, we need to seek all opportunities to deliver and then improve on this plan:

- **CIPS:** Clinical Units and Corporate Teams must deliver to the trajectory described in this paper, to ensure we identify routes to delivery for the full £28m pipeline of opportunities. This will allow the Board to review the plan, and identify opportunities to deliver.

- **Contract:** Contract negotiations are, at this stage, partly in the hands of regulators. However, the Trust must continue to work with CCGs to develop a robust and clear contract, mitigating penalty clauses and seeking reinvestment of MRET monies.

- **Grip and Control:** the new Director of Recovery (role TBC) will support the Trust in reviewing all areas of grip and control to ensure that all opportunities to reduce discretionary expenditure are secured, in a sensible and sustainable way.

- **Cost Pressures and Investments:** the cost pressures and investments included in the financial plan need further review and evaluation to establish opportunities to improve the financial position.

The April Finance and Investment Committee provides an opportunity to refresh the assumptions, followed by the May Committee. A further NHSI submission is required in April – if the Trust can secure an improved CIP pipeline, this will allow for further revision to the plan.

# Nursing Establishment Review

| Meeting information: | | | |
|---|---|---|---|
| Date of Meeting: | 17th April 2018 | Agenda Item: | 12 |
| Meeting: | Trust Board | Reporting Officer: | Vikki Carruth, Director of Nursing |

| Purpose of paper: (Please tick) | | | |
|---|---|---|---|
| Assurance | ☐ | Decision | ☐ |

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

## Executive Summary:

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

This paper provides the Trust Board with the recommendations arising from the bi-annual review of the nursing establishments in inpatient wards and the Emergency Department review.

Nationally mandated nursing establishment tools calculate the staffing needed in each area alongside professional judgement for the ward to be safely staffed the majority of the time. However, whenever there is a significant acuity or dependency change the area may need to use additional staff to meet patients' care needs safely. This is known as Enhanced Care, currently referred to as "Specials" within the Trust.

The ward budgets may need to be supplemented on occasion under the circumstances above and much tighter controls are being recommended regarding the creation of additional duties and requesting of additional staff.

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

Executive Team Meeting - 13 March 2018
Finance and Investment Committee - 28 March 2018 (recommendations supported)
Due to be shared with the People and Organisational Development Committee - 9 May 2018 for info.

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

- Approval of the recommended changes to staffing templates to deliver safer staffing
- Decision on the proposal that recruitment into uplift/headroom be capped
- Decision on the 18% uplift/headroom and agreement to accept the risks arising from this
- Decision on the revision of ward level access to create additional duties.

**Nursing and Midwifery Safer Staffing – Bi-annual Establishment Review**

## 1. Purpose

The purpose of this paper is to provide a 6 monthly report on Nursing and Midwifery staffing as part of the Trust's Safer Staffing governance and in accordance with requirements as set out in the National Quality Board (2013) report following the Mid Staffs Inquiry (2013). This paper provides assurance that a robust establishment review has been undertaken and sets out the findings for safer staffing levels in the inpatient adult and paediatric wards, assessment units and emergency departments at the acute and intermediate care sites. It further provides assurance regarding the Trust processes in place for setting, monitoring, maintaining and escalating concerns regarding safe nursing and midwifery staffing levels.

The Emergency Department establishment review is included in Part 2 given the level of detail involved.

## 2. Background

Following the Francis Inquiry report (2013), the National Quality Board (NQB) published guidance, *'How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability' (2013),* for commissioners and providers for safe nursing and midwifery staffing to enable delivery of high quality care and the best possible outcomes for patients. This was followed by both NICE guidance *'Safe staffing for adult inpatient wards in acute hospitals' (2014)* and further NQB guidance 'Supporting NHS providers to deliver the right staff, with the right skills in the right place at the right time: Safe, sustainable and productive staffing' (2016).

The Lord Carter Review (2016) highlights the importance of ensuring that workforce and financial plans are consistent in order to optimise the delivery of high quality care and achieve efficient use of resources. The review introduced a new metric, Care Hours per Patient Day (CHPPD) which has been collected monthly from April 2016 and daily from April 2017. Also suggested is improved efficiency in the use of e-rostering and implementation of the concepts of Enhanced Care.

CHPPD is calculated by adding the hours of registered nurses to the hours of health care support workers on each ward and dividing the total number of inpatients in 24 hours. However, this broad calculation is limited by the lack of any assessment of the individual nursing care needs (based on their acuity and dependency) of each patient.

Demonstrating appropriate safe staffing is one of the essential standards that all health care providers must achieve in order to be compliant with Care Quality Commission (CQC) registration. The Trust is required to evidence publically available staffing data and does this via high level reporting to its public Trust Board meetings and by publishing ward level staffing data on its website and in clinical areas.

Boards at any time must be able to demonstrate to their commissioners that robust systems and processes are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient to provide safe care. All NHS Trusts are accountable to NHS Improvement (NHSI) and are expected to provide assurance that they are implementing the NQB staffing guidance and that, where there are risks to quality of care due to staffing, actions are taken to minimise the risk.

## 3. Approach to safe staffing at ESHT

### 3.1 Establishment Reviews – to set planned staffing levels

This review has been completed using robust and nationally validated tools, which are ratified by NICE and meets NQB and NHSI requirements. This includes;

Inpatient adult and paediatric wards

- A 20 day audit on each ward using the Safe Nursing Care Tool (SNCT) to assess nursing care hours based on patient factors (acuity, dependency and holistic assessment), ward factors (turnover, layout, size of ward) and staffing factors (nursing activities as well as direct patient care)

Emergency Department

- A 7 day audit in both emergency departments using the validated Royal College of Emergency Medicine and Royal College of Nursing Baseline Emergency Staffing Tool (BEST) to assess nursing care hours required based on patient factors, environmental factors and staffing factors. The recommendations are presented in Part 2 of this paper.

Maternity

- A Birth Rate Plus review of midwifery staffing has been undertaken by an expert external team. The analysis is underway and will be reported with recommendations for the staffing establishment and location of staff. The full report will be received at the June 2018 Board Meeting as delays in securing funding for the work meant the data is not available as planned. It is not envisaged that significant investment will be required but this detailed piece of work needs to be completed in full first.

Process

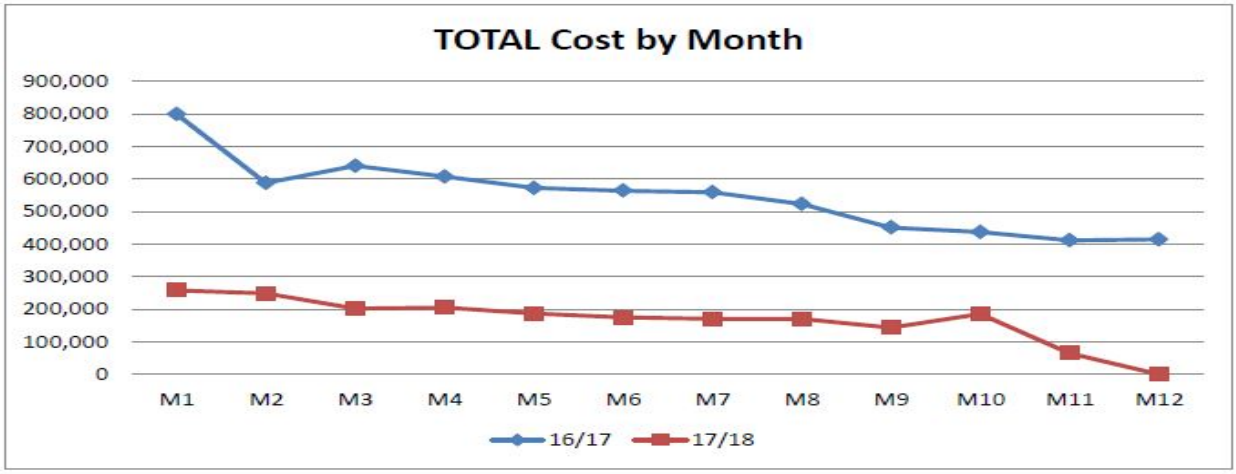
- Ward level meetings occurred with the Matron and related Head of Nursing to review the SNCT/ BEST findings and triangulate this with professional judgement to capture the reality of nursing on the ward.
- Triangulation of the SNCT/ BEST and initial review meetings findings with other validated tools; Hurst Professional Judgement tool, Hurst acuity tool, NICE nurse to bed ratio and NICE registered nurse to patient ratio.
- Director of Nursing meetings with the Associate Director of Nursing for each Division and their deputies to review the triangulated findings from both the validated tools, nurse sensitive quality indicators and professional judgement to agree the recommended staffing level for each area.
- Executive panel review of the findings of the nurse establishment review which included the Chief Executive, Chief Operating Officer, Director of Human Resources, Director of Finance, Medical Director and Director of Nursing at an exec meeting.
- Presentation for scrutiny and assurance of the findings at both the People & Organisational Delivery Committee (POD) and Finance and Investment Committee (F & I) of the Trust Board.
- Presentation to the Trust Board of the recommendations from the establishment review at their meeting in public.

### 3.2 Monitoring Safe Staffing levels

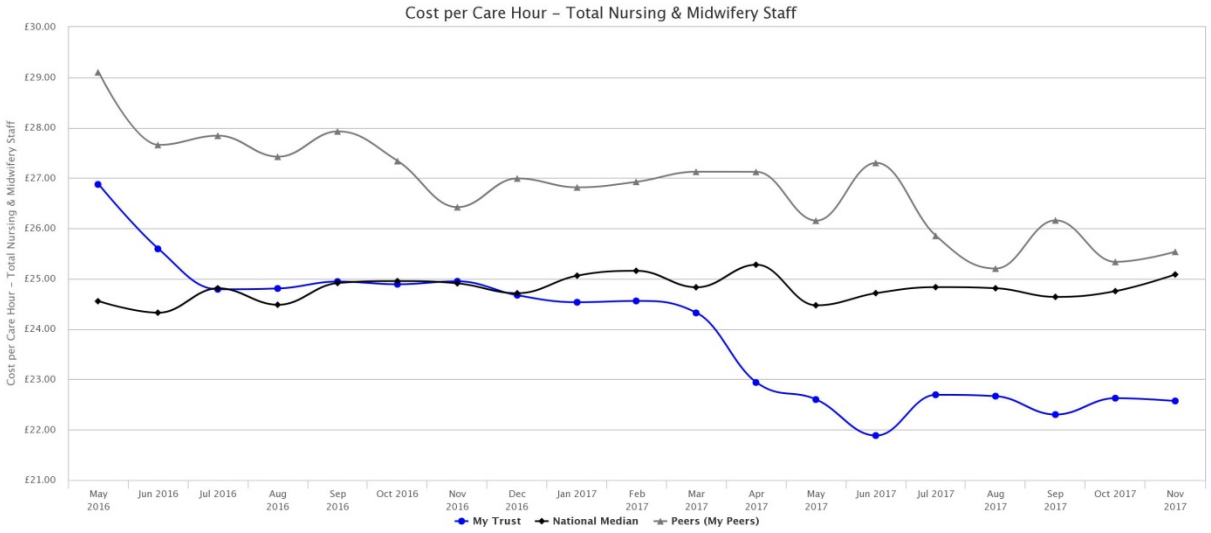
Once the Trust Board has agreed the planned staffing levels for each ward / department following the establishment review these are entered into the Trust's electronic rostering system as the template by which each ward is safely staffed.

When there is a shortfall in staffing wards continue to staff to their approved template and use the Temporary Workforce Service (TWS) to obtain additional staff. TWS focuses on using substantive staff and TWS employed bank staff to fill any shortfalls first. Where necessary to maintain safe staffing levels the Trust will utilise agency staff to work alongside our staff. It should be noted that since July 2017 the trust has not employed any agency HCA staff and only uses TWS (bank) and substantive HCAs.

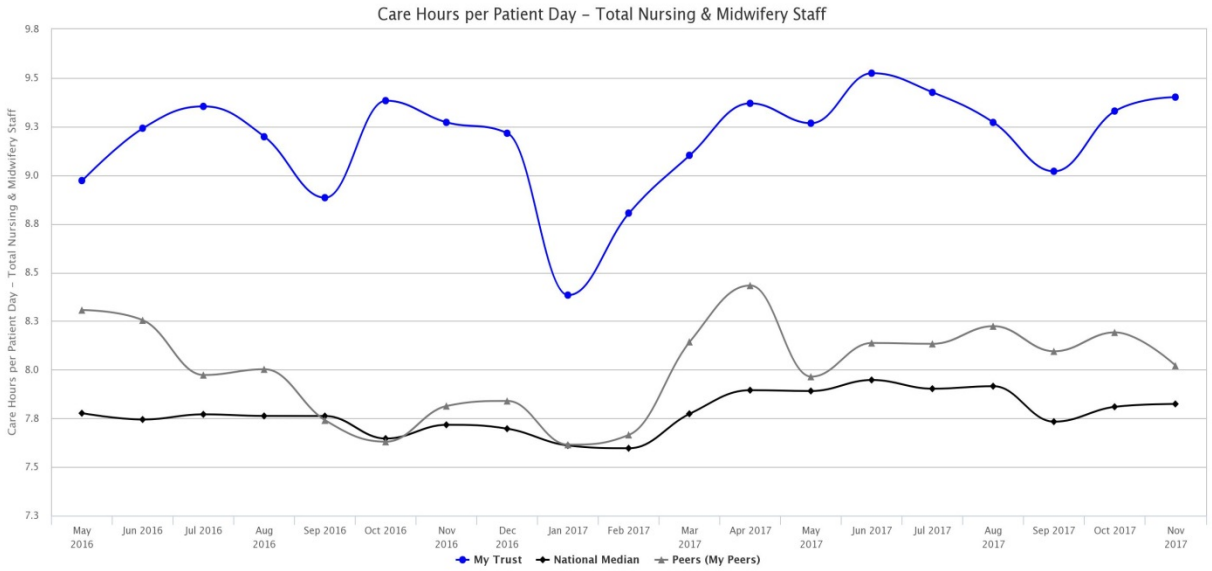
**Graph 1: Nurse RN Agency Usage – 2017-18**




**Graph 2: Model Hospital Benchmark Cost per Care Hour (accessed 01/03/18)**



**Graph 3: Model Hospital Benchmark Care Hours per Patient Day (accessed 01/03/18)**




The tables above demonstrate the effects of improved grip and control on nursing expenditure achieved through the implementation of Safe Care and improved visibility of staffing and the reduction in agency expenditure have contributed not only to a real, sustained reduction in agency spend but has also reduced the real cost of nursing to deliver an hour of patient care. The Trust cost per care hour is below both the national and that of the other providers in Kent, Surrey and Sussex. For assurance we have not seen a reduction in the number of care hours provided to our patients each day whilst achieving this reduction in spend.

However, care hours per patient day measures total care hours available to patients from all nursing staff in each ward divided by 24 hours. This means that for areas where the use of specials is higher than would be expected there could be high care hours with low costs as most specials are undertaken by healthcare assistants. As we work to optimise how enhanced care is provided to patients who need this level of input we will see a reduction in HCA usage for specials which could appear to be a reduction in total care hours per day and an increase in spend compared to this year. The committee should expect to see the Trust move towards national medians for both graph 2 and 3 as we 'right size' skill mix and deliver optimised enhanced care.

In addition to e-rostering the Trust has implemented the NICE validated Safer Care tool which gives visibility of all nursing staff on shift and the acuity and dependency of all adult inpatients on our wards to monitor whether levels are safe. The assessment of patients' care needs takes place three times in each 24 hour period providing instant visibility of;

| Safe Care Indicator | Description |
|---|---|
| CHPPD | Total care hours needed by the patients on the ward, by shift, at the time of assessment having assessed their needs individually using the Safe Care validated tool. |
| NICE Red Flags | Nationally required measures which indicate circumstances where there is the potential for staffing to be misaligned to patient care needs and quality of care to be negatively impacted. |
| Missing Skills | Such as IV drugs, ILS trained |
| Missing charge cover | The Trust funded all ward budgets to have a senior nurse (band 6 or above) in charge of the ward 24/7. Where there is no band 6 or band 7 this is highlighted in Safe Care |
| Total Nurse to patient ratio | The ratio of RNs plus HCAs on the ward and the total number of patients |

| | |
|---|---|
| Unfilled duties | Identifies the number of shifts on the ward unfilled compared to both the safer staffing template and any additional duties created to meet patient acuity or increased capacity. |
| Skill mix | % split of RNs on duty versus HCAs |
| % temporary staff | The % of total nursing staff present who are working a bank or agency shift compared to a substantive shift. |

Senior clinical oversight of safe staffing at each acute site was undertaken on a daily basis by the Senior Nurse of the Day. This approach was reviewed as part of the Safe Care implementation as there was no linkage between staffing and patient flow throughout the hospital with the potential for limited decision making and for negative impact on patients.

The 24/7 oversight of site staffing, including the intermediate care beds associated with the acute site, has now moved to the site team in conjunction with the divisions who are accountable for ensuring safe staffing on the wards. Staffing meetings are held twice daily, prior to the site meetings, where the divisional nursing representatives from Medicine and Surgery, the site team and TWS representative all discuss staffing on each ward and reach a consensus decision on any staff moves to optimise safe staffing in each ward and how to achieve this. These meetings also look 24 hours ahead and any gaps / concerns are identified, shifts put out to TWS where necessary and where necessary there is escalation to the corporate nursing team and Director of Nursing.

## 4. Findings

### 4.1 Changes

The changes to nurse staffing recommended to the Trust Board following the executive team review as part of this annual establishment review are as follows

| Division | Ward | Additional Staff on template | HCA FTE increase | RN FTE increase | Investment | Bed increase |
|---|---|---|---|---|---|---|
| DAS | ITU EDGH | 1 LN HCA 7/7 | 2.53 | | **79,852** | |
| Medicine | Berwick | 1 LN HCA 7/7 | 2.53 | | **79,852** | |
| | Cuckmere | 1 LN HCA 7/7 | 2.53 | | **79,852** | |
| | Folkington | 2 LD HCA 7/7 | 5.07 | | **125,075** | |
| | Jevington | 1 LN RN 7/7 | | 2.53 | **188,313** | |
| | | 1LD HCA 7/7 | 2.53 | | | |
| | AMU | 1 LD RN 7/7 | | 5.07 | | **199,143** |
| | | 1 LN RN 7/7 | | | | |
| | Wellington | 1 LN HCA 7/7 | 2.53 | | **79,852** | |
| OOH | BIU | 2 LD HCA 7/7 | 7.60 | | **204,927** | |
| | | 1 LN HCA 7/7 | | | | |
| | **Total template changes** | | **25.33** | **7.60** | **837,724** | **199,143** |

| | FTE | Total £ | Medicine | DAS | ITU | OOH |
|---|---|---|---|---|---|---|
| **1718 current budget for wards** | **1,322.85** | **44,018,102** | **23,826,544** | **13,045,956** | **4,716,343** | **2,429,259** |
| Template changes | **27.86** | **837,724** | 552,945 | - | 79,852 | 204,927 |
| 3% headroom adjustment | **29.96** | **93,270** | 31,121 | 64,505 | - 8,503 | 6,148 |
| Specialling budget | **- 26.25** | **- 511,372** | - 511,372 | - | - | - |
| ITU Conquest budget reduction | **- 7.52** | **- 283,440** | - | - | - 283,440 | - |
| Other budget changes | **9.24** | **113,584** | 56,431 | 96,300 | - 29,463 | - 9,683 |
| **Proposed budget changes** | **33.29** | **249,767** | **129,124** | **160,805** | **- 241,554** | **201,392** |
| | | | | | | |
| **Proposed ward 1819 budget** | **1,356.14** | **44,267,869** | **23,955,668** | **13,206,761** | **4,474,789** | **2,630,651** |
| Increased capacity EDGH AMU | **5.07** | **199,143** | 199,143 | - | - | - |
| Seaford 4 escalation part of baseline | **46.42** | **1,387,533** | 1,387,533 | | | |
| *Specialling/ agency premium provision | **20.00** | **500,000** | | | | |
| **Proposed ward 1819 budget** | **1,427.63** | **46,354,545** | **25,542,344** | **13,206,761** | **4,474,789** | **2,630,651** |
| | | | | | | |
| **201718 forecast actual costs** | **1,447.49** | **47,447,315** | **27,039,221** | **13,309,457** | **4,261,439** | **2,837,198** |
| **Comparison 1718 to 1819 proposed budget** | 19.86 | 1,092,770 | 1,496,876 | 102,696 | -213,350 | 206,548 |

### 4.2 Uplift/ Headroom

When agreeing the ward establishment, Trusts are expected to ensure it is sufficient to provide planned staff requirements at all times. This should include capacity to deal with planned and predictable variations in nursing staff available, such as annual leave, parenting leave, sickness and some study leave. This is commonly known as uplift / headroom. The Trust currently has a 21% uplift in place, across all nursing areas, with 18% held at ward level and a further 3% held by the division. This covers;

| Absence Cover | | Days per Annum per FTE | Hours Per Annum per FTE | Hours per Week per FTE | % |
|---|---|---|---|---|---|
| Annual Leave (inc B/H) | Average | 30.00 | 225.00 | 4.32 | 11.51% |
| Bank Holidays | | 7.00 | 52.50 | 1.01 | 2.68% |
| Training | | 5.00 | 37.50 | 0.72 | 1.92% |
| Short Term Sickness | | 5.00 | 37.50 | 0.72 | 1.92% |
| **Total Uplift applied to Budgets** | | **47.00** | **352.50** | **6.76** | **18.03%** |
| parenting leave/ other headroom | | | | | 3.00% |
| | | | | | **21.03%** |

The uplift, as described above, aims to provide the ward with the ability to cover planned and some unplanned leave within these levels. This may not always be sufficient especially when annual leave is set at an average.

- Where the sickness, annual leave entitlement and/or training requirements exceed these funded limits the ward will likely overspend against their allocated budgets.
- The current uplift does not include any funding for continuous professional development (CPD) above minimal statutory and mandatory training. A recent additional requirement relates to nurse revalidation. This requires registrants to evidence a minimum of 35 hours of CPD every 3 years which includes 20 hours of participatory CPD.
- Areas such as ITU, Maternity, ED, CCU, Stroke and SCBU all have high induction and training requirements to reach basic competence levels which will likely create a cost pressure.

Thus far, wards have been able to use their allocated uplift budget to maintain their agreed safer staffing template by recruiting additional staff or by using temporary staff. Where wards choose to recruit into their uplift with substantive staff this then adds a cost pressure as these posts also need uplift to enable these staff to take planned and unplanned leave. It also leaves very little flexibility in terms of planning rosters and also assumes that extra is always needed

Currently there is no trust-wide decision on the level of uplift that wards should/can recruit into and workforce reporting does not afford transparency of core FTEs and "uplift" FTEs.

### 5. Enhanced Care – Use of specials

The total funded nursing establishment in each ward should meet the (typical) needs of the number and acuity of patients as it was measured during the establishment review process. However, if there is an increase in bed numbers, increase in acuity or change of specialty focus in an area, the staffing template and establishment may no longer be sufficient.

The most common reason a ward needs to exceed its staffing template is when patients are admitted who are assessed as having a very high acuity or dependency and requiring higher nurse to patient ratios. This practice is known as enhanced care or 'specialling'. As patients requiring enhanced care are largely unknown until they are admitted, the wards will typically request additional staff from TWS.

The Trust policy for the 'Introduction and Use of Special Observations for adult patients' provides the framework for ward staff to use alongside their clinical judgement for heightened levels of observation where patients are assessed as being at serious risk of harm to themselves or others e.g. wandering, falls or aggressive/challenging behaviour.

Enhanced observation is predominantly delivered by HCA and the need is largely unplanned as it is driven by individual patient assessment following admission in most areas leading to the creation of additional shifts over and above the planned staffing template to ensure the patient care needs are met. The additional HCA need is predominantly filled by TWS and as the Trust has not used agency HCA staff since July 2017.

Safe Care implementation has improved and provided a more consistent approach to patient acuity and dependency assessment. Staff are able to identify how many patients they have requiring enhanced care as part of their safe care assessment three times a day and these are included in the overall Safe Care calculation for the ward.

The Director of Nursing has begun a review of Specials as the usage appears high ins some areas and her team are now reviewing how the Trust manages specials/enhanced care, benchmarking ESHT practice with other Trusts. The current policy is being audited as is the risk assessment and sign off process and resulting actions will be taken forward throughout 2018/19 to ensure that staff make the best use of scarce resources.

In the short term, following approval of the safe staffing templates, the Director of Nursing will be able to implement strengthened controls for enhanced care. The short term actions will include the removal of ward level access to book additional staff above the template and introduce a senior nurses' authorisation process.

### 6. Supernumerary nursing staff

At any time there will be a number of staff, both RN and HCA, who will require supernumerary time in their work areas. This is generally associated with local induction at employment with the Trust, local induction on moving to a new area/specialty/ward within the Trust or staff on an educational programme who are required to have supernumerary time which the Trust has committed to as part of their training/course. Staff complete this supernumerary time in clinical areas but currently they do not all show in the Safe Care system. This lack of visibility is being addressed by the Director of Nursing and her team to ensure these staff are captured in Safe Care but don't artificially affect the CHPPD.

The Director of Nursing and her team are also beginning work with the University of Brighton to start to record student nurses on Safe Care as they are at present supernumerary (albeit they contribute) and currently the visibility of this staff group is poor.

These steps will provide the Trust with a more detailed picture of all staff present on the ward/area and ensure staff have the accurate information to inform decision making regarding safer staffing of all areas.

## 7. Safer Staffing Governance and Reporting Framework

The safe, sustainable staffing requirements placed on provider Trust Boards are detailed in Appendix A. The NQB has updated its guidance on "Safe, sustainable and productive staffing an improvement resource for adult inpatient wards in acute hospitals (2018)". This outlines a rigorous set of expectations which ESHT will be expected to meet.

The Director of Nursing and her team are currently undertaking a baseline assessment of current practice against these requirements to identify any gaps, risks and actions. The Trust Board meeting via POD will receive regular Safer Staffing reports to from March 2018 and high level assurance will continue to be presented to the Trust Board meetings in public within the Integrated Performance Document.

## 8. Risks

8.1 Gaps in compliance with national guidance – detailed in the appendices with mitigating actions

8.2 Risk on the Trust risk register

8.3 Variation in the rostering skills of nursing staff and ability to produce optimal rosters

8.4 Embedding of Safe Care and assurance regarding the accuracy of acuity and dependency scoring in all areas.

8.5 Safe Care implementation nurse in post until March 2018 then no business as usual resource. Initially agreed areas will have the system however there is no business as usual resource to lead on Safer Staffing.

8.6 Site team and divisional attendance and ownership of staffing as a key factor to optimise site safety and ensure safety in patient flow is not embedded.

## 9. Recommendations

The Board is asked to;

- Decide on the recommended staffing changes arising from the establishment review
- Agree for the removal of ward level access to add additional duties (above the staffing template) and replace with divisional authorisation processes.
- Decide on whether uplift will remain at 21% in total for all areas and acknowledge the financial risks associated with this decision for specialist areas.
- Decide on ceiling of uplift which each area can recruit into (DoN is recommending no more than 10%).

**Part 2**

# Nursing Establishment Review – Emergency Department Conquest & Eastbourne District General Hospital

## Executive Summary

The national regulatory and best practice requirements placed on NHS providers is to have robust and timely nursing establishment reviews in place across all of their services. The Emergency Department nursing establishment was last reviewed over 5 years ago.

Since the last review, the **Care Quality Commission** (CQC) inspected the ED services (in 2016) at both acute sites highlighting that;

- Staffing is not in line with national recommendations
- Nurse to patient ratios fall short of established safe minimum standards on both sites but there is a significant difference on the Eastbourne site particularly at night. It should be noted that staffing has been increased by 2 registered nurses per night shift via our divisional Integrated Performance Reviews (IPR) to ensure capacity meets current demand. These 2 additional nurses provided a second registered nurse in Resus and a second registered nurse in Zone 1; this was based on a number of clinical incidents within the resuscitation and major's area.
- Awareness of the staffing issues were reported via incident reporting

It was previously agreed that to ensure safety, the levels of staffing at Eastbourne ED were increased as an interim measure albeit the department is rarely able to staff to full capacity as it also supports the CDUs. This review has been overseen by the Director of Nursing and conducted using the BEST tool with data collection undertaken (on an hourly basis every hour for a period of 7 consecutive days) in line with the recommended methodology. Whilst the BEST tool does not recommend staffing levels it does calculate nurse to patient ratios using the validated Jones Dependency Tool, a skill mix breakdown within the whole time equivalent (WTE) based on the Faculty of Emergency Nursing (FEN) competencies.

### Current position

The total current funded ED establishment for both sites for all services is **139.65 wte** with a budget of **£5,176,565**

### Proposed position

The proposed funded ED establishment for both sites for all services is **182.93 wte** with a budget of **£7,600,311**

### Difference and cost

This is 37.68 wte (excludes 5.6 wte streaming nurses) and £1,584,872 with adjusted forecast outturn.

Risks and benefits are described in more detail in the paper.

**Background**

The national regulatory and best practice requirements placed on NHS providers is to have robust and timely nursing establishment reviews in place across all of their services. The Emergency Department nursing establishment was last reviewed over 5 years ago.

Since the last review, the **Care Quality Commission** (CQC) inspected the ED services (in 2016) at both acute sites highlighting that;

- Staffing is not in line with national recommendations
- Nurse to patient ratios fall short of established safe minimum standards on both sites but there is a significant difference on the Eastbourne site particularly at night. It should be noted that staffing has been increased by 2 registered nurses per night shift via our divisional Integrated Performance Reviews (IPR) to ensure capacity meets current demand. These 2 additional nurses provided a second registered nurse in Resus and a second registered nurse in Zone 1; this was based on a number of clinical incidents within the resuscitation and major's area.
- Awareness of the staffing issues were reported via incident reporting

ED attendances have significantly increased across the 2 sites with no corresponding change in funded establishment.

| **Attendances** | **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2016/17** |
|---|---|---|---|---|---|
| Conquest Hospital | 50178 | 51417 | 52894 | 54013 | 54979 |
| Eastbourne District General | 51342 | 50327 | 50255 | 52863 | 55558 |
| **Total** | **101,520** | **101,744** | **103,104** | **106,876** | **110,537** |

Whilst there are two EDs, one at each acute site, there are some differences between the two sites. The Conquest ED is a trauma unit. The Eastbourne ED receives acute stroke patients. **The Clinical decision Units (CDU's) on both sites are part of the ED footprint and staffed by the same establishment.**

**This paper will focus on Adult ED as discussions are ongoing regarding Paediatric Emergencies for the Eastbourne site. This will be addressed in the subsequent DoN review in six months' time.*

**Current position**

The total current funded ED establishment for both sites for all services is **138.6 WTE** with a budget of **£5,043, 824.**

| **Site** | **No of attendances Per day** | **Number of Cubicles** | **Number of CDU beds** | **Number of Resus bays** | **RNs & HCAs on duty Long** | **RNs & HCAs on duty Twilight** | **RNs & HCAs on duty Night** |
|---|---|---|---|---|---|---|---|
| Eastbourne | 167 | 15 | 8 | 6 | 9&3 | Zero | 6&3 |
| Conquest | 158 | 15 | 7 | 4 | 10&5 | 1&1 | 8&4 |

***The number of attendances is based on the median number for December 2017. More detailed breakdown below.*

As is apparent above, despite similar activity staffing is different on the Eastbourne site with no funded twilight shifts. Also important to note is that Eastbourne is established for 8 CDU Beds but has had 11 beds open for the past 12 months. An executive decision is required going forward in relation to the Eastbourne CDU bed numbers.

Breakdown of staff on duty per site as follows:

**Conquest registered: non registered staff (excluding Emergency Nurse Practitioner [ENP] service)**

| Area | Long Day | Night | Twilight |
|---|---|---|---|
| Nurse in Charge | 1:0 | 1:0 | o |
| Assessment | 1:0 | 1:0 | o |
| Majors | 4:3 | 3:3 | o |
| Resus | 2:0 | 2:0 | o |
| *Clinical Decision Unit* | *1:2* | *1:2* | *o* |
| Float | 1 | n/a | 1:1 |
| **Total staff** | **10:5** | **8:5** | **1:1** |

**Eastbourne registered: non registered staff (excluding ENP service)**

| Area | Long Day | Night | Twilight |
|---|---|---|---|
| Nurse in charge | 1:0 | 1:0 | 0 |
| Assessment | 1:0 | 1:0 | 0 |
| Majors | 3:2 | 2:1 | 0 |
| Resus | 2:0 | 1:0 | 0 |
| *Clinical Decisions Unit* | *1:2* | *1:2* | *0* |
| Float | n/a | n/a | 0:0 |
| **Total staff** | **8:4** | **6:3** | **0:0** |

**Risk and concerns with current establishment**

The funded establishment and staffing templates cover both EDs and both CDUs and have differing impacts on each site. Concerns are as follows;

- 1 nurse in resus at Eastbourne ED overnight (should be 2)
- 1 nurse for each area within the ED at Eastbourne overnight. Dept. is zoned and some areas have higher dependency e.g. Resus so require more. Nurses also have to leave dept. to transfer patients out. This is covered by Nurse In Charge (NIC) but not ideal as they have overall responsibility for whole dept. and 4 hour standard etc.
- Streaming nurses in place but as skill mix insufficient in main ED, frequently they also have to take charge of dept. and be the NIC.
- Lack of twilight nursing to meet increased demands in attendances and increased operational flow/ discharge issues - dept. is usually busy until 03:00.
- High and varied usage of ED agency nurses driving overspends of current budget (whilst agreed at IPR to ensure safe staffing levels).

- Agency ED nurses being booked requiring band 6 payment to ensure appropriate skills to maintain patient safety.
- Mismatch between workforce capacity and demand supported by both the BEST Tool data (see appendix one) and lived experience.
- Multiple moves from ward inpatient areas to support ED staffing and reduce risk
- Decreasing compliance with the nationally mandated triage/assessment by nurse within 15 minutes of arrival driven by an increase in attendances and lack of ability to assign more resource to assessment.
- Potential risk associated with unknown and unassessed patient need.
- CQC concerns related to funded staffing levels, delays in nursing assessment and treatment as well as changing leadership and lack of robust governance arrangements due to new post-holders.
- Risk of maintaining mandatory and statutory training compliance due to inability to release staff for training. The risk of staff not having an annual appraisal effects ability to ensure staff are supported and progress both professionally and clinically. Also affects retention of staff.
- Negative impact on Safeguarding framework related to reduced compliance with safeguarding training, inability to progress Child Protection Information System (CP-IS) and training to identify children at risk/in need/on protection at point of admission to ED.
- Serious Incidents and patient safety incidents has on occasions cited lack of staffing and or competence/seniority as a contributing factor/root cause. (Incidents raised especially at night where there have been delays in medications being administered and patients deteriorating where there has been reduced numbers of registered nurses. This was at the Eastbourne site and was immediately addressed in the IPR forum.

**ENP nursing**

The ENP service is a fundamental aspect of Urgent Care and supports assessment and treatment of a number of patients who attend both ED's. Their primary role is in assessment and treatment of minor illness/injury. Without this service, these kinds of patients (approximately 25-30% of attendances) would be seen in main ED and impact on the four hour standard in an already overcrowded dept.

- Current numbers of wte does not enable robust cover of the Trust requirement for a 16.5hr per day service from 08.00hrs to 00.30hrs hence a reliance on temporary workforce.
- Inability to cover the nursing rota leads to increased impact on medical staff in the department and worsens overall performance.
- Further negative impact on assessment times due to lack of senior review and backfilling using main ED nursing staff which further impacts majors quality, safety and flow.

**For detailed breakdown of ENP recommendations **pls see appendix 2.***

**Establishment Review Approach**

There is no nationally mandated nursing establishment tool for Emergency Departments and the Safer Nursing Care Tool (SNCT) used throughout the rest of the Trust is not validated for use in ED's. The ward focused SNCT measures both acuity and dependency whilst the Jones Dependency Tool, validated for EDs, measures dependency in terms of nursing input. The Royal College of Nursing (RCN) and Royal College of Emergency Medicine (RCEM) provide a suite of workforce tools with the recommended nursing tool being the Baseline Emergency Staffing Tool (BEST).

BEST enables the identification of any disparity between nursing workload and staffing to be identified by allowing the Trust to;

- Analyse the volume and pattern of nursing workload in ED
- Track this against rostered staffing level
- Calculate the whole time equivalent workforce and skill mix which would be required to provide the nursing care needed in the department during the audit period.

This review has been conducted using the BEST tool with data collection undertaken (on an hourly basis every hour for a period of 7 consecutive days) in line with the recommended methodology. Whilst the BEST tool does not recommend staffing levels it does calculate nurse to patient ratios using the validated Jones Dependency Tool, a skill mix breakdown within the whole time equivalent (WTE) based on the Faculty of Emergency Nursing (FEN) competencies.

The Emergency Departments (ED's) within East Sussex Health Care Trust (ESHT) currently plan their staffing rotas in line with all the other divisions using 12 hour shift patterns split into days and nights. The reduction from day staff to night staff causes inconsistency in the ability to meet demand, with a subsequent impact on operational performance and quality. To plan current rotas to match capacity to demand within agreed establishment the team pay particular consideration to predictors, the use of weekly performance data, In Phase (peaks/troughs) geographical layout, professional judgement and clinical expertise. The team have used learning from serious incidents, complaints, reviews of incidents, patient, carer and staff feedback as quality markers.

A triangulated approach using the decision support tool with clinical quality indicators and professional judgement was used with Human Resources and Finance partners to meet the needs of the service & patients. Professional judgement for specific local needs considered;

- Departmental facilities and layout which can affect the nursing capacity needed to deliver efficient patient care.
- Proximity of ward area's and other relevant departments
- Escort duties
- Separate streaming facilities i.e. majors, minors, paediatrics, triage and resus

**Additional elements considered in addition to numbers of staff on duty:**

- Annual leave entitlements and long service enhancements
- Sickness and absence based on ESHT target of 4.3%
- Study Leave – with allowances made for both mandatory and role-specific training. Estimate for study leave is higher for nurses working in ED's than those working in inpatient wards.

Emergency nurses care for patients from all areas of practice (adult, mental health, learning disabilities and children's nursing) and need the knowledge and skills to recognise and deal with life threatening illness and injury in all biological systems, and respond to out of hospital major incidents including chemical, biological and mass casualty events. In addition, the nursing of adults and children in the ED setting require a more detailed understanding of safeguarding issues (National Quality Board 2017). Greater study leave is also required for larger numbers of newly qualified nurses or nurses new to the speciality and requiring essential training to be competent in emergency nursing (The Royal College of Nursing Emergency Care Association Competency Framework for Emergency Nurses 2017)

- Quality improvement initiatives: The ED facilitates training and development and service improvement initiatives by creating link roles. Regular time away from clinical duties is required to undertake the non-clinical element of these roles. For example we have quarterly skills study days for Band 5's which are led by the Band 6 and 7's which saw us successfully convert agency nurses into substantive nurses.

**Baseline Emergency Staffing Tool (BEST)**

To ensure optimal output from the tool, seven days of data was collected over 7 consecutive days and recorded hour by hour. "Patterns of urgent and emergency referrals and presentations, while not random will always exhibit variation hour by hour and day by day, which is normal variation. When calculating demand, it is therefore essential to take account of the normal variation and not to plan around averages. Ignoring variation and planning to meet average demand will inevitably mean the service is under regular stress and queues will develop that may be difficult and expensive to manage "(NHS England 2015).

***Please note that within the BEST Model the proposal does not include staffing for the clinical decisions unit, a shift coordinator or an Emergency Nurse Practitioner Service.***

With a significantly large and expanding workforce BEST and other comparative tools suggest that Emergency Departments are secured a realistic uplift of 25% in order to effectively manage planned and unplanned leave and absences. Underestimation may result in an establishment that cannot meet daily staffing requirements with an over reliance on unexpected and unfunded temporary staffing solutions.

The data was collected from 30TH April – 7th May 2017 using an evidenced based tool at Eastbourne. It was an extensive piece of work that was undertaken and unfortunately at the time, resources were not available to mirror the review at the Conquest site. Data was collected at the Conquest from 11th – 18th December 2017. Results are illustrated in **appendix 1.**

**Anticipated Benefits of investment**

**For patients**

- Increased compliance with 95% four hour target
- Reduced waiting times
- The delivery of safe high quality care
- Appropriate workforce to meet patient demand

- A robust provision of ENP cover will ensure timely and appropriate management of patients attending with minor illness/injury. Will also allow senior medical staff to focus on patients within the major and resuscitation areas
- Well trained, experienced and supported staff to deliver safe, high quality care

**For clinical unit**

- Reduced and mitigated risks associated with crowding within EDs
- Improved patient flow with GP streaming service
- Increased morale in nurse-led ENP service
- Retention of staff, as career progression is visible
- Support for junior nursing staff / medical staff with dissemination of ENP's experience/knowledge and support
- Early decision making in patients with minor illness/ injury supporting the 4 hour standard from a fully established ENP service
- Considerable reduction in agency spend
- High performing CU with regards to meeting 4 hour standard

**For Trust**

- Compliance with CQC recommendations
- Assurance to ESHT board that ENP have a robust ENP rota
- Increase in 4 hour standard performance
- Sustained performance
- Reduce the risk of crowding within the ED with patients receiving fast and efficient treatment and enabling timely transfers to wards.
- Reduction in complaints regarding waiting times
- Increase in positive patient experience responses
- Significant reduction in agency spend

**Conclusion - investment required**

This paper outlines the current and proposed staffing levels for both Emergency departments (including both CDUs) at ESHT. It focuses on Adults as Paediatrics will be covered in more detail in a future review. An options appraisal is not included as it is felt that the recommendation of substantively increasing the Eastbourne establishment to meet demand is essential and not one that can be phased. The Eastbourne ED has been running at increased levels that were previously agreed to ensure safety. In reality recruitment to any additional posts is likely to take time and therefore the substantive impact is likely to be over a period of time.

Investment is required to ensure mitigation of current quality/safety & performance risks.

- There must be parity across both sites with sufficient staff to ensure safe allocation on a shift by shift basis
- Twilight nurse to meet capacity – peak in attendances afternoon / evening and support ward discharge profile which is later in the day

- Currently running a cost pressure with additional staffing at Eastbourne site overnight with two trained nurses to maintain clinical safety.
- There is only one assessment nurse per 12 hour shift, with an increase in attendances and a decrease in compliance of meeting the 15 minute assessment standard.

**The proposed model will enable;**

- B7 streaming nurse 10:00-22:00
- Two nurses per resus per shift (per site) Level 3 critically ill patients require a nurse to patient ratio of 1:1 and level 2 patients a ratio of 1:2 to deliver direct care during the resuscitation phase of care (Faculty of Intensive Care Medicine and the Intensive Care Society 2015)
- 1 twilight nurse will provide a second registered nurse triage (per site) 12-12am. With the increase in attendances of the past 12 months. There has been a decrease of compliance of patients being assessed within the 15 minutes standard (90.1%-83.9%). There is significant risk associated with unassessed patients awaiting triage. The CQC commented in previous inspections that delays to triage, assessment and treatment led to continually poor care, and changing leadership and governance systems had not addressed this.
- 1 twilight nurse will provide a second registered nurse 11-18 (Conquest) second registered nurse zone 1 (12-12 am). In majors, owing to the more specialist care environment, higher staffing levels than outlined in the adult inpatient improvement resource maybe required to take account of acuity, dependency, full assessment needs and patient transfer times (National Quality Board 2017)
- A robust ENP service 16.5 hours per day 7 days a week
- The nursing capacity to meet demand with careful consideration of the discharge and admission profile.
- Maintenance of ED clinical indicators, such as 4 hour standard and 15 minute assessment time.
- A rapid assessment nurse to ensure ambulance handover times were met and sustained.
- Although the footfall through triage is expected to decrease with a GP streaming nurse in place 10-10pm. It will be high acuity patients that will be assessed via the triage so this will allow a full assessment and diagnostics to be commenced from admission, which is currently difficult to achieve due to current demand and the 15 minute assessment standard.
- Skill mix of the nursing staff is provided in a separate excel document in appendix 3. Simply the new rosters would look as below;

| Site | Long Day | Long Night | Twilight | ENP Long Day | ENP Long Twilight | Streaming Nurse | Rapid assessment nurse |
|---|---|---|---|---|---|---|---|
| Eastbourne | 10:5 | 8:4 | 2:2 | 1 | 1 | 1 | 11-7pm |
| Conquest | 10:5 | 8:4 | 2:2 | 1 | 1 | 1 | 11-7pm |

The additional investment suggested is 182.93 wte with an increase in budget of £1,584,872 (adjusted forecast outturn)

**Current** 139.65 wte

**Proposed** 182.93 wte

**Difference** 37.68 wte (excluding 5.6 streaming nurses)

**Cost** £1,584,872 adjusted forecast outturn

| | Nurse Model | | | BEST Model | |
|---|---|---|---|---|---|
| | Fte | £ | Incl agency premium for SALT £ | Fte | £ |
| New Requirement | 177.08 | 7,527,709 | 7,675,562 | 201.83 | 8,632,093 |
| Core Budget 2017-18 | 139.65 | 5,176,565 | 5,176,565 | 139.65 | 5,176,565 |
| GP Streaming Budget 2017-18 PYE | 5.60 | 81,244 | 81,244 | 5.60 | 81,244 |
| GP Streaming Budget 2017-18 Resdiual | | 259,858 | 259,858 | | 259,858 |
| Investment compared to Budget | | | | 56.58 | 3,114,426 |
| New Requirement | 177.08 | 7,527,709 | 7,675,562 | 201.83 | 8,632,093 |
| Core Forecast Outturn 2017-18 (M9) | 150.80 | 5,959,219 | 5,959,219 | 150.80 | 5,959,219 |
| GP Streaming Forecast outtung 2017-18 | 5.33 | 56,220 | 56,220 | 5.33 | 56,220 |
| Investment Compared to Budget | 20.9 | 1,512,270 | 1,660,123 | 45.7 | 2,616,654 |
| Adjsuted for FYE GP Streaming | | | | | 284,882 |
| | 20.9 | 1,512,270 | 1,660,123 | 45.7 | 2,331,772 |

Note:
Revised Model includes additional 11.2 FTE:
5.6 FTW Handover/RR
5.6 FTE GP streaming

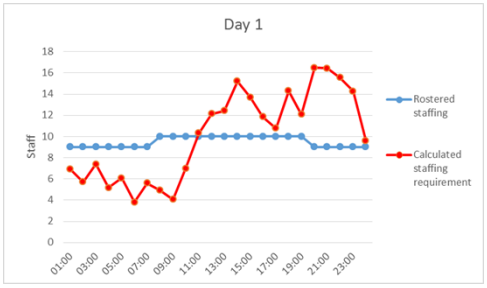
***Best Model does not include Emergency nurse Practitioners, CDU staff or nurse in charge.***

## Appendix 1

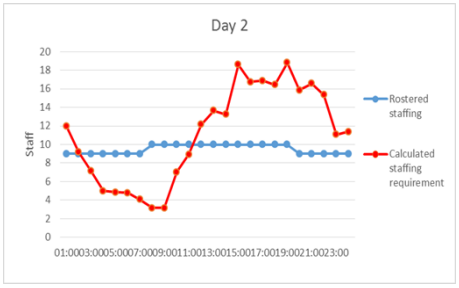
Patients who would be seen by an ENP or GP are not included within the data. The suggested requirement of nurses does not include ENP's or nurses allocated to the Clinical Decisions Unit these would be an additional requirement.

**The graphs below illustrate activity at the Eastbourne Site**

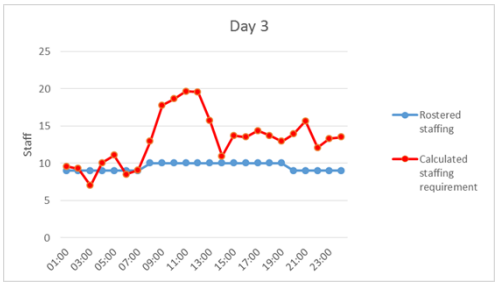
Monday 1st May 2017



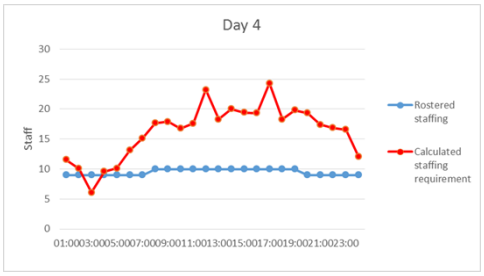

Tuesday 2nd May 2017



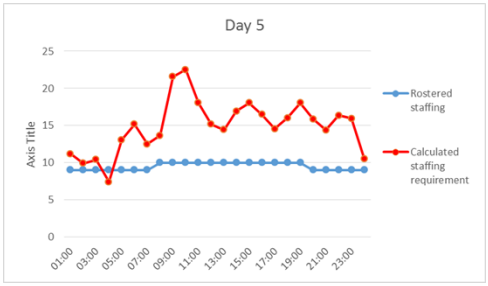

Wednesday 3rd May 2017



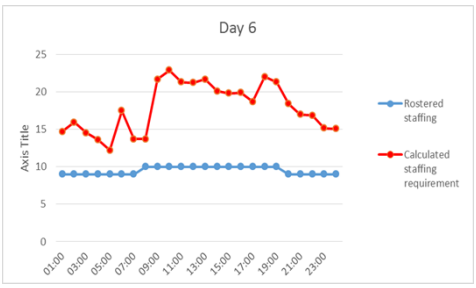

Thursday 4th May 2017



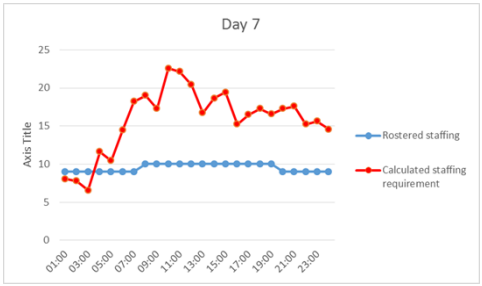

Friday 5th May 2017




Saturday 6th May 2017




Sunday 7th May 2017



The information collected clearly shows in comparison to BEST that in the main department it was not sufficiently staffed to meet demand. On days 1 and 2 demand was lower than available staff overnight.

**BEST suggested requirement**

**Whole-time equivalent**

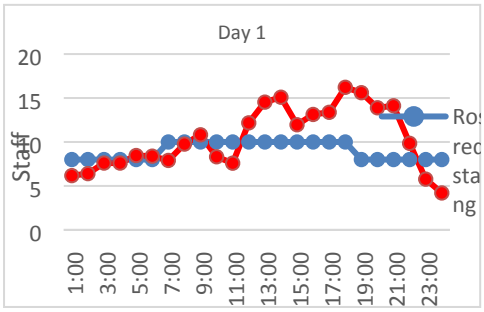
| | |
|---|---|
| Daily hours required | 456.0 |
| Daily hours + on costs @ 25% | 570.0 |
| Weekly hours | 3,990.0 |
| Whole-time equivalent | 106.4 |

| Skill level | Requirement |
|---|---|
| Senior Emegency/Emergency Charge Nurses | 10.64 |
| Emergency Nurses | 31.92 |
| Foundation Staff Nurses | 42.56 |
| Clinical Support Workers or Nurse Associates | 21.28 |

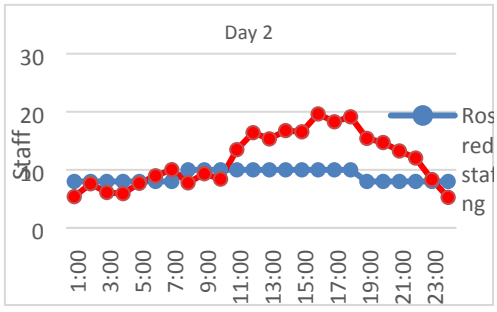
**It should be noted that Eastbourne is the designated site for acute stroke.* Stroke patients automatically score a dependency one, however it does not take into account that there is a stroke nurse who supports the Emergency Department when a hyper acute stroke attends the department. It is felt that this is why the suggested requirement is higher than the Conquest site.

**The graphs below illustrate activity at the Conquest Site**

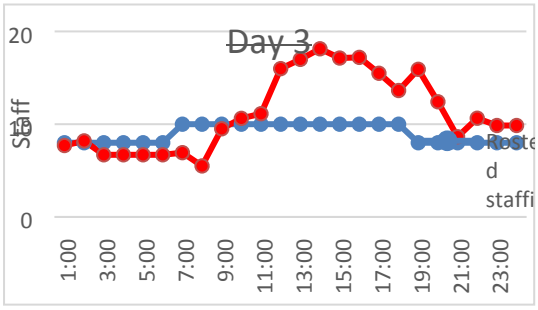
Monday 11th December 2017



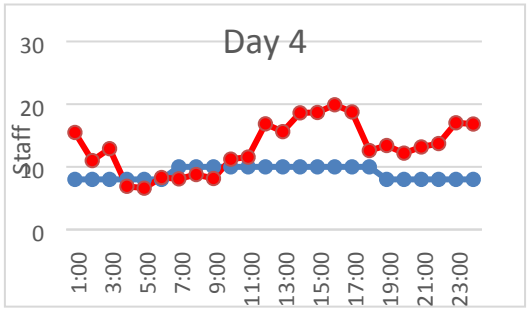

Tuesday 12th December 2017




Wednesday 13th December 2017

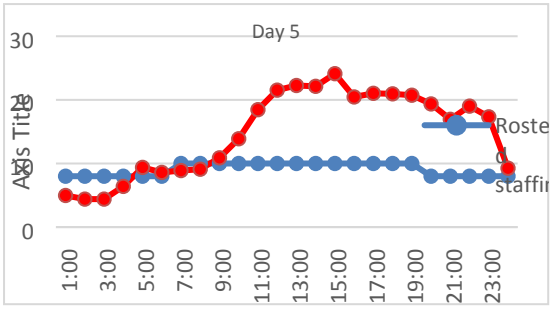


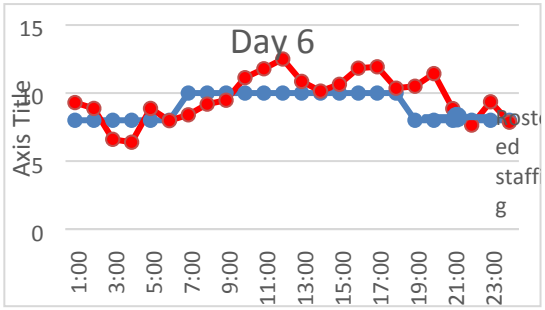

Thursday 14th December 2017



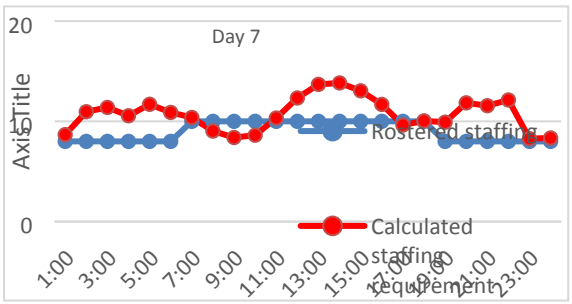

Friday 15th December 2017

Saturday 16th December 2017




Sunday 17th December 2017




The audit would suggest that on the majority of the dates the night cover was moving towards adequate for the demand but the nursing cover between 11:00 and 23:00 did not meet demand.

**BEST suggested requirement**

**Whole-time equivalent - ECA BEST TOOL TEST**

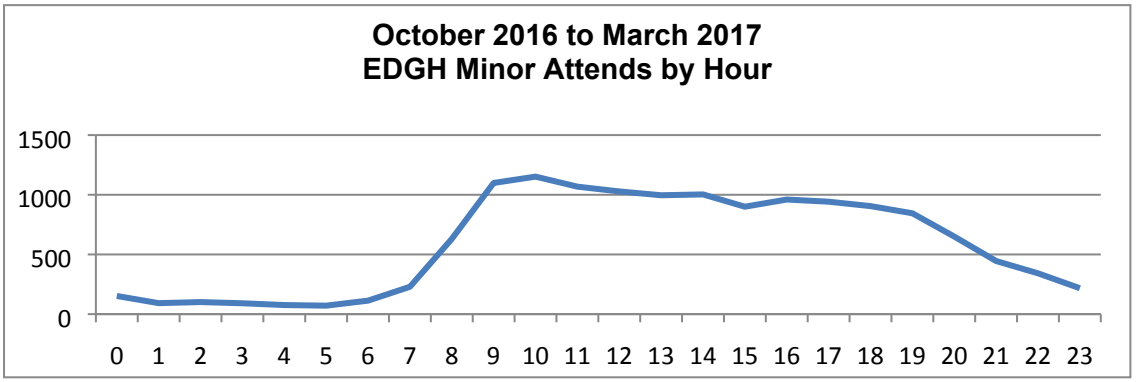
| | |
|---|---|
| **Daily hours required** | 409.0 |
| **Daily hours + on costs @ 25%** | 511.3 |
| **Weekly hours** | 3,578.8 |
| **Whole-time equivalent** | 95.4 |

| **Skill level** | **Requirement** |
|---|---|
| Senior Emergency/Emergency Charge Nurses | 9.54 |
| Emergency Nurses | 28.63 |
| Foundation Staff Nurses | 38.17 |
| Clinical Support Workers or Nurse Associates | 19.09 |

**Appendix 2**

**Proposed ENP nursing establishment**

Attendances demonstrate the need for 16.5 hours cover per day, 7 days a week to ensure that minors patients are managed appropriately and to enable medical staff to focus on the majors patients where possible.




The ENP nursing recommendation per site is 1 ENP per long day 8-20:30 and 1 ENP per Long twilight 12-00:30

- ENPs are required to provide an appropriate service, 7 days a week, which includes 25% uplift for study leave and absence. It is not currently a viable option to train more staff within the ED, as newly-qualified ENPs need intense supervision and need to be working as wte ENPs to gain experience and confidence rather than work on rotation.
- The recurrent cost of this would be approximately £122k, based on midpoint band 7. This is costed within the future nursing model proposal.
- This would ensure a robust 16.5 hour per day service, 7 days a week 08:00-00:30
- Covering 8 00am to 00 30 hours for 2 shifts per day. Current cover is reliant on Temporary Workforce or using the B7s or B6s to back fill ENP shifts. Only 1 B6 across site has the appropriate qualification to act as ENP. When an ENP is back filled by a B6 or B7, productivity is significantly reduced. This has resulted in a 10% reduction in patients seen by an ENP on the CQ site per month
- Current Assessment times are suboptimal as a result of the lack of senior medical and nursing decision makers on both sites and this increase will address these issues

**Appendix 3**

## EMERGENCY DEPARTMENT

| Ratio | Trained | Trained Ratio | Support Workers | SW Ratio | Total Headcount |
|---|---|---|---|---|---|
| 00:00 | 11 | 73% | 4 | 27% | 15 |
| 01:00 | 8 | 67% | 4 | 33% | 12 |
| 02:00 | 8 | 67% | 4 | 33% | 12 |
| 03:00 | 8 | 67% | 4 | 33% | 12 |
| 04:00 | 8 | 67% | 4 | 33% | 12 |
| 05:00 | 8 | 67% | 4 | 33% | 12 |
| 06:00 | 8 | 67% | 4 | 33% | 12 |
| 07:00 | 9 | 64% | 5 | 36% | 14 |
| 08:00 | 9 | 64% | 5 | 36% | 14 |
| 09:00 | 10 | 67% | 5 | 33% | 15 |
| 10:00 | 11 | 69% | 5 | 31% | 16 |
| 11:00 | 12 | 71% | 5 | 29% | 17 |
| 12:00 | 14 | 74% | 5 | 26% | 19 |
| 13:00 | 16 | 76% | 5 | 24% | 21 |
| 14:00 | 16 | 80% | 4 | 20% | 20 |
| 15:00 | 16 | 80% | 4 | 20% | 20 |
| 16:00 | 16 | 80% | 4 | 20% | 20 |
| 17:00 | 15 | 79% | 4 | 21% | 19 |
| 18:00 | 15 | 79% | 4 | 21% | 19 |
| 19:00 | 13 | 76% | 4 | 24% | 17 |
| 20:00 | 13 | 76% | 4 | 24% | 17 |
| 21:00 | 13 | 76% | 4 | 24% | 17 |
| 22:00 | 12 | 75% | 4 | 25% | 16 |
| 23:00 | 12 | 75% | 4 | 25% | 16 |

# Developing and Delivering Safe and Sustainable Services

| Meeting information: | | | |
|---|---|---|---|
| Date of Meeting: | 17th April 2018 | Agenda Item: | 13 |
| Meeting: | Trust Board | Reporting Officer: | Catherine Ashton |

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

**Has this paper considered: (Please tick)**

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

**Other stakeholders** please state: ESBT Alliance partners

……

| 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

ESHT are, like many Provide organisation in the South East, looking at how we can best deliver safe and sustainable services to an increasingly aging population where we have on year increase in demand for our services with a flat line financial investment.

We are developing a cost improvement programme based on analysis from the Model Hospital work, Lord Carter reports and our Service Line Reporting (SLR) programme; all of which clearly identify a savings opportunity based on our current care models.

There remains however a gap between this efficiency opportunity and financial sustainability which we believe needs to be addressed by moving beyond incremental performance improvements to deeper internal transformation and greater external collaboration.

This programme of delivering safe and sustainable services will build on productivity improvements already identified by the Trust, and will explore the opportunity to offer our service in a different way through new integrated pathways, working in partnership or networks to manage our workforce issues and the consideration of consolidation of services.

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

FISC March 2018

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

The Board are recommended to confirm assurance in the process that the Trust is undertaking to ensure the delivery of safe and sustainable services as part of ESHT 2020.

East Sussex Healthcare NHS
NHS Trust

# Delivering Safe and Sustainable Services

# ESHT 2020- Strategic Planning Process and Governance

ESHT are, like many Provider organisations in the South East, are looking at how we can best deliver safe and sustainable services to an increasingly aging population, where we have year on year increase in demand for our services with a flat line of financial investment.

We are developing a cost improvement programme based on analysis from the Model Hospital work, Lord Carter reports and our Service Line Reporting (SLR) programme; all of which clearly identify a savings opportunity based on our current care models.

There remains however a gap between this efficiency opportunity and financial sustainability which we believe needs to be addressed by moving beyond incremental performance improvements to deeper internal transformation and greater external collaboration.

This programme of delivering safe and sustainable services will build on productivity improvements already identified by the Trust but will also explore the opportunity to offer our service in a different way, through new integrated pathways , working in partnership or networks to manage our workforce issues and the consideration of consolidation of services.

FY18/19 & Beyond

# Redesign B (Structural) – Approach

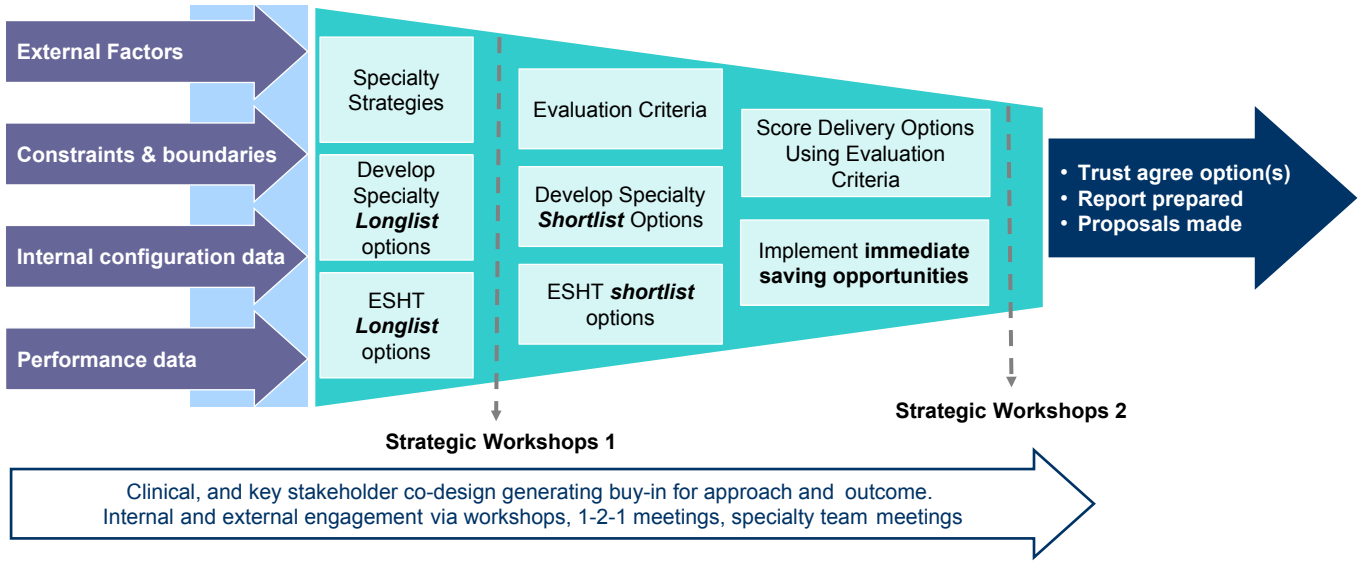
East Sussex Healthcare NHS Trust

To address its estimated £15m structural deficit and achieve true long term financial and clinical sustainability, the Trust will need to move beyond incremental performance improvements to deeper internal transformation and greater external collaboration. This section outlines the Trust's portfolio optimisation approach and lays out a phased plan of strategic productivity improvements and key implementation actions.

This programme will build on productivity improvements identified in Redesign A (Efficiency), particularly the Clinical Service Reviews, and recommend service configuration options that take into account both internal and external factors, to inform decision making, strategy development and negotiation. The programme will start with services that have already been identified as unsustainable in their current form e.g. ENT, Breast, and Urology.

Ultimately this will facilitate a joined-up Operational and Clinical Strategy that complements the STP and enables Trust to meet its obligations.

## Portfolio Optimisation Approach




**Key Output**

- Recommended service reconfiguration options (Transfer, Maintain, Grow) starting with services that the Trust has identified as unsustainable in the current model
- **Key Considerations**
- *External factors*: STP planning, commissioning intentions, partnerships, competitors, market share opportunities.
- *Internal factors*: Understanding service interdependencies, (clinical, operational, financial and market share), service pressures (e.g. demand, estate, workforce and culture), data quality.

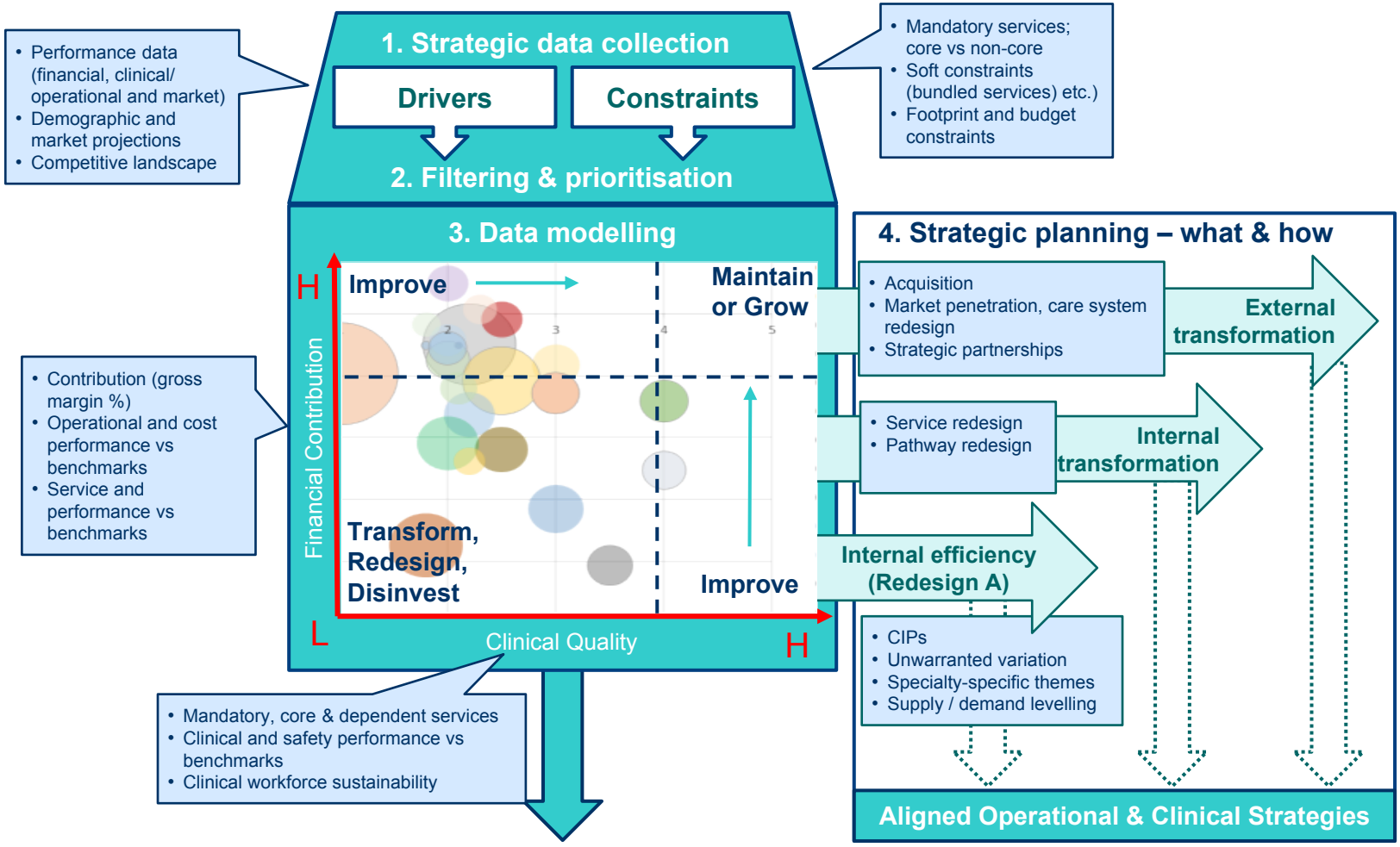
**Enables**

- Aligned Operational and Clinical Strategies enabling the Trust to meet its objectives and which complements the STP.

# Strategic Decision Framework

East Sussex Healthcare NHS Trust

The decision framework encompasses the key steps of strategic data collection, filtering and prioritisation, detailed data modelling, strategic planning, and finally alignment of the Trust's operational and clinical strategies.

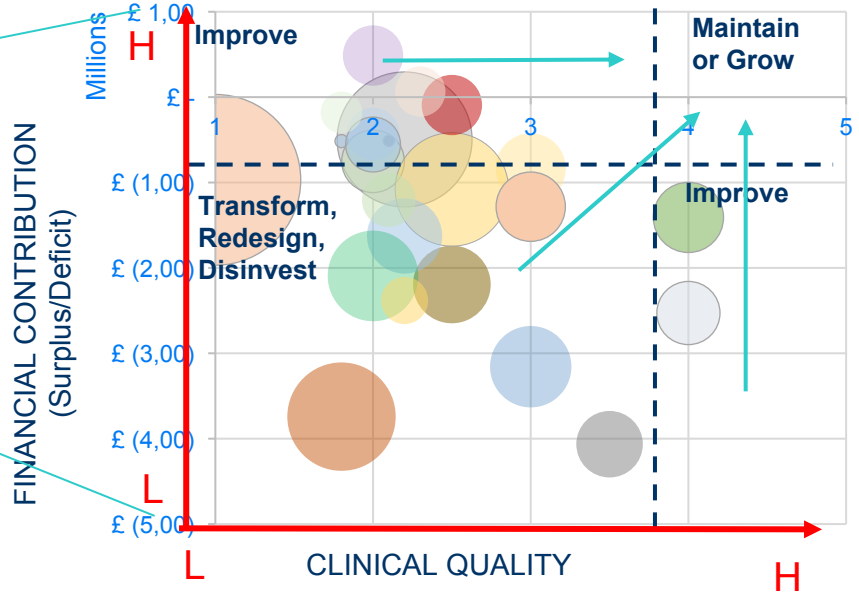


# Deep analysis

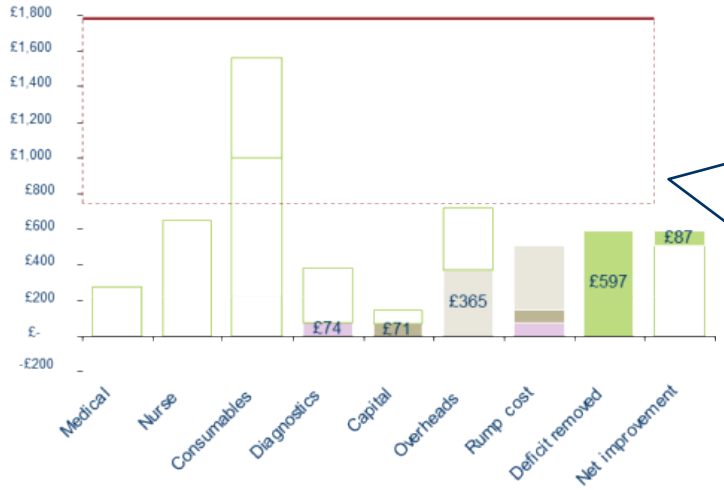
East Sussex Healthcare NHS Trust

This indicative chart plots ESHT specialities by financial performance and clinical quality. The size of the bubble indicates volume of activity. Whilst this version is indicative only, following the financial performance and clinical quality analysis, each service can be plotted on a similar chart to inform decision making about the configuration of services.

**Illustrative only**




**Removal of a Service – evaluation**




**Closure of Speciality X evaluation**

- Service runs a loss of £597k with expenditure of £3.7m and income of £3.1m.
- If we close it, we will release 100% of the medical, nursing and consumable costs, 80% of diagnostic costs, 51% of capital costs and 50% of the overhead costs, leaving remaining fixed costs of £510k. If you offset this by the loss the specialty was making, there is a net positive impact for the Trust of only £87k.
- Therefore, it can be difficult to improve the Trust's overall position even by closing a loss making service. Furthermore, these assumptions exclude the additional cost of accommodating the activity elsewhere.

FY18/19 & Beyond

# Redesign B (Structural) Timeline

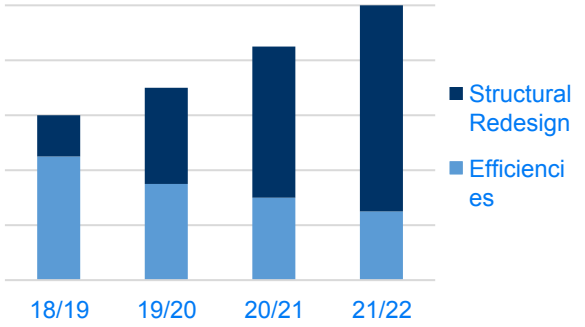
East Sussex Healthcare NHS Trust

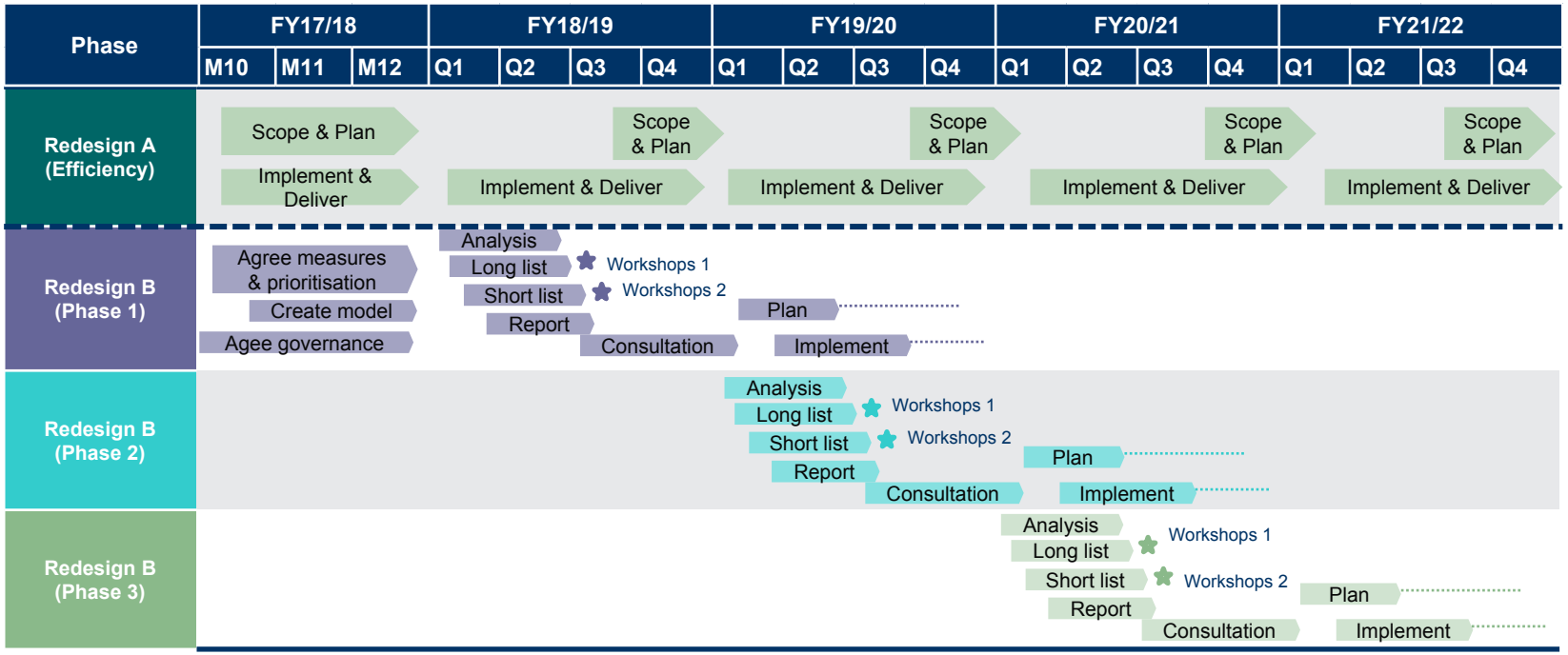
The Redesign B (Structural) workstream sits alongside Redesign A (Efficiency) workstream. It is proposed that work will be split into three phases over four years – as outlined in the table below.

Prioritisation of the Trust's specialities into the phases will consider the following (1) deliverability or quick-win opportunities, (2) the scale of opportunity, and (3) strategic enablers for longer term opportunities.

While Redesign A (Efficiency) workstream is focused on identification of opportunities for operational efficiency, Redesign B (Structural) will address the more complex structural reconfiguration needed to ensure the Trust has the right configuration of clinics, beds, theatres and workforce for optimum service delivery.

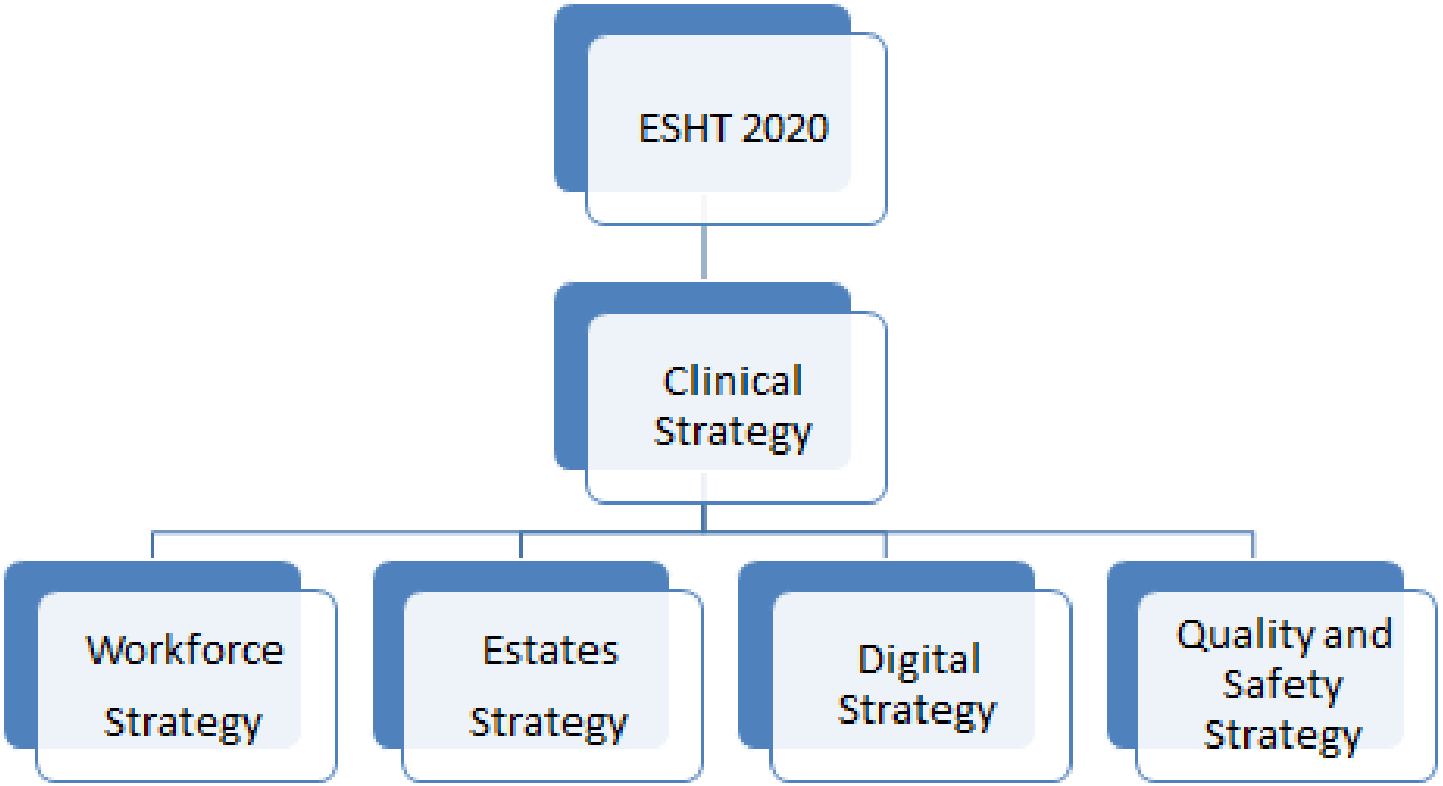
**Operation vs. Structural efficiencies**



East Sussex Healthcare NHS
NHS Trust

# New Governance Structure


ESHT 2020
Clinical Strategy
Workforce Strategy
Estates Strategy
Digital Strategy
Quality and Safety Strategy

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

# The Strategy, Improvement and Planning Programme Board (IPR)

A Strategy, Improvement and Planning Programme Board will be established. This Board directs and monitors the progress on strategic planning, improvement programmes, and business development. It also ensures that there is alignment between the Trust and the ESBT Programme including the development of the Accountable Care Model in East Sussex, and the wider work of the STP.

The Programme Board Agenda would include:

- Business development Group: Report
- Improvement Group Report
- Improvement Programmes exception report
- Strategic Development:  Report
- Sustainable Services: report
- ESBT update
- STP update
- Leadership
- Finance
- H.R

# Strategic Development Group (SDG)

East Sussex Healthcare NHS
NHS Trust

To develop and promote a consistent approach for strategic development within the Trust that will ensure alignment with National strategy, with the Sustainability and Transformation Plan (STP) and with the local commissioning intentions of East Sussex Better Together (ESBT

•To identify how the Trust might best meet the current and future health needs of the population of East Sussex
•To contribute to and drive forward the strategic planning process in the Trusts and to ensure that it is in accordance and alignment with the Trust's overarching strategic direction (ESHT2020), the Sussex and East Surrey Sustainability and Transformation Partnership (STP) plans and East Sussex Better Together (ESBT) plans .
•To meet the requirements of all relevant NHS policy and guidance (for example the Five Year Forward View, and regulatory requirements)
•To receive and act upon information from the STP and ESBT
•To inform and advise the development of the STP and ESBT
•To ensure sustainability and flexibility into the future, clinically and financially
•To encompass and build on existing work to optimise resources; including any strategies such as the Estates and IM&T, identifying their key messages, interdependencies and how we deliver plans over the next 5 years and beyond
•To act as the first gateway review for all strategic developments or organisational strategies. The group will advise service leads on content, test assumptions and assist in steering new strategies through the governance and authorisation process. The next steps range from rejection of the strategy, advising on amendments to recommending progress/approval to executive directors and or F&I or Q&S as appropriate.
•To support the Divisional Integrated Performance Review (IPR) process to monitor and track the development of key strategies
•To assess, guide and advise on the viability and negotiation of potential strategies.
•To provide key triggers and guidance as to refinement or refreshing of the strategy will be required.

# Employer-based Clinical Excellence Awards (CEA) 2017 for Consultants

| Meeting information: | | | |
|---|---|---|---|
| Date of Meeting: | 17th April 2018 | Agenda Item: | 15 |
| Meeting: | Trust Board | Reporting Officer: | Monica Green |

**Purpose of paper: (Please tick)**

Assurance ☐ Decision ☒

The paper details the recommendations made by the Clinical Excellence Awards Local Committee, which have been agreed by the Trust Remuneration Committee and are now presented to the Trust Board for final approval.

**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 ☐<br>*(Please highlight these in the narrative below)*<br>*N/A* | On the risk register?<br><br>N/A |

## Executive Summary:

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

The Trust Local Awarding Panel for Clinical Excellence Awards has made recommendations for the award of points backdated to 1st April 2017 and these are now presented to the Trust Board for final approval.

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

These recommendations have been approved by the Trust Remuneration Committee.

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

The Trust Board is asked to give final approval for the award of Clinical Excellence Awards to Consultants backdated to 1st April 2017.

**East Sussex Healthcare NHS Trust**

**Employer-based Clinical Excellence Awards (CEA) 2017 Round**
**For Consultants**

## 1. Purpose of the paper

This paper details the recommendations made by the Clinical Excellence Awards Local Awarding Committee which met on 28 March 2018. These recommendations were agreed by the Trust's Remuneration Committee at its meeting on 4th April 2018 and are now presented to the Trust Board for final approval.

## 2. Background

2.1 The Clinical Excellence Awards (CEAs) scheme is a mechanism to recognise excellent performance for consultant medical staff over and above contractual requirements. It provides for 12 levels of award, of which the first 8 are employer-based with level 9 awards being awarded either nationally or locally, dependent upon the type of achievement being recognised, and levels 10-12 being awarded nationally. Awards are cumulative and for awards lower than level 9, there is no current mechanism for re-evaluation of past awards which are paid on a year on year basis.

2.2 Until 2014, CEAs were part of the national contract for consultants based on a process determined by the Advisory Committee on Clinical Excellence Awards (ACCEA). Whilst higher awards are still awarded nationally, local awards were at this time discretionary for individual employing Trusts. The majority of Trusts still operate some sort of awards scheme. The system for the allocation of local awards is now changing and awards will be mandatory for all Trusts with effect from April 2018 and will be subject to a review process.

2.3 The Local Employer Based Awarding Committee is responsible for making recommendations for award of the local levels and is made up predominantly of consultants with the maximum number of local awards and of higher award holders. The Chairman, the Chief Executive, a Non-Executive Director, the Medical Director and the Director of Human Resources are also members. An observer from the Local Negotiating Committee (LNC) also attends.

2.4 In allocating awards the panel follow the locally agreed policy document and the national guidance around scoring of applications. Support and training sessions are offered to consultants applying for awards.

2.5 In agreeing the determination of awards and in accordance with the guidance, the following factors are taken into account:

- Delivering a high quality service
- Developing a high quality service
- Managing and leading a high quality service
- Contributing to the NHS through research and innovation
- Contributing to the NHS through teaching and training.

2.6 All panel members score all applications following the nationally specified system of scoring, taking into account the above criteria. Only information recorded on the application form is taken into account when scoring, and applicants can only include work undertaken since their last award.

2.7 The awards now being made are to recognise performance up to 31 March 2017 and will be paid backdated to 1 April 2017.

## 3. Awards available for distribution

Using the ratio of 0.20 per eligible consultant, the maximum number of awards available for 2017 is 29.

## 4. Allocation of Awards

The process is not formally linked to appraisal, however, to be eligible for points all applicants must have actively participated in the job planning process, have met contractual obligations and undertaken an appraisal in the twelve months prior to submitting their application. Applicants must have also completed mandatory training.

## 5. Recommendations for Awards

5.1 The panel's recommendations for award of points are based on the combined scoring of panel members.

5.2 The panel proposed to award two awards to the top highest scoring candidate as this person had scored in the top three positions in terms of scoring, ranking and number of 10's (the maximum score) received.

5.3 Single awards were then proposed to be awarded to the next twenty six highest scoring applicants with a total of twenty eight awards proposed to be awarded.

5.4 The recommended awards would have an initial value of £90,480 however, when employers' costs are added to this and the figure is adjusted for those consultants working either more than or fewer than 10 PAs, the total in year cost to the Trust would be £127,666.

## 6. Examples of excellent practice awarded

Below are examples of the practice recognised by the award of Local Clinical Excellence Awards:

6.1 <u>Delivering a high quality service</u>

- *Despite large increases in 2WW referrals and reductions in pathology and radiology staff my service has managed to maintain 2WW symptomatic targets (95.5% vs compliance of 93%) and 62 day breach targets (currently 94.74% against a target of 85%). This was possible through flexible working patterns, accommodating 2WW patients into follow-up slots and providng extra clinics where necessary.*

- *6.6% of my patients had a second operation for positive margins following wide excision and none had >3 procedures (national average 20% and <5%).*

- *5.3% of mastectomies and 0% of my complex reconstructions were admitted for post-operative complications (national average 10% and 16.6%).*

- *I drafted and implemented "antibiotic suppression and release rule in lab" initiative. According to this initiative, specific antibiotic against each organism will be released to help the clinicians to choose appropriate antibiotic effective against isolated organism.*

6.2 Developing a high quality service

- *Wrote evidenced proposal for delivery of Looked After Children service to repatriate within ESHT.*
- *As a high volume stone surgeon I have helped pioneer the miniaturisation of minimal access renal surgery and have the largest series of Mini and Ultra-mini PCNL nationally. This data has been published and presented at International meetings.*
- *Developed local pathways for long line inserions in conjunction with the Anaesthetic team,for the children with CF when indicated. This ensured timely start of IV treatment without a trip to Kings. This was a facility that was not available in many DGH's.*
- *After establishing the Rheumatology clinics, developed local pathways with the anaesthetic team and theatres for intra-articular injections under short GA for children with JIA. This has redced the referrals to the teritiary centre, improved patient care and satisfaction.*

6.3 Managing and leading a high quality service

- *Organised a multi-professional seminar for the public to improve awareness of osteoporosis, as part of the campaign to support the Fracture Liaison Service. Received excellent feedback including a press-release.*
- *I worked as a Trust Medical Appraiser receiving excellent feedback from my 10 appraisees.*
- *I undertook anaesthetic rota management, assigning over 20 consultants, plus 20 junior doctors on a day to day schedule; responding to last minute sickness, cancellation and service provision changes. It is a rare occurrence that cancellations occur due to no anaesthetic availability.*

6.4 Contributing to the NHS through research and innovation

- *Awarded the excellence in delivery of the commercial research studies by the Department of Health.*
- *Continuing in the role of Principal Investigator for multi-national clinical trials.*
- *Observational studies in Sjogren's syndrome, Interstitial lung disease, RA, Ankylosing spondylitis and Osteoporosis with vertebral fractures.*

6.5 Contributing to the NHS through teaching and training

- *I have developed new materials and delivered a tutorial on Ethical Issues in High Risk Anaesthesia for the MSc in Perioperative Medicine, Brighton and Sussex Medical School.*

- *I designed, organised, established and run a new Frailty training programme; Frailty Practitioners (FP). This enabled FPs to do quality medical frailty assessments independently in the community.*

- *I trained and supervised my juniors in preparing and delivering regional geriatric medicine KSS SpR training days on Psychosis and Depression in the Elderly and Ethical, legal and mental capacity respectively.*

- *I deliver a wide range of lectures in geriatric medicine and for all my talks I have a trainee doctor doing presentation first. I help, support and guide them prior to the teaching, and comment and teach on how to improve their teaching skills after their talk. I complete developing clinical teacher forms for their e-portfolio.*

## 7. Feedback to unsuccessful candidates

7.1 It was agreed that the Medical Director and Director of HR would offer to meet with all unsuccessful applicants to provide feedback and it was noted that any notice of appeal would not be accepted until such feedback had been sought.

7.2 The appeals process is clearly set out in the Trust's local procedure which states that appeals can only be made about the process followed.

## 8. Recommendation

The Trust's Remuneration Committee are requested to review and approve the recommendations made by the Local Awarding Committee on behalf of the Trust Board and to endorse the process followed.

Monicat Green

**Monica Green**
**Director of Human Resources**

**April 2018**

# Minimising Mixed Sex Accommodation Declaration

| Meeting information: | | | |
|---|---|---|---|
| Date of Meeting: | 17th April 2018 | Agenda Item: | 16 |
| Meeting: | Trust Board | Reporting Officer: | Vikki Carruth, Director of Nursing |

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

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

## Executive Summary:

The NHS Operating Framework 2012/13 requires all providers of NHS funded care to confirm whether they are compliant with the national definition to minimise mixed sex accommodation except where it is in the overall best interests of the patient, or reflects patient choice. The Trust is required to report breaches of sleeping accommodation and confirm each year if they are compliant. There is also guidance (since revised) from the CNO office regarding this issue. An important point to note is that until very recently there has been no standard approach nationally to reporting as many areas have different local agreements in place with CCGs. Following a recent audit of practice a decision was made to change the reporting for the Kent, Surrey & Sussex (KSS) region. The trust is required to implement this change (from Feb 2018 led by NHSI/E) and therefore has a revised policy for Mixed Sex Accommodation.

The impact of this change is that more breaches are likely to be reported even though the trust is not doing anything differently. Some may be deemed clinically justified and some unjustified according to the new guidance.

The key change is the standardisation in the KSS region of what constitutes a breach and/or a clinically justified breach. Another key change is no longer doing a daily snapshot census, replacing this with real time breach monitoring. The main areas of challenge for ESHT (and nationally) remain critical care and rapid assessment areas. As before, staff's priority will always be safety and ensuring patients are seen and treated promptly. This may, on occasion, mean that they are initially treated in the first available bed, with a plan to move them ASAP during outbreaks or if the trust is in business continuity mode. The key issue is transparency of reporting, which includes all breaches, and narrative for any considered justified.

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

The Operating Framework 2012/13 states that:

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

From April 2011, all providers of NHS funded care were required to routinely report breaches of sleeping accommodation, as set out in national guidance, and will attract contract sanctions in respect of each patient affected.

In respect of the above requirements the Trust Board will be made aware of any breaches as part of its performance reporting and this practice will continue.

The Trust Board is asked to note the statement of intent which is displayed on the Trust website

**Risks** - Non-compliance could result in poor patient experience, damage to reputation and a financial penalty.

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

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

Patient Experience Group

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

The Trust Board is asked to note the statement of intent which is displayed on the Trust website.

**Our commitment to minimizing mixed sex accommodation**

We remain committed to ensuring and protecting the privacy and dignity for all of our patients. Part of this relates to sleeping accommodation. We will always endeavor to treat patients in the "right" bed in the right specialty and will not mix except where it is in the overall best interest of the patient. This would usually relate to specialist treatment, for example intensive or critical care or specialist services such as acute stroke. We monitor this very closely and report on it nationally to ensure transparency. If there is a need to mix we will explain why to patients. We are committed to providing every patient with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

**What does this mean for patients?**

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

There will be both male and female patients on the ward, but they typically will be in different bays, or on occasions in side rooms.

You may share some communal space, such as day rooms or dining rooms, and it is very likely that you will see both male and female patients as you move around the hospital.

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

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

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

**How will we measure success?**

Every day we will make an assessment of all our areas and review any incident where same sex accommodation has not been provided. Should this occur it will be rectified as soon as possible.

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

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

Vikki Carruth
Director of Nursing

March 2018

# Annual Self-Certification

| Meeting information: | | | |
|---|---|---|---|
| Date of Meeting: | 17th April 2018 | Agenda Item: | 18 |
| Meeting: | Trust Board | Reporting Officer: | Lynette Wells, Director of Corporate Affairs |

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

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

## Executive Summary:

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

Each year NHS trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence and that they have complied with governance requirements.

We need to self-certify the following after the financial year end:

- **That we have taken all precautions necessary to comply with the licence, NHS acts and NHS Constitution (Condition G6(3)).**

  This condition requires NHS trusts to have processes and systems that a) identify risks to compliance and b) take reasonable mitigating actions to prevent those risks and a failure to comply from occurring. We must annually review whether these processes and systems are effective and publish our G6 self-certification by the end of June.

- **That we have complied with required governance arrangements (Condition FT4(8)).** We are required to review whether our governance systems achieve the objectives set out in the licence condition. There is no set approach to meeting these standards and objectives but NHSi expect any compliant approach to involve effective board and committee structures, reporting lines and performance and risk management systems.

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

Audit Committee review the Draft Annual Governance Statement

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

Based on the evidence highlighted in Appendix A, it is recommended to the Board that the 'Condition G6' Self-Certification is formally signed-off as **"Confirmed".**

Based on the evidence highlighted in Appendix B, it is recommended to the Board that the 'Condition FT4 (8)' Self-Certification is formally signed-off as **"Confirmed".**

The self-certification template (see page 3) will then be signed off and published on the Trust website by the end of June deadline.

## Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

*The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.*

**1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)**

| | | | |
|---|---|---|---|
| 1 | Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. | Confirmed | OK |

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

| | | | |
|---|---|---|---|
| **Signature** | | **Signature** | |
| **Name** | | **Name** | |
| **Capacity** | [job title here] | **Capacity** | [job title here] |
| **Date** | | **Date** | |

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

**APPENDIX ONE**

**Compliance with the Provider Licence Conditions**

**SECTION 1: GENERAL CONDITIONS**

| | Licence Condition: | Explanation: | Board Assurance: | Lead Director(s): |
|---|---|---|---|---|
| G1. | Provision of information | This condition requires licensees to provide Monitor/NHSi with any information they may require for licencing functions. | ESHT has robust data collection and validation processes and the proven ability to submit large amounts of accurate, complete and timely information to regulators and other third parties to meet specific requirements. | Director Finance<br>Chief Operating Officer |
| G2. | Publication of information | This condition contains an obligation for all licensees to publish such information as Monitor/NHSi may require, in a manner that is made accessible to the public. | ESHT is committed to operating in an open and transparent manner. The Board meets in public and agendas, minutes and associated papers are published on our website.<br>The website also contains information and referral point details providing advice to the public and referrers who may require further information about services.<br>Copies of the Trust's Annual Report and Accounts and Quality Account are published on the website and the Trust operates a publication scheme. | Chief Executive<br>Director of Corporate Affairs |
| G3 | Payment of fees to NHSI | The Health & Social Care Act 2012 ("The Act") gives NHSI the ability to charge fees and this condition obliges licence holders to pay fees to NHSI if requested. | NHSI does not currently charge fees. However, the obligation to pay fees is a condition and will be accounted for within the Trust's financial planning as required.<br>ESHT pays fees to other parties such as the Care Quality Commission and the NHS Litigation Authority. | Director of Finance |

| | Licence Condition: | Explanation: | Board Assurance: | Lead Director(s): |
|---|---|---|---|---|
| G4 | Fit and Proper Persons | This condition prevents licensees from allowing unfit persons to become or continue as Governors or Directors (or those performing similar or equivalent functions). | All members of the Board and their deputies who may 'act up' into a Board role have been subject to a Disclosure & Barring Service (DBS) check.<br><br>Directors are required to sign an annual declaration that they remain a FPP.<br><br>The CQC reviewed the Trust's Fit and Proper Persons compliance in October 2016 and found the Trust to be compliant. This was also reviewed as part of the recent March 18 inspection. | Director of Human Resources |
| G5 | NHS Guidance | This condition requires licensees to have regard to any guidance that NHSI issues. | The Trust has had regard to NHSI guidance through submission of required annual and quarterly planning requirements, declarations and exception reporting. | Director of Finance<br>Director of Operations |
| G6 | Systems for compliance with licence conditions and related obligations | This requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements. | The Trust has a robust governance framework in place as outlined in the Annual Governance Statement. The Board and its sub Committees (Audit Committee, Quality and Safety Committee, People and Organisational Development Committee and Finance and Investment Committee) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance. All Committees undertake a review of their annual work programme and effectiveness and revisions are made as required. | Chief Executive<br>Director of Corporate Affairs |

| | | | | |
|---|---|---|---|---|
| | | | The Trust has a Risk Management Strategy and processes are in place to enable identification, management and mitigation of current risk and anticipation of future risk. The Risks are identified through incident reporting, risk assessment reviews, clinical audits and other clinical and non- clinical reviews with a clearly defined process of escalation to risk registers. The Board Assurance Framework is reviewed by the Board and its sub committees.<br><br>The Board has regard to the NHS Constitution, compliance with access targets has improved significantly in 2017/18 and actions are in place to support delivery and achievement of trajectories. | |
| G7 | Registration with the Care Quality Commission | This licence condition requires providers to be registered with the Care Quality Commission and to notify NHSI if registration is cancelled. | The Trust is registered with the Care Quality Commission without condition. | Chief Executive<br>Director of Corporate Affairs |
| G8 | Patient eligibility and selection criteria | This condition requires licence holders to set transparent eligibility and selection criteria for patients and to apply these in a transparent manner. | The Trust publishes descriptions of the services it provides and who the services are for on the Trust website.<br><br>Eligibility is defined through commissioners' contracts and the choice framework.<br><br>Assurance is gained through the assessment stages to ensure that the appropriate services are provided. | Chief Operating Officer |

| | Licence Condition: | Explanation: | Board Assurance: | Lead Director(s): |
|---|---|---|---|---|
| G9 | Application of Section 5 (Continuity of Services) | This condition applies to all licensees. It sets out the conditions under which a service will be designated as a Commissioner Requested Service. Licensees are required to notify NHSI at least 28 days prior to the expiry of a contractual obligation if no renewal or extension has been agreed.<br><br>Licensees are required to continue to provide the service on expiry of the contract until NHSI issues a direction to continue service provision for a specified period or is advised otherwise.<br><br>The conditions when Commissioner Requested Services (CRS) shall cease is set out. Licencees are required under this Condition, to notify NHSI of any changes in the description and quantity of services which they are under contractual or legal obligation to provide. | Requested Services are set within the contracts agreed with commissioners. The Trust has strong working relationships with its commissioning partners within the local health economy.<br><br>The Finance Director is responsible for leading on contract negotiations and across the Trust there is partnership working to deliver service transformation, efficiency and quality improvement to meet the needs of the local population.<br><br>Regular meetings take place with NHSi and they would be notified prior to the expiry of a contractual obligation if no renewal or extension has been agreed. | Chief Executive<br>Director of Finance<br>Chief Operating Officer |

## SECTION 2 PRICING

| | Licence Condition: | Explanation: | Board Assurance | **Lead Director** |
|---|---|---|---|---|
| P1. | Recording of information | Under this condition, NHSI may oblige licensees to record information, particularly information about their costs, in line with Monitor guidance. | The Trust records all of its information about costs in line with current guidance. | Director of Finance |
| P2. | Provision of information | Having recorded the information in line with Pricing condition 1 above, licensees can then be required to submit this information to NHSI. | The Trust complies with any requirements to submit information to NHSI. | Director of Finance |
| P3. | Assurance report on submissions to NHSI | When collecting information for price setting, it will be important that the submitted information is accurate. This condition allows NHSI to oblige licensees to submit an assurance report confirming that the information that they have provided is accurate. | The Audit Committee receives and monitors all Internal Audit reports | Director of Finance |
| P4. | Compliance with the national tariff | The Health and Social Care Act 2012 requires commissioners to pay providers a price which complies with, or is determined in accordance with, the National Tariff for NHS health care services. This licence condition imposes a similar obligation | The Trust is on a PbR contract for acute provision and community services are on a block contract. Any local variation is in line with national guidance. | Director of Finance |

| | | | | |
|---|---|---|---|---|
| | | on licensees, i.e. the obligation to charge for NHS health care services in line with the National Tariff. | | |
| P5. | Constructive engagement concerning local tariff modifications | The Act allows for local modifications to prices. This licence condition requires licence holders to engage constructively with commissioners, and to try to reach agreement locally, before applying to NHSI for a modification. | As above | Director of Finance |

**SECTION 3: CHOICE AND COMPETITION**

| | Licence Condition: | Explanation: | Board Assurance | **Lead Director** |
|---|---|---|---|---|
| C1. | Patient Choice | This condition protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. This condition applies wherever patients have a choice under the NHS Constitution, or where a choice has been conferred locally by commissioners. | The Trust complies with patient's right to choose and the choice framework | Chief Executive |
| C2. | Competition Oversight | This condition prevents providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. It also prohibits licensees from engaging in other conduct that has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. | All licensed provider organisations are treated as 'undertakings' under the terms of the Competition Act 1998. This means that as a licensed provider the Trust is deemed to be an organisation engaging in an 'economic activity' and therefore is required to comply with the Competition Act. The Board and Executive Management team has access to expert legal advice to ensure compliance with this condition. | Chief Executive |

**SECTION 5: CONTINUITY OF SERVICES**

| | Licence Condition: | Explanation: | Board Assurance | Lead Director |
|---|---|---|---|---|
| CoS1. | Continuing provision of Commissioner Requested Services | This condition prevents licensees from ceasing to provide Commissioner Requested Services, or from changing the way in which they provides Commissioner Requested Services, without the agreement of relevant commissioners. | As for condition G9 above. | |
| CoS 2. | Restriction on the disposal of assets | This licence condition ensures that licensees keep an up to date register of relevant assets used in the provision of Commissioner Requested Services. It also creates a requirement for licensees to obtain NHSI's consent before disposing of these assets when Monitor is concerned about the ability of the licensee to carry on as a going concern. | The Finance Department maintains a capital asset register. The Trust complies with requirements regarding disposal of assets. | Director of Finance |
| CoS 3. | Standards of Corporate Governance and Financial Management | This condition requires licensees to have due regard to adequate standards of corporate governance and financial management.<br>The Risk Assessment Framework will be utilised by NHSI to determine compliance | The Trust has adequate systems and standards of governance, oversight by the Board and establishment and implementation of associated governance systems and processes including those relating to quality and financial management.<br><br>Refer to the Trust Annual Governance Statement and Annual Report | |

| | | | | |
|---|---|---|---|---|
| CoS 4. | Undertaking from the ultimate controller | This condition requires licensees to put in place a legally enforceable agreement with their 'ultimate controller' to stop ultimate controllers from taking any action that would cause licensees to breach the license conditions. This is best described as a 'parent/subsidiary company' arrangement. **If no such controlling arrangements exist then this condition would not apply.**<br>Should a controlling arrangement come into being, the ultimate controller will be required to put in place arrangements to protect the assets and services within 7 days.<br>Governors, Directors and Trustees of Charities are not regarded by NHSI as 'Ultimate Controllers'. | The Trust is a Public Benefit Corporation and neither operates or is governed by an Ultimate Controller arrangement so this licence condition would not apply. | Not applicable |
| CoS 5. | Risk Pool Levy | This licence condition obliges licensees to contribute, if required, towards the funding of the 'risk pool' – this is like an assurance mechanism to pay for vital services if a provider fails. | The regulatory Risk Pool Levy has not come into effect to date.<br>The Trust currently contributes to the NHS Litigation Authority risk pool for clinical negligence, property expenses and public liability schemes. | Director of Finance |

| | | | | |
|---|---|---|---|---|
| CoS 6. | Cooperation in the event of financial stress | This licence condition applies when a licensee fails a test of sound finances, and obliges the licensee to cooperate with NHSI and any of its appointed persons in these circumstances in order to protect services for patients. | The Trust is in Financial Special Measures and co-operates fully with NHSI. | Director of Finance |
| CoS 7. | Availability of Resources | This licence condition requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services. | As with the provision of Mandatory Services, the Trust has well established services in place and currently provides all of the Commissioner Requested Services to a high standard.<br>The Trust has forward plans and agreements in place with commissioners that meet this condition. | Director of Finance |

**SECTION 6: NHS FOUNDATION TRUST CONDITIONS**

| | Licence Condition: | Explanation: | Board Assurance | Lead Director |
|---|---|---|---|---|
| FT1. | Information to update the register of NHS Foundation Trusts. | This licence condition ensures that NHS Foundation Trusts provide required documentation to NHSI. NHS Foundation Trust Licensees are required to provide NHSI with:<br>• a current Constitution;<br>• the most recently published Annual Accounts and Auditor's report;<br>• the most recently published Annual Report; and<br>• a covering statement for submitted documents. | The Trust is not an FT and therefore does not have a constitution.<br><br>Annual Accounts, Auditors Report and Annual Report are all published. | Director of Corporate Affairs |
| FT2. | Payment to NHSI in respect of registration and related costs. | If NHSI moves to funding by collecting fees, they may use this licence condition to charge additional fees to NHS Foundation Trusts to recover the costs of registration. | Not applicable. See G3 above. | Not applicable |
| FT3. | Provision of information to advisory panel. | The Act gives NHSI the ability to establish an advisory panel that will consider questions brought by governors. This licence condition requires NHS Foundation Trusts to provide the information requested by an advisory panel. | Not applicable as Trust does not have governors. | Not applicable |

## FT 4 Annual Corporate Governance Statement

**Appendix B**

| | | | |
|---|---|---|---|
| 1 | The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. | Confirmed | As evidenced in the Annual Governance Statement |
| 2 | The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time | Confirmed | Board reporting cycle and seminars allows new guidance to be brought to the Boards attention as required |
| 3 | The Board is satisfied that the Licensee has established and implements:<br>(a) Effective board and committee structures;<br>(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and<br>(c) Clear reporting lines and accountabilities throughout its organisation. | Confirmed | Governance framework in place. Clarity of reporting and accountabilities, highlighted in 2020 document and communicated across the organisation. Annual review of committee structure and effectiveness in place. Revisions made if review highlights any requirements.<br><br>CQC recognised improved governance and clarity of structure. |
| 4 | The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:<br>(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;<br>(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;<br>(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;<br>(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);<br>(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;<br>(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;<br>(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and<br>(h) To ensure compliance with all applicable legal requirements. | Confirmed | Annual Governance Statement, Quality account along with Annual Report document compliance with regulatory requirements. Robust external and internal audit processes esalate any concerns on key internal controls and processes.<br><br>Regular board and sub-committee meetings undertake reviews of planned work and include regular oversight of the governacne framework including performance information, financial information and the BAF and corporate risk register.<br><br>Compliance with NHS Constitutional standards improved significantly in 2017/18 and actions are in place to support continued delivery and achievement of trajectories.<br><br>The Trust is in financial special measures and a programme of work is in place to support the Trust in improving its financial position to achieve financial stability. This is supported by NHSi. |

**EAST SUSSEX HEALTHCARE NHS TRUST**

**AUDIT COMMITTEE**

**Minutes of the Audit Committee meeting held on Wednesday 31st January 2018 at 1400 in the Committee Room, Conquest**

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

**In attendance** Dr Adrian Bull, Chief Executive
Mr Jonathan Reid, Director of Finance
Mrs Lynette Wells, Director of Corporate Affairs
Dr David Walker, Medical Director
Mr Stephen Hoaen, Head of Financial Services
Ms Lisa Forward, Head of Governance
Mr Jamie Bewick, Senior Manager, Grant Thornton
Mr Chris Lovegrove, Counterfraud Manager, TIAA
Mr Adrian Mills, Audit Manager, TIAA
Nick Thomas, TIAA

Mr Andy Bissenden, Associate Director, ESHT Digital (for item 005/18 (i))
Ms Debbie Lennard, Assistant Director of Nursing (for item 005/18 (ii))

Jenny Darwood, Associate Director of Transformation (observing)

Mr Pete Palmer, Assistant Company Secretary (minutes)

**Action**

**001/18 Welcome and Apologies for Absence**

Mr Stevens opened the meeting and introductions were made. Apologies for absence had been received from:

Ms Vikki Carruth
Mrs Emma Moore
Mr Mike Townsend, TIAA.
Mr Darren Wells, Grant Thornton.

**002/18 Minutes of the meeting held on 22nd November 2018**

The minutes of the meeting held on 22nd November 2018 were reviewed and agreed.

**003/18 Matters Arising**

Mr Stevens noted the importance of replacing the Cardiac Cath lab and Dr Walker agreed, explaining that the lab broke down on an increasingly regular basis. Dr Bull explained that a long term strategy was being developed and a solution to the issues would be pursued at pace.

*Internal Audit Progress Report*
Mr Mills updated that he had met with Mrs Wells to discuss the recommendations and was satisfied that Trust management had taken appropriate actions in line with their interpretation of guidance. TIAA had agreed to close the action.

*Local Counter Fraud Service Progress Report*
Mr Lovegrove updated that he was waiting to hear back from HR teams about including counterfraud training in all Trust inductions. Dr Bull suggested that Mr Lovegrove should contact Dawn Urquhart to resolve the issue.

**004/18 Board Assurance Framework and High Level Risk Register**
Mrs Wells presented the BAF and Risk Register. She explained that no additions were being proposed to the BAF. Following a recent review of the Risk Register, 55 risks were listed. She explained Joe Chadwick-Bell had agreed at the last Audit Committee to undertake a review of the operational risks on the Register to ensure that the descriptions and scoring reflected the risk; this would be feedback to the divisions Mr Stevens noted that he was impressed with the updated BAF.

**The Committee reviewed and noted the revised High Level Risk Register and Board Assurance Framework and were of the view that the main inherent/residual risks had been identified and that actions were appropriate to manage the risks.**

**005/18 Clinical Audit and Risk Register Reviews**

**i) Out of Hospital**
Ms Lennard reported that the Out Of Hospital (OOH) Division were 99% compliant with NICE guidelines. They had 15 guidelines that were being reviewed. Two action plans were currently rate as red, with 19 rated as amber. Many of those plans sat within pharmacy and were expected to be closed following review at the MOG meeting in January.

Mr Stevens asked whether it was felt that pharmacy fitted well with OOH and Dr Bull explained that he felt that it was a good fit and that it was valuable for OOH to run a service that supported Divisions within the hospital.

Mrs Wells praised the division on their progress in improving their compliance. Dr Bull noted that a lot of work had been done on outcome reporting by the Division and suggested that this should be included in future reports. Measures were being developed to ensure that each department could provide at least one outcome and he felt that a lot of good was coming out of the work that was being undertaken.

Risk 1667 – Aseptic Labelling and Worksheet System
In response to a query from Mr Stevens, Ms Lennard confirmed that a plan had been developed to control this risk.

Risk 1596 – Archiving Hazard of patient notes
Mrs Bernhauser confirmed that this issued had been discussed by the Quality and Safety Committee and had been addressed. Ms Lennard noted that once the Division had confirmed that changes were effective and embedded then the risk would be removed from the register.

Risk 1527 – Impact of ESBT role recruitment on core community nursing services

Ms Lennard explained that OOH had a shortage of staffing due to staff seeking promotional opportunities within ESBT which had not been available within the division. She reported that additional training was being offered to district nurses and new models of working had been proposed which would offer additional opportunities for staff. Dr Bull noted that local leadership and resilience training were vital when staffing levels were low, and HR had been offering support to staff and to teams.

**ii) Digital / IT Risks**

Mr Bissenden reported that 24 risks were included on the department's risk register, two of which were extremely high and were included on the Trust's High Level Risk Register. 15 risks were rated as high. All risks on the register were reviewed on a monthly basis by the Division, as well as at Finance Directorate meetings and by Mr Bissenden. He noted that the actions for the mitigation of risks had accidentally been omitted from the document he was presenting.

Dr Bull asked about inadequate recording of non-PTL follow up appointments and Mr Bissenden reported that training programmes had been introduced to address the issue.

Dr Walker noted that he was aware of two risks that weren't included on the register. The first concerned the rollout of Evolve and Electronic Document Management, where some computers had not been upgraded prior to the introduction of the system. Mr Bissenden confirmed that the computers had now been replaced and advised that the risks for the EDM project would be included on the project risk register and not the divisional risk register. The risk had been discussed during IPRs and continued to be monitored.

The second risk concerned paperless reporting in radiology. Several serious DATIXs had been submitted about incidents where paper reports had not been reviewed, and Dr Walker explained the importance of ensuring that paperless reporting was introduced in an effective fashion. He hoped that any system would be linked to eSearcher to ensure that consultants were appropriately notified when reports required reviewing. Mr Bissenden agreed to add the risk to the risk register.

Mrs Wells noted that a risk concerning data flows, a requirement for the Information Governance Toolkit, had recently been discussed at the Information Governance Meeting. She explained that the risk was likely to increase and that the Trust was expected to be compliant with the General Data Protection Regulatons (GDPR) by 25th May 2018. The Trust had initially focussed on systems where data flowed outside the organisation and TIAA had undertaken an audit looking at the issue, which had shown that the Trust was aware of all existing issues. Mrs Wells reported that a new member of staff would be joining the Trust who would help with the issue, and agreed to present a paper at March's Audit Committee setting out progress against the requirements. **LW**

**006/18 Clinical Audit Update**

Ms Forward reported that two priority one audits (The National Audit of Breast Cancer in Older Patients (NABCOP) and Endocrine and Thyroid National Audit) were being flagged as red. Both had been discussed at the Clinical Effectiveness Group and actions to resolve issues were being undertaken.

The issues with completion of the NABCOP audit were caused by capacity and had also been discussed at the DAS IPR. Miss Imelda Donnellan and James Wilkinson would be taking actions to resolve the issue and an update on progress would be provided at the next Audit Committee.

Dr Walker noted that an audit of pain scores in children in A&E was also rated as red. Dr Bull explained that this had been discussed in the Emergency Care IPR and that a plan had been developed.

Dr Bull noted that the organisation continued to carry out too many clinical audits, albeit against a much improved position than had previously been seen. A new process to increase scrutiny of applications for clinical audits was being introduced, with Divisions being held to account for their audit performance in IPRs.

Mr Stevens suggested that audits should stop being flagged up on reports when doctors left the organisation. Dr Bull agreed, explaining that reporting captured every audit that had been started. He suggested that future reporting should focus on progress against nationally mandated audits and those that posed a threat to organisational risk.

**007/18 Internal Audit Progress Report**

Mr Mills reported that management responses had been received from the Emergency Readmissions and Cross Trust Requirement Processes audits and he anticipated that final reports would shortly be issued.

He presented an update on internal audit progress, noting that a number of draft reports had been issued since the previous meeting. Two draft reports offering limited assurance had been issued concerning End of Life Care (EOLC) and procurement. Both had shown progress since they had been audited the previous year.

EOLC remained limited as the policy for babies and children was out of date, and the outcomes from the first audit had shown a lack of evidence for regular medical review of EOLC patients and writing up of notes. Dr Bull noted that the benefit of the work that had been undertaken so far was now being seen, and that the EOLC project was expected to be moved into business as usual. Mr Mills noted that the report had only just returned limited assurance, explaining that if the audit had been carried out a few months later he felt that the outcome would have improved.

Procurement had also been given limited assurance, but was another area where a lot of work had been undertaken. An NHSI study had rated Trust processes highly. A regular review of tender and waivers had not been undertaken regularly by the Audit Committee during the previous year and this had been rectified.

Mr Mills reported that good progress had been made against the audit plan for 2017/18. Three additional audits had been requested during the year, all of which were at a draft stage. Quarter Four work had been agreed and work was underway on a number of audits. An audit of RTT pathways had been requested, which had been added at the expense of the scheduled consultant job planning audit. Dr Walker requested that the job planning audit was undertaken in Quarter 1 of 2018/19.

Mr Mills noted that a number of recommendations had passed their due date. Mr Reid agreed to chase up colleagues for their responses.

**008/18 Local Counter Fraud Service Progress Report**

Mr Lovegrove provided an update on the progress of the counterfraud team. He advised that there had been one referral since the previous meeting.

He noted that an audit on the usage of corporate credit cards was undertaken and that a report would be submitted to the Committee in the future. He anticipated that this would provide assurance about the number of cards that had been issued and their use.

262 matches had been flagged up by the National Fraud Initiative and Mr Hoaen anticipated that these would be resolved by the end of the financial year.

**009/18 External Audit Progress Report**

Mr Bewick presented a progress report, explaining that the audit team had visited the Trust the previous week to review financial systems and would be issuing an audit plan for the Committee's approval. Mr Hoaen reported that the meeting the previous week had been very positive. Mr Stevens hoped the change of auditors would flag up different issues to those that the previous auditors had identified.

Mr Reid noted that the Trust had received an adverse value for money opinion during previous years, and auditors had indicated that it was likely to remain for 2017/18. Use of resources would be assessed as part of the CQC inspection and also by NHSI. Mr Bewick didn't anticipate that Grant Thornton would look at this as there would be clear indications of progress from other organisations.

Mrs Wells noted that the submission of the annual report and accounts was scheduled for 29th May at 1200 and as a result May's Audit Committee would have to be rescheduled. It was agreed that the meeting would be rescheduled to Thursday 24th May.

**010/18 Information Governance Toolkit Report and Registration Authority Report**

Mrs Wells presented an update on progress with the Information Governance Toolkit (IGT), which would be submitted on 31st March. A first audit had been completed, showing good progress, and Mrs Wells didn't anticipate that there would be any issues with meeting the deadline. 54 IG incidents had been reported to date during the year.

She noted that the IGT would be replaced by the Data Security and Protection Toolkit (DSPT) in 2018/19. Scoping work had been undertaken

to ensure that the Trust complied with new data protection legislation, but further work was still required. A paper would be presented at the next Audit Committee showing progress against meeting these requirements. **LW**

Mrs Wells noted that no charges would be made for accessing medical records by the public from 2018/19, which could lead to an increase in requests, and loss of income for the work that was being undertaken.

**011/18 Review of Losses and Special Payments**

Mr Hoaen reported that the value of losses and special payments for the year was anticipated to be smaller than in 2016/17. He noted that there were no areas of concern within the report.

**012/18 Tenders and Waivers**

Mr Reid reported that a lot of work had been undertaken on waivers during the previous year.

Mr Reid provided clarification to Mr Stevens about a waiver issued for an emergency order of sheets on the Trust's behalf, and about a waiver issued for the purchase of maternity beds.

Mrs Wells noted that a review of the waiver relating to ophthalmology was being undertaken due to potential conflicts of interest and that the results of this review would be reported to the Audit Committee once completed.

Mr Reid noted that two items related to DAS were extensions of contracts with suppliers and agreed that additional information about the reasons for waivers being issued should be included within future reports.

**013/18 Audit Fees for 2018/19**

Mr Hoaen reported that the Audit costs for 2018/19 would be the same as for 2017/18 plus inflation. Mr Bewick agreed to clarify what would constitute inflation with Darren Wells. **DW**

**014/18 Emergency Planning and Resilience Committee**

Mrs Wells reported that Mr Stevens was NED lead for Emergency Planning, and had supported the proposal that Emergency Planning and Resilience Committee would report into the Audit Committee and that minutes would be presented at future meetings. The Committee agreed with this recommendation.

**015/18 Date of Next Meeting**

The next meeting of the Audit Committee would be held on:
Thursday, 24th March 2018, 1000-1200, EDGH

Signed: ……..

Date: ……

**EAST SUSSEX HEALTHCARE NHS TRUST**

**FINANCE & INVESTMENT COMMITTEE**

Minutes of the Finance & Investment Committee held on
Wednesday 31 January 2018 at 8.30am – 11.30am
In the Committee Room, Conquest

Present:
Mr Barry Nealon, Non-Executive Director, Chair
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Mr Jonathan Reid, Director of Finance
Mrs Lynette Wells, Director of Corporate Affairs
Dr Adrian Bull, Chief Executive
Mrs Alex Graham, Head of Financial Management, representing Mr Dan Bourdon, Interim Deputy Director of Finance

In attendance:
Mr David Hoppe & Christian Laidlaw, NHSI (observing)
Dr David Walker, Medical Director (for item 011/18)
Mrs Jo Brandt, Head of Planning & Performance (for items 022/18 & 023/18)
Miss Chris Kyprianou, PA to Director of Finance (minutes)

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| 007/18 | **Welcome and Apologies for Absence**<br><br>Mr Nealon welcomed members, and the team from NHSI, to the Finance & Investment Committee. Apologies were received from Tracey Rose and Dan Bourdon. | **Action** |
| 008/18 | **Minutes of the Meeting of 20 December 2017 and 17 January 2018**<br><br>The minutes of the meeting held on 20 December 2017 and 17 January 2018 were agreed as an accurate record subject to following clarification to the January minutes:<br><br>Mrs Churchward-Cardiff said she had queried total spent on temporary staff as she thought that the position at month 9 was close to the total spend in 16/17. There was a concern therefore that although agency had fallen due to successful use of bank, the total spend on temporary staff was at least equal to that of last year. Mr Reid said he would provide this information.<br><br>It was noted that the minutes of the Finance & Investment Committee would be presented to the private Meeting of the Board and that Mr Nealon would present a summary for the public Board Meeting. | JR |
| 009/18 | **Action Log**<br><br>(i) Lord Carter Operational Productivity<br>On the agenda and discussed under item 023/18 below. | |

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| | (ii) Ambulatory Emergency Care<br>A briefing paper was discussed later in the meeting.<br><br>(iii) Workforce Plan<br>Dr Walker presented a report under item 011/18 below.<br><br>(iv) Pay and Non Pay<br>It was noted that the run rate graphs had been refreshed and re-presented in a different format for this month's meeting.<br><br>(v) Cashflow<br>Detailed information on loan rates and values were included in the new 'liquidity' report which was presented under item 013/18 below.<br><br>(vi) Additional F&I Committee Meeting<br>An additional meeting took place on 17 January 2018.<br><br>(vii) Bank & Agency Spend<br>Information on bank and agency spend was included in the workforce report below.<br><br>(viii) Technical Adjustments<br>This was an agenda item and was discussed under item 018/18 below.<br><br>(ix) Assurance statement<br>Mr Reid reported that the assurance statement has not yet been submitted to NHSI. However a full paper would be presented to the Private Board meeting the following week. | |
| 010/18 | **Finance Report - Month 9**<br><br>Mr Reid presented the Month 9 finance report which highlighted the year to date, in-month, and forecast outturn position for the Trust and included a detailed divisional analysis.<br><br>The key messages had been discussed in detail at the additional Finance & Investment Committee meeting earlier in the month.<br><br>The Committee noted that the Trust forecast year end position was £57.4m deficit, before STF. This had been discussed with NHSI following the outcome of mediation and the resulting fixed income agreement. There still remained a degree of risk within this position. Mr Reid gave a brief explanation of the elements of risk. It was noted that some of these were around the technical adjustments.<br><br>**Action**<br>**The Committee noted the finance update at month 9 noting the key messages.** | |
| 011/18 | **Temporary Workforce Plan** | |

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| | At the December meeting, the Committee asked for a report on the temporary workforce plan.<br><br>Dr Walker was welcomed to the Committee to present a report covering permanent and temporary workforce spend from month1-9. The Committee noted that:<br><br>• Workforce expenditure had been tracking above budget since Mth 5<br>• Substantive spend had increased month on month<br>• Temporary workforce spend in total had not reduced<br>• Bank usage had remained within a range of £1,267k – £1,347k per month<br>• Agency expenditure had decreased<br>• Medical locum spend had increased<br><br>It was noted that Vacancies and the opening of non-budgeted additional capacity were the top 2 reasons for temporary workforce spend.<br><br>All agency HCAs had transferred to the bank on Trust rates since June and no agency HCAs had been booked. There had been a gradual transference of medical agency workers to the Bank and fixed term contracts. However remuneration packages above usual NHS rates had been agreed.<br><br>Dr Walker gave an update on the introduction of reduced WLI payments from January 2018. It was felt that this could be impacting on the waiting list. Dr Bull explained that the Associate Director for Transformation (Workforce) was pulling together some of the information to get a final position of bank and waiting list initiative rates.<br><br>The Committee noted that within nursing, a bank incentive scheme had been introduced to encourage substantive staff (bands 5 – 7) to work additional shifts to reduce agency spend.<br><br>With regard to AHPs, these were still very much agency dependent and there was still some work to do in this area.<br><br>The Committee noted the actions in place to reduce temporary workforce. These have been undertaken through the Workforce Productivity workstream and were being monitored through the monthly Financial Improvement and Sustainability Committee (FISC).<br><br>**Action**<br>**The Committee noted the trends since April 2017 and actions being undertaken to address the reductions in Temporary Workforce Spend.** | |
| 012/18 | **Contracts Income Report** | |

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| | Mr Reid presented the Committee with detailed Activity and Income Report which provided an update on the M9 2017/18 Contract Income position.<br><br>It was noted that the main contract issues with the CCGs for this year had been settled. The Trust and the two local CCGs had agreed a Minimum Income Guarantee, which alleviated the majority of the risk.<br><br>Mr Reid gave a brief update on the other contract risks faced by the Trust.<br><br>Dr Bull explained that there was a real concern on the overall contracts process and Mr Reid had put in place an additional regular meeting with the Deputy Chief Finance Officer of the two local CCGs to cover both contract disputes and the reconciliation process, and Dr Bull would be meeting Amanda Philpott; Chief Officer, East Sussex CCGs, Sarah Valentine; Strategic Director of Contracting & Performance Sussex & East Surrey CCGs, Alison Gale; Deputy Chief Finance Officer, East Sussex CCGs and Mr Reid on a monthly basis to ensure progress on contract issues and to act as a rapid early escalation point.<br><br>**The Committee noted the full contracting report.** | |
| 013/18 | **Liquidity Report**<br><br>Mr Reid presented the month 9 Liquidity report and gave a high level update on the cash position.<br><br>He reported that the cash position was improving for three reasons<br><br>• The financial services team had a better grip on cash flow forecasting<br>• The Trust had received additional exceptional cash funding from NHSI<br>• As the Trust had formally moved its forecast the Trust is able to get access to additional working capital.<br><br>Mr Reid reported that there was a plan in place that would bring the creditor position to between 30 - 60 days over the remaining three months of the financial year. This was a substantial improvement, however there still remained work to do to.<br><br>Mr Reid reported that there was a fairly systematic process for testing what were the major debtors and creditors.<br><br>The Committee reviewed the schedule of loans received from the Department of Health to support the cash gap left by reporting losses over the last few years.<br><br>Mrs Churchward-Cardiff raised a query regarding creditors and asked if | |

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| | there was a plan on how the Trust could effectively manage creditors. Mr Reid said that he would be happy to bring a further analysis to a future meeting.<br><br>**Action**<br>**The Committee noted the ongoing management of cash within the Trust.** | |
| 014/18 | **Capital Review**<br><br>Mr Reid presented the Committee with a brief paper on the capital position and highlighted the key messages.<br><br>The Committee noted that the Trust's capital resource limit (CRL) for 2017/18 was £15.2m. The plan and CRL could increase by a further £0.8m as a result of the Ambulatory Care PDC bid for the Conquest site. If successful this would increase CRL to £16m. There was a possibility of the CRL increasing by a further £1.5m if a capital loan was approved by NHSI, this would increase CRL to £17.5m.<br><br>At the close of M9 the cumulative capital expenditure amounted to £8.4m (£7.9m on owned assets and £0.5m relating to donated assets).<br><br>The year to date position included expenditure on the following schemes:<br>• Relocation of Fracture Clinic £0.9m<br>• A&E/GP Streaming and Ambulatory Care £1.7m<br>• Minor capital £1.3m<br>• Medical equipment £0.9m<br>• Digital schemes £0.8m<br><br>Capital forecast at month 9 was £13.7m and marginally below plan. The Capital Review Group (CRG) was reviewing the possible purchase of items to ensure the CRL was met.<br><br>Mr Reid explained that there was a high level of demand for capital, however the Trust had not spent as much capital as it was anticipating. He explained the reasons for this, which included a delay in some projects.<br><br>**Action**<br>**The Committee noted the current position on the capital programme.** | |
| 015/18 | **Activity Review**<br><br>The Committee received an activity review paper provided by Mrs Goldsack, and the key issues were noted.<br><br>The activity, year to date, was monitored against the indicative plan developed as part of the business planning process for 17/18. The | |

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| | Committee received information on the performance against this.<br><br>The paper gave an overview of current and predicted activity levels and highlighted that 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.<br><br>Elective inpatient and day case activity remained lower than previous years and below the agreed plan.<br><br>Whilst new outpatients were down, follow ups had increased. The Trust was undertaking further analysis of the changes in new to follow up ratios across the specialities. This was particularly important given the changes in funding under HRG4+ which allocated increased funding to new appointments and a reduction in funding for follow ups.<br><br>The Trust was working with the key areas to understand the gaps in performance as part of the current capacity and demand refresh process and this analysis would be reviewed as part of business planning.<br><br>A projected view of demand and capacity would also be used on a monthly rolling basis to improve delivery against plan, CIPs and address recovery requirements; forecasting would also therefore improve.<br><br>Developing the tools and capability would assist divisions and specialties to deliver their plans, help the Executive team forecast outturn and anticipate challenges in-year and provide stronger assurance to the Board through governance processes (initially FISC).<br><br>The plan was to introduce this capability in time to support 2018/19 business planning and then the subsequent delivery of the 18/19 plan.<br><br>The Committee noted that activity was reviewed on a weekly basis internally and included in the monthly reporting for IPRs with the divisions and reported to the Trust Board.<br><br>**Action**<br>**The Committee noted the activity review.** | |
| 016/18 | **Divisional Assurance – Medicine**<br><br>The Committee received a paper which showed that the full year budget for expenditure for Medicine (as of December 2017) was £65.4m. Of this £ 57m related to pay (87%) and £8.4m to non pay (13%). | |

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| | The paper also showed:<br><br>• The full year budget for income was £91m.<br>• The net budget planned contribution was £25.2m.<br>• The position at M9 (year to date) was off plan by £0.4m arising from an overspend in expenditure of £2.1m offset by additional income £1.7m<br>• Contract Income: YTD was £1.6m (2%) above plan with activity -1,828 (-1%) below plan.<br>• Divisional Income: YTD was 0.1m above plan<br><br>For Pay, the year to date position was an overspend of £1.2m predominantly due to the need to cover substantive posts/vacancies at premium rates and increased requirement for Special Observation.<br><br>For Non Pay the £0.9m related to:<br>• Endoscopy<br>• Cardiology<br>• CIP CSR<br><br>**Action**<br>**The Committee noted the update paper from Medicine.** | |
| 017/18 | **Financial Special Measures Update – Month 9**<br><br>The Committee received a copy of the presentation that was shared with NHSI at the FSM checkpoint meeting on 22 January 2018. This provided an overview of the latest Trust forecast for 2017/18, and the emerging draft plans for 2018/19.<br><br>Mr Reid reported that this was a very helpful and supportive meeting. The conversation with NHSI was to develop the CIP programme and to give a progress update on the 2018/19 FRP at the next meeting which would be week commencing 19 February 2018, date to be confirmed.<br><br>Mr Reid reported that the two key issues were around:<br><br>• the contract negotiations for next year<br>• the delivery of the CIP programme<br><br>It was noted that the Divisions had presented their initial CIP ideas and these were in the process of being finalised and reviewed for quality impact assessment. Mr Reid explained that the level of engagement was much improved. The Committee noted that the process was for all the plans to go through FISC.<br><br>Dr Bull said that it would be helpful to see the month by month savings trajectory as early as possible.<br><br>**The Committee noted the FSM update and the work summarised** | |

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| | **within. It was noted that work was underway on the development of the 2018/19 FRP for February.** | |
| 018/18 | **Technical Adjustments**<br><br>Mr Reid presented a paper on the potential changes to the year end accounting.<br><br>It was noted that there were six components to the Trust's CIP programme and the paper presented showed the methodology, assumptions and recommendations for each one.<br><br>These included:<br><br>• Injury cost recovery<br>• Equipment life review<br>• Alternative site valuation<br>• Increase inventories<br>• Research & Development funding<br>• Increase Revenue to capital transfers<br><br>The paper set out a range of potential changes to existing accounting policies, their risks and future impacts.<br><br>Mr Stevens said that his view was that the Trust should not rely on these and he did not like the idea of putting this into the budget as it created an unrealistic result for the Trust.<br><br>Mrs Chadwick-Bell reported that members should assess the risk of doing this and the risk of not doing it. This would be reviewed by the Executive Directors.<br><br>Dr Bull expressed his concern about the impact on the depreciation charge for next year.<br><br>It was the Committees recommendation that the use of Technical Adjustments should be limited because of its impact on depreciation and the true underlying operating performance.<br><br>**Action**<br>**The Committee reviewed the proposals for each of the six proposed schemes.** | **JR** |
| 019/18 | **Business Planning for 2018/19**<br><br>The Committee received a paper providing an update on the Trust Business Planning process. It was noted that this sat alongside the Trust FSM presentation and update, covering the key steps required to develop a robust annual plan for 2018/19.<br><br>Mr Reid reported that the process was going well and there was a good | |

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| | level of engagement. Mrs Ashton was overseeing the Business Planning process, and the item was due to be discussed at the private Board meeting to following week.<br><br>**Action**<br>**The Committee noted the Business Planning paper** | |
| 020/18 | **ESBT/Alliance Executive Financial Plan 2017-18**<br><br>Mr Reid gave a brief update on the ESBT Alliance Executive Financial Plan.<br><br>The Committee noted that Financial Planning for 2018/19 at a system level continued to develop through the Alliance Executive. The Committee reviewed the overall financial planning framework in December, noting that there were two key programmes (Cost Reduction, which included the Trust CIP programme) and Service Redesign. These programmes were being developed through the Alliance Executive Governing Body, with individual organisations drawing together the cost reduction programmes, and the Integrated Strategic Planning Group drawing together the Service Redesign Plans. The ESBT Finance Group, chaired by Keith Hinkley, was co-ordinating the overall planning process.<br><br>Mr Reid gave a brief overview of the challenges for next year.<br><br>**Action**<br>**The Committee noted the update on the Alliance Executive Finance Plan.** | |
| 021/18 | **Sussex and East Surrey STP Financial Plans**<br><br>Mr Reid provided the Committee with a summary of the STP position.<br><br>The Committee noted that the STP was working on a number of key schemes to support the financial planning process for 2018/19 and future years.<br><br>**Action**<br>**The Committee noted the ongoing work within the STP.** | |
| 022/18 | **Costing Assurance Programme**<br><br>Mrs Brandt provided the Committee with an overview of the Costing Assurance Review 2017/18 undertaken by Ernst & Young. (EY)<br><br>It was noted that the Trust had volunteered to be an early implementer of the Costing Transformation Programme. The 2016/17 Patient Level Costing return was submitted to NHSI and subsequently the Trust was selected for audit by EY of this collection and its 2016/17 Reference Cost Collection. | |

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| | The objective of the review was to provide a view of the Trust's PLICS submission against certain criteria.<br><br>The review provided an assessment of the Trust's compliance with the Costing Transformation Programme (CTP) standards aligned to the transition path advised for Year 1 and sought confirmation that the submission reflected all the costs. The review also aimed to provide an indication of the progress the Trust is making towards implementing the Year 2 costing methods per the NHSI transition path.<br><br>The review assessed:<br><br>• Governance and Stakeholder Engagement<br>• Compliance with Year 1 Costing Transformation Programme (CTP) Standards<br>• Assessment of progress towards implementation of Year 2 CTP Standards<br>• Focused audit of the Reference Cost Return<br><br>It was noted that the Trust received a Moderate Assurance rating for Compliance with CTP Year 1 Standards and a rating of Satisfactory for accuracy of the 2016/17 reference cost return.<br><br>Mrs Brandt gave an update on the areas that the Trust needed to further develop, and the plan to address these which had been submitted to NHSI and the actions in place to address these.<br><br>**Action**<br>**The Finance and Investment Committee noted the findings of the Costing Assurance Review 2017/18 undertaken by Ernst & Young, and the action plan created to mitigate the issues highlighted by the review.** | |
| 023/18 | **Operational Productivity Programme (Carter)**<br><br>Mrs Brandt gave an overview on the current and proposed use of the Model Hospital data within the Trust.<br><br>The Committee noted the Trust's Weighted Activity Unit (WAU) outlier position and Mrs Brandt explained how this information was being shared within the Trust. It was noted that ESHT was one of the top highest hitting trusts for using this information but there was still more that could be done. Mrs Brandt explained that the WAU was a 'common currency' of hospital output (unit of production) which took account of casemix and complexity and could be used to quantify all types of trust activity including inpatients, outpatients, diagnostic testing and others.<br><br>Mr Nealon asked how Mrs Brandt felt about the quality of the Trust data. Mrs Brandt reported that the quality of costing in the NHS was | |

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| | improving.<br><br>The Committee noted the Trust's 2016/17 Potential Productivity Opportunity (PPO) which was based on 2016/17 reference cost data. Mrs Brandt explained how this worked and that they had chosen the top 10 loss making specialties to undertake deep dive reviews.<br><br>Mrs Brandt explained the Clinical Services re-design process for the top 10 loss making specialities and the meetings that were taking place with the Financial Improvement Director. Mrs Brandt reported that this work had a £14m target for 18/19 with good engagement from across the Trust.<br><br>Mrs Churchward-Cardiff queried what the Trust does when it has an outlier who is unable or unwilling to get towards the median. Dr Bull explained the work that KPMG were doing on this and Mr Reid reported that Finance were working with the Director of Strategy on a timetable to present this information later in the year at a Board Seminar.<br><br>Mrs Brandt reported on the national Getting it Right First Time (GIRFT) Programme. It was noted that there were 35 specialities that would have a GITFT review. Dr Walker and Mrs Brandt launched this to Consultants and Senior Managers. There were 8 GIRFT speciality reports to date for which action plans were being created. The Trust had been offered some free resource to complete the action plans required following a GIRFT review and to RAG rate progress.<br><br>Mrs Brandt reported that the proposal was to disband the Lord Carter working group and replace this with the Getting it Right First Time (GIRFT) Programme Group.<br><br>The Committee commended the detail of the work undertaken by Mrs Brandt and thanked her for attending the meeting.<br><br>**Action**<br>**The Committee noted the Trust's 2016/17 Weighted Activity Unit and Potential Productivity opportunity positions.** | |
| 024/18 | **Ambulatory Emergency Care (AEC)**<br><br>Mr Reid provided an update paper on the AEC. The Committee noted that the Trust opened the expanded Eastbourne AEC unit in late November/early December 2017, and received a PDC grant for the capital works.<br><br>The AEC was a key part of the system urgent care strategy and form a part of the Trust's UTC development bid. The Trust believed the expanded AEC has had a material impact on the Trusts 4 hour A&E target over the festive period. | |

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| | The costs in the business case were quoted as £1.4m, during December costs were slightly higher than anticipated due to the use of high cost agency staff. Plans for substantive recruitment were progressing.<br><br>At a recent Finance and Investment Committee it was discussed that opening the service would remove the need for escalation beds at both Firwood and Bexhill. It had always been assumed that inpatient beds would need to close from 1 April 2018. The actions were designed to mitigate the increased running costs.<br><br>It had always been planned that moving to an expanded AEC model would not change the overall levels of activity. However what does change is the number of patients that (following earlier discharge) attract the reduced non-elective short-stay tariff rather than the full non-elective tariff. The business case made some assumptions about the likely impact of this and quoted a range of between £1.4 and £2.4m for the Eastbourne site.<br><br>The Committee noted that it was too early to tell if the new model was having the anticipated level of impact. There was work going on to monitor this however several month's worth of data were required for a complete picture.<br><br>The Committee reviewed the income and activity modelling from the original business case.<br><br>Mrs Chadwick-Bell gave an update on the position since the AEC had opened. It was noted that an ambulatory tariff was yet to be agreed. It was noted that the 8 additional AMU beds were funded through the NHSE winter pressures money.<br><br>The Committee expressed its full support for the benefits of the Ambulatory Care Project, but it did express its concern that the commitment to proceed was made without the full impact of the ongoing operating cost being fully understood.<br><br>The Committee requested that a paper be presented before the process is put in place at the Conquest site.<br><br>**Action**<br>**The Committee noted the update.** | |
| 025/18 | **Conquest MRI Programme Board**<br><br>The Friends of Conquest Hospital were actively fundraising for a new scanner and had almost reached their £1million target and were seeking commitment for the housing for the scanner to be finalised by Autumn 2018; this had previously been agreed several years ago and would be funded by the Trust. | |

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| | The Friends had expressed concern about the lack of progress and had reservations about the Trust entering into a commercial arrangement for the service. They were committed to purchasing a scanner and had fundraised on this basis.<br><br>It was agreed that the CEO, Director of Finance and Medical Director/Director of Corporate Affairs would arrange to meet with Bill Hamilton and Douglas Flint of the Appeal Board to discuss the project. Kelly Porter would be asked to co-ordinate.<br><br>The Committee discussed the proposed replacement MRI scanner and noted that an MRI Programme Board had been established to ensure the plans could be developed and expedited The Committee reviewed the draft terms of reference and affirmed their support for the continued exploration of all options including the option of a commercial partnership to deliver the necessary housing and support of the scanner service.<br><br>**Action**<br>**The Committee noted the update on the MRI replacement scanner and supported the MRI Programme Board in expediting the options once finalised.** | **AB** |
| 026/18 | **2017/18 Work Programme**<br><br>The Committee received the 2017/18 work programme and a draft 2018/19 work programme.<br><br>**Action**<br>**The Work Programmes for 2017/18 and 2018/19 were noted.** | |
| 027/18 | **Format of the meetings**<br><br>Mr Nealon raised an issue around the volume of papers the Committee receives and the way in which they are received, and welcomed members views on how these could be better presented.<br><br>Mrs Wells reported that she had met with Mr Reid to discuss the agenda and work plan. It was agreed that there were a lot of papers that did not necessary give the Committee enough assurance or highlight the risks and actions. It was also felt that the Committee were spending too much time on operational matters.<br><br>Mrs Churchward-Cardiff agreed that there was too much data and not enough analysis.<br><br>The Committee queried whether this was the right forum for the divisions to be attending to provide assurance as they were already providing this information at other meetings. It was agreed that the divisions would not be asked to attend unless the Committee had any particular issues. | |

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| | Mr Reid explained that part of the plan which came out of the of the BDO review of the finance function, was about how to refine the financial reporting cycle and the type of information that is provided.<br><br>Mr Reid said the Operational Financial Performance detailed reports would be grouped into one more streamlined report that has the key messages, and the same with the Strategic reports.<br><br>It was agreed that the Committee would focus on specific issues so there was sufficient time to receive assurance on key financial strategic matters.<br><br>**Action**<br>**The Committee's concerns were noted. It was agreed to review the agenda and work plan against the Terms of Reference and to provide more streamlined reports with key messages.** | JR |
| 028/18 | **Minutes to note – for information only**<br><br>The Committee received the minutes of the following meetings for assurance and information:<br><br>• Financial Improvement & Sustainability – 30.11.17 and 18.12.17<br>• Capital Resources Group – 20.12.17<br>• Business Development Group – 20.12.17 and 17.1.18<br><br>**Action**<br>**The Committee noted the above minutes.** | |
| 029/87 | **Date of Next Meeting**<br><br>The next meeting is scheduled to take place on Wednesday 27 February 2018 at 8.30am – 11.30am in St Mary's Board Room at Eastbourne DGH. | |

**EAST SUSSEX HEALTHCARE NHS TRUST**

**FINANCE & INVESTMENT COMMITTEE**

Minutes of the Extra-ordinary Finance & Investment Committee held on
Wednesday 17 January 2018 at 1.15pm – 3pm
In the Committee Room, Conquest

Present:
Mr Barry Nealon, Non-Executive Director, Chair
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Mr Jonathan Reid, Director of Finance
Mrs Joe Chadwick Bell, Director of Operations
Mrs Lynette Wells, Director of Corporate Affairs
Mr David Clayton-Smith, Trust Chairman
Mr Dan Bourdon, Interim Deputy Director of Finance
Miss Tracey Rose, Associate Director of Planning & Business Development (representing Catherine Ashton)

In attendance:
Mrs Kirsty Watts, Head of Financial Sustainability & Efficiency
Miss Chris Kyprianou, PA to Director of Finance (minutes)

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| 001/18 | **Welcome and Apologies for Absence**<br><br>Mr Nealon welcomed members to the Finance & Investment Committee. Apologies were received from Adrian Bull. | **Action** |
| 002/18 | **Trust Reforecast 2017/18**<br><br>Mr Reid advised that the aim of the meeting was to formalise the Trust reforecast and to test some of the assumptions that the Trust was making in the next FSM presentation.<br><br>The Committee noted that the Trust had received the full results of the mediation from NHSI/E and had a confirmed income figure from the East Sussex CCGs of £257.1m. This represented a reduction on the in-year forecast of £261.4 following the first round of mediation.<br><br>The Trust had completed the full reforecast, building on the forecast in December 2017.<br><br>Mr Reid presented a paper which had been reviewed by the Executive Directors on 16 January 2018 and the reforecast value had been discussed and confirmed with the NHSI team following the outcome of the mediation in January.<br><br>Mr Reid highlighted the following key issues:<br><br>• The 2017/18 forecast outturn had been finalised and was | |

£57.4m deficit, following the mediation by NHSI and NHSE.

- The underlying deficit had moved from £57.3m in 2016/17 to £53.5m in 2017/18 under PBR, with an exit run-rate of £4.45m/month.

- The Trust set a start plan of £36.4m deficit. The movement in the forecast represented a £21m movement against the starting plan. The Committee reviewed the components of the movement

- Additional winter funding of £1m was provided to the Trust in December. This has to be taken directly to an improvement in the financial position, and will improve the reported deficit by £1m to £56.4m.

- The Trust was offered £9.9m STF funding, but as a result of non-delivery of the financial plan has recovered the Q1 payment only of £1.264m. This will improve reported financial performance, but not NHS financial performance.

- Through mediation, the Trust lost £1.2m CQUIN – reflecting the national position on the 0.5% risk reserve. At Month 12, all Trusts who did not receive this CQUIN were having this returned to improve their year end position. At this point, the Trust does not know whether this CQUIN money will be received, but is making the assumption that it will not. Mr Reid explained the implication of the Trust position.

Mr Nealon queried how the reported deficit (accounts) figure of £55m for 17/18 compared to the previous year's figure. Mr Reid reported that the underlying position was slightly better than 16/17 and gave an explanation of the run rates for each year. Mr Reid also noted that the reported figure would be worse than the previous year.

Mr Reid reported that the Trust had delivered significant operational efficiency improvements in year around length of stay and around a shift from elective inpatient activity to elective day case activity. This was being managed in a much better way and had resulted in an improved flow and an improved operational performance. It was noted that the length of stay was significantly lower for non elective and marginally lower for elective than the previous year.

The Committee reviewed the 17/18 outturn position, post mediation, and the reasons for variance. Mr Reid explained some of the key things that the Trust will be doing differently next year and the lessons that had been learned from this year.

Mr Reid drew the attention of the Committee to the slide on the 17/18 exit run rate which provided more detail on the 17/18 underlying position. It was noted that there were no further mediations or disputes

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| | with the CCG for 17/18.<br><br>A brief update was given on the month 9 position. A more detailed update would be given at the next Finance & Investment Committee meeting. Mrs Churchward-Cardiff queried the level of bank and agency spend compared with last year and asked for further information on this to be provided for the next meeting.<br><br>The Committee reviewed the 17/18 improvements update which showed the progress that had been made on the delivery of the £4.6m additional improvements that were identified in December.<br><br>The Committee expressed a degree of concern around the feasibility of the technical adjustments shown at the bottom of the table. Mr Stevens said he felt that these should not be included on the table. It was noted that a decision had not yet been made on whether the technical measures would be implemented but these would be reviewed in more detail.<br><br>Mr Reid reported that the Trust will continue to explore all the improvement opportunities and a detailed paper on the technical adjustments would be provided at the next Finance & Investment Committee.<br><br>Mr Reid and Mrs Chadwick-Bell clarified some of the queries raised by the Committee around the improvements update. The Committee was pleased to note that the Trust had received the AEC/AMU winter funding.<br><br>Mr Nealon said he felt that a core issue was that the divisions had not delivered much in savings during the year. Mrs Watts explained that the divisions themselves had come forward with the specific schemes identified, and the finance team had worked with the division to ensure that the schemes were robust enough. The divisions have all been written to and were committed to delivering the savings.<br><br>The Committee noted the following risks to delivery:<br><br>• The forecast includes an assumption of £1m saving on asset valuation discussed at the December FIC. This figure needs validation, and the Committee expressed concern at the impact on the capital programme for 2018/19. The implications are being reviewed by the Director of Finance and alternative approaches to securing this improvement are under review.<br><br>• The forecast includes a further £1.3m of technical measures, supported by a review of the balance sheet, which are non-recurrent and will increase audit risk at the year end. However, as the Trust will have no year end disputes with East Sussex CCGs and will take care only to implement technical measures which are appropriate, the level of audit risk is considered | JR<br><br>JR |

manageable. The Trust will discuss all technical measures with the auditors in advance of implementation.

- The forecast includes a number of assumptions around reductions in run-rate and improvement in expenditure controls over Q4. Actions are in train to secure these reductions, and a summary of all expenditure reduction actions is shown overleaf. A letter has been sent to all Clinical Unit leaders seeking their continued commitment to meeting the Trust forecast, and progress will be tracked on a weekly basis through the Finance Department and Confirm and Challenge sessions.

It was noted that a more detailed review of all actions in train will be provided at the next meeting.

The Committee remained concerned over the level or risk within the re-forecast and requested further assurance on this.

Mr Reid presented the NHSI protocol for changes to an in-year financial forecast. The protocol states that where a provider plans to make an adverse change to the in-year forecast, it must be reported through the national reporting process and accompanied with the Board Assurance Statement signed by the Trust Chair, Chief Executive and Director of Finance.

This states that the Board Assurance Statement should confirm:

***For finance:***

- The Board has been fully briefed on the planned adverse change to the forecast
- All reporting revisions are accompanied with detailed actions and the Trust will continue to explore all options to recovery the position and achieve delivery of the original financial plan
- The Board is fully committed to the delivery of the Trust recovery plan and will activity monitor the recovery plan milestones
- In advance of formally reporting a forecast outturn variance from plan the Trust has discussed the financial deterioration and remedial actions with the NHSI Regional Managing Director and Regional Director of Finance

***For Governance:***

- Relevant commissioners have been informed of the position and all opportunities for support have been explored and the recovery actions agreed
- The Senior Clinical decision making body within the Trust has been engaged with and are party to the identification and delivery of the recovery actions
- The Trust Executive Committee, Finance Committee and Board have considered and agree the proposed financial forecast revision and recovery actions

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| | Mr Stevens said that before this could be agreed, he would expect to see a paper which demonstrates what has been done to meet the above obligations, and in particular, the actions being taken to address them.<br><br>Mr Clayton-Smith agreed that the Board would need to see the further evidence to support this.<br><br>Mr Reid reported that NHSI were comfortable that the Finance & Investment Committee consider this in advance of the next Board meeting.<br><br>It was agreed that the approach to the Board Assurance Statement would be to provide further detail on what the Trust was doing for each of the individual indicators, with a caveat around the Finance Committee and the Board, and a caveat that the Board would like to see further detail on the recovery actions. It was agreed that there should also be a caveat that this was being circulated to the Board and signed off at the next meeting.<br><br>The Committee agreed that the Trust would need to demonstrate that it has done everything it possibly can to give them greater assurance.<br><br>Mr Reid confirmed that he would like to provide the Committee with as much assurance as possible and was keen that the Trust delivers as well as possible against the £4.6m. The Committee requested regular updates tracking progress and any variances.<br><br>It was agreed that Mr Reid would provide an assurance statement to the Committee within the next few days with a covering letter around the re-forecasted programme.<br><br>**Action**<br>**The Committee expressed deep concern over the level of risk in the forecast but confirmed they were content to submit the reforecast so long as their concerns were also included.** | **JR** |
| 003/18 | **Draft FSM Presentation – January 2018**<br><br>The Committee noted that the Trust was presenting an update to the NHSI FSM team on 22 January 2018, following a positive session in December 2017.<br><br>Mr Reid presented a paper setting out the latest Trust forecast for 2017/18, and the emerging draft plans for 2018/19. The paper was being further reviewed by the Executive Directors and the Financial Improvement Director, alongside colleagues from the FSM team.<br><br>It was noted that detailed work was in train to develop the 18/19 financial plan. The delivery infrastructure for both 17/18 and 18/19 had been strengthened and further resources were being secured. | |

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| | Divisional engagement had improved and all financial planning was being directed through divisional leadership teams.<br><br>Mr Reid reported that the Trust had received confirmation that, in line with previous communications, the issued control total for 2018/19 was £26m.<br><br>Mr Clayton-Smith gave a brief update to the Committee on the changes in the way that FSM will be run next year.<br><br>The Committee reviewed the 18/19 indicative plan in detail and raised a few queries. It was noted that work on the 18/19 financial plan was progressing and that detailed work in Q4 will drive the final plan for presentation in February.<br><br>The key requirement was a robust contract with the CCGs, backed by 'production plans' linked to the demand plan and detailed CIP plans.<br><br>Mr Reid advised the Committee that the Trust was not making any commitment, at this early stage, to NHSI about the control total. The Trust was being very explicit that that any decision will need to go through the Finance & Investment Committee and the Board. A control total will need to be agreed with NHSI that is achievable.<br><br>Mr Nealon reported that the Committee needs to take a much more robust approach and would not want to see something go through which they feel is not achievable. The Committee agreed that there would need to be a more robust process in place.<br><br>**Action**<br>**The Committee noted the development of the FSM presentation, and the work summarised within.** | |
| 004/18 | **Draft Financial Plan 18/19**<br><br>The Committee received a paper on the draft Financial Plan for 2018/19 which supplemented the FSM presentation discussed under item 003/18.<br><br>It was noted that the Trust was working with the Financial Improvement Director and key stakeholders across the organisation to develop the initial financial plan for 2018/19.<br><br>Further work remains to strengthen the key assumptions and components of the plan and this paper sets out the headline messages, and key areas of continuing focus, alongside a timetable for completion.<br><br>**Action**<br>**The Committee noted the progress on the development of the financial plan** | |

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| 005/18 | **Developing the CIP 2018/19**<br><br>The Committee received a paper on the development of the CIP Programme for 2018/19.<br><br>It was noted that the Trust had been working closely with the new Financial Improvement Director, the Executive Team, and KPMG to develop the CIP programme for 2018/19.<br><br>The paper presented, developed with support from KPMG, set out the emerging form and content of the programme for the next year. It was noted that this will be developed over time, aimed at supporting the wider organisation to develop a full programme for 2018/19 alongside the financial plan for the year, and ready for Board approval by March 2018.<br><br>**Action**<br>**The Committee noted the progress on the development of the CIP plan for 2018/19.** | |
| 006/18 | **Date of Next Meeting**<br><br>The next meeting is scheduled to take place on Wednesday 31 January 2018 at 8.30am – 11.30am in the Committee room Conquest. | |

**EAST SUSSEX HEALTHCARE NHS TRUST**

**FINANCE & INVESTMENT COMMITTEE**

Minutes of the Finance & Investment Committee held on
Wednesday 28th February 2018 at 8.30am – 11.30am
by conference call

Present: Mr Mike Stevens, Non-Executive Director (Acting Chair)
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Dr Adrian Bull, Chief Executive
Mrs Joe Chadwick-Bell, Chief Operating Officer (part)
Mr Jonathan Reid, Director of Finance
Mr Dan Bourdon, Interim Deputy Director of Finance

In attendance: Mr Joel Newman, Specialty Lead for Pathology
Mr Rod Smith, Project Director, Sustainability Programme
Miss Chris Kyprianou, PA to Director of Finance (minutes)

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| 030/18 | **Welcome and Apologies for Absence**<br><br>Mr Stevens, deputising for Mr Nealon as Chair, welcomed members to the Finance & Investment Committee. Apologies were received from Barry Nealon, David Clayton-Smith, Lynette Wells and Tracey Rose (on behalf of Catherine Ashton). | **Action** |
| 031/18 | **Minutes of the Meeting of 31 January 2018**<br><br>The minutes of the meeting held on 31 January 2018 were agreed as an accurate record. | |
| 032/18 | **Action Log**<br><br>(i) Temporary Staff<br><br>The Committee noted the information on the total spent on temporary staff was included in the month 10 finance report.<br><br>(ii) Technical Adjustments<br><br>It was noted that this was to be discussed with Executive Directors in March 2018.<br><br>(iii) MRI Programme Board<br><br>Dr Bull reported that he had had a very helpful and constructive discussion with Mr Douglas Flint and Mr Bill Hamilton on the MRI Project and he had agreed to attend the League of Friends meeting on 28 February. Mr Flint and Mr Hamilton have been invited to nominate a | |

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| | representative to join the MRI Programme Board and they were pleased to have this option.<br><br>(iv) Format of Meetings<br><br>A new more streamlined finance report was included within the papers. | |
| 033/18 | **Performance Highlights – Month 10**<br><br>Mr Reid, in a verbal update, explained that there were no issues of concern in terms of Month 10 performance and he wanted the Committee to devote its time to other agenda matters. | |
| 034/18 | **Overarching Monthly Finance Review - Month 10**<br><br>Mr Reid presented the new consolidated finance report for Month 10 and highlighted the key issues.<br><br>The Committee noted the year to date, in-month, and forecast outturn position for the Trust and the more detailed divisional analysis.<br><br>The Trust forecast year end position was £57.4m deficit, before STF, and the paper presented set out the key variances and analysis of movements in month and in-year.<br><br>It was noted that the CIP forecast delivery was £26.9m against the £28.7m plan, £1.8m away from plan, this included the additional improvements of £4.6m identified in December. Work is continuing to progress the improvement plans between now and the end of the year.<br><br>Mr Reid reported there the Trust has seen a significant reduction in the overall creditors. It was noted that the CCGs had paid the historical debtors in February.<br><br>Mr Reid gave an update on the capital position. It was noted that the Trust had spent £9m and the Trust's capital resource limit for 2017/18 was £15.2m. The Trust has had considerable success in securing additional funding for 2017/18, with support from NHS Improvement.<br><br>Dr Bull raised a query with regard to the loan funding from the Department of Health to support the cash gap left by reporting losses over the last few years and queried whether the cost of this was affecting the annual performance and asked at what point does the Trust start running into problems with renewing significant loans.<br><br>Mr Bourdon explained that the Trust had done some work on the weighted average cost of capital (WACC) which was currently being reviewed. With regard to repaying the loans, there is one loan of £35m which expires in February 2019, the Trust's planning assumptions is that this will be repaid via a new loan of equal value although this new loan is likely to be at 3.5% rather than the 1.5% charged on the existing loan. Dr Bull queried if these loans would be converted to PDC at some | |

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| | point in the future, Mr Reid replied that he wasn't aware of any plans or mechanisms for this to happen. It was agreed that further information on more specifics on the weighted average cost for capital and the loan profiling draw down for next year would be discussed at the FIOG and provided for the April Finance & Investment Committee meeting.<br><br>The Committee felt that the report was much clearer this month and it was agreed that this would be relayed to the finance team.<br><br>Mrs Churchward-Cardiff said that she would find it helpful if the report would periodically include data which showed year on year spend on non substantive staff.<br><br>Mr Reid said that the team would continue to strengthen the finance reporting.<br><br>**Action**<br>**The Committee noted the finance update at month 10 noting the key messages.** | |
| 035/18 | **Financial Special Measures Update – Month 10**<br><br>The Committee received a copy of the presentation that was shared with NHSI at the FSM checkpoint meeting on 21 February 2018. This provided an overview of the latest Trust forecast for 2017/18, and the emerging draft plans for 2018/19.<br><br>It was noted that the Month 10 results were consistent with refreshed forecast and improvement plan. The Trust was working with the CCG to ensure all elements of 17/18 fixed income agreement were landed, and that no further disputes emerge. There was good progress to date.<br><br>The 2018/19 financial plan elements were being tested through detailed budget setting and contracting rounds. Planning assumptions remained valid, although cost pressures were under review by both the Trust Board and the NHSI FSM team to ensure only unavoidable ones were included.<br><br>It was noted that the 2018/19 CIP programme was progressing as per submitted plan, with pipeline of £11m schemes against £23.5m initial CIP target. The Committee reviewed progress of schemes as part of agreeing all components of plan for submission to Board and NHSI.<br><br>There is continued review within the Trust, and with system colleagues, of the support required for delivery of the CIP programme.<br><br>The Committee noted that Month 10 was aligned with forecast, with Trust at £47m deficit YTD. No new issues were emerging, and the Trust continued to forecast delivery of the £57.4m deficit. Technical measures were anticipated to impact M11 & M12. | |

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| | The Committee also noted the position on the contract reconciliation.<br><br>The report showed the top 10 schemes by value. Mr Stevens said it would be helpful to know what these savings represent. Mr Reid explained the approach set up by the Financial Improvement Director in that each scheme needs to be supported by detailed PID, which then goes through a sign off process. It had been agreed that there would be an additional sign off process by the Financial Improvement & Sustainability Committee (FISC), rather than just the divisional sign off.<br><br>**The Committee noted the FSM update and the work summarised within.** | |
| 036/18 | **Financial Planning for 2018/19**<br><br>Mr Reid presented the Committee with a paper summarising progress on the development of the Financial Plan for the Trust for 2018/19. This built on draft papers and the plan that were considered in December 2017 and January 2018.<br><br>It was noted that the national planning process required a draft plan to be submitted to NHSI on 8th March 2018, with a final plan to be agreed in April 2018. However, the Trust planning process was aimed at ensuring the Trust starts 2018/19 with a robust financial plan and agreed budgets.<br><br>The Committee noted the following key priorities:<br>• Review current planning assumptions and status of plan on behalf of Trust Board<br>• Consider progress on the Contract Income position for 2018/19<br>• Consider progress on the Cost Improvement Programme for 2018/19<br>• Review implications of new Control Total issued by NHS Improvement<br>• Note progress on the Capital Plan for 2018/19<br>• Agree next steps to finalise Trust Plan for 2018/19<br><br>Mr Reid presented the Committee with a bridge which showed the composition of the financial plan for 2018/19 and further detailed information relating to this.<br><br>In 2018/19, the Trust is taking a series of actions to improve the 2019/20 financial position. These will not impact on 2018/19 directly, but will strengthen the starting point for 2019/20 – moving the Trust closer to financial sustainability.<br><br>It was noted that the Trust had started to develop a three year financial plan, and the Committee reviewed the initial outputs. Further work was needed to move to the 'structural deficit' position and KPMG were providing support to the Director of Strategy. | |

The Trust had been issued with a new control total of £21,289m, reflecting the reduction in the CNST bill and building on the £36.4m control total issued in 2017/18.

The Trust has been offered STF of an increased value (£14.3m), which would deliver a deficit control total after STF of £7.1m.

Failure to agree the control total would mean that the Trust was at risk of moving into FSM and was not eligible for STF, neither of which were likely to impact in 2018/19. However, it was noted that the Trust was exempt from a series of fines and penalties as a result of being in the STF framework. It was noted this could have an impact on the financial position.

It was noted that the Trust should therefore engage in a two-fold strategy:

- to continue to press through the FSM process for a revision to the control total to allow access to the STF funding and entry into the STF regime.
- to explicitly engage with clinical commissioners to ensure that any fines and penalties which are levied are reinvested into the Trust to support the financial position.

Mr Reid reported that the team had been testing the assumptions in the original bridge through detailed budget setting. The team have been working with divisional leads. The Committee reviewed the cost pressures identified during financial planning.

The Committee noted the following next steps:

- The draft plan is for £47.7m deficit, significantly above the control total of £21m. An initial submission to NHSI is expected on 8th March 2018.

- The Trust is working closely with the CCG to agree an initial contract value for 2018/19. As at February, the contract value would mitigate the planned assumptions around loss of income for GP streaming and urgent care – however, the contract has not been signed. This does provide an opportunity for mitigation of CIP risk.

- The Trust is working to deliver the identified CIP opportunities, shown later in this report, but there is a significant risk of non-delivery as at February 2018. The target of £23.5m should be maintained, but the Committee may wish to note the risk of non-delivery – with potential mitigations of up to £5m, subject to agreeing the contract income for the year.

- Detailed budget-setting work continues at pace, and is in line with the agreed timetables. This will validate the baselines, and

the activity/workforce plans, providing the foundation for the CIP programme in year.

- As at February, it is therefore proposed to submit the plan as described, with the Chief Executive and Director of Finance having delegated authority to vary the CIP/Urgent Care lines as the contract negotiation progresses – as an initial submission to NHSI.

The Committee expressed a level of concern over whether the divisions would deliver their CIPs. Mr Reid reported that the team were still keeping the pressure on internally to get to £23.5m, however, a discussion followed on what mitigations could be applied against that. It was agreed that there was a strong process in place but the Committee did not feel assured that they could see the content.

Mr Reid presented with the Committee with an update on the Contract Income position. It was noted that as at February 2018, the Trust-CCG contract value was broadly aligned, with a difference in value between the CCG and the Contracts of around £8m - £3m on contract value and £5m on unrecognised QIPP. However, the Trust and the CCG were aligning towards a contract value of c£269.5m, with only one issue potentially being escalated, around the proposal for price changes made by the Trust.

The Committee discussed the assumptions around urgent care activity levels in some detail.

The Trust and the CCG have a regular contract negotiation process and timetable, with appropriate escalation to Chief Officers and Chief Executives over time.

The Committee noted the key differences in the plan at the end of February 2018.

The Trust had submitted a request for pricing corrections, and had also requested clarity on the reinvestment of MRET. As a result, and subject to QIPP outcomes and the CCG being able to sign the contract, the Trust will have achieved the planned level of income for 2018/19. The Committee noted that the local health economy financial position was challenging.

It was noted that the Trust had agreed that all contract issues would be resolved or escalated by end February, with meetings in place with CEO & Chief Officer to ensure agreement and appropriate escalation.

The Committee noted that the Trust Financial Improvement Director and Strategic Adviser were leading the development of the efficiency programme for 2018/19.

The programme was being developed through and with the Clinical

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| | Units and Corporate teams, rather than through centralised workstreams. Clinical Units and Corporate teams were having a weekly 'Confirm and Challenge' session with Mark Hackett and Nick Gerrard to develop the schemes, and support was provided outside the C&C meetings to develop the pipeline and overall programme.<br><br>It was noted that the Trust PMO had been reshaped, with a new Programme Support Office in place, led by Kirsty Watts from the Trust, and with Programme Support Officers placed with each team to assist in the development and delivery of schemes.<br><br>Oversight is provided through a weekly FIOG (Financial Improvement Oversight Group) chaired by the Director of Finance, and on a monthly FISC (Financial Improvement Sustainability Committee), chaired by the Chief Executive.<br><br>The Committee noted the progress in the development of the programme.<br><br>Mr Reid said he will consider putting in place some evidence to provide assurance around how the CIPs will be delivered during the year for the March Finance & Investment Committee.<br><br>**Action**<br>**The Committee noted the Business Planning paper** | |
| 037/18 | **ESBT/Alliance Executive Financial Plan 2017-18**<br><br>The Committee received a brief paper on the ESBT Alliance Executive Financial Plan for information.<br><br>It was noted that the Financial Planning for 2018/19 at a system level continues to develop through the Alliance Executive.<br><br>**Action**<br>**The Committee noted the update on the Alliance Executive Finance Plan.** | |
| 038/18 | **Sussex and East Surrey STP Financial Plans**<br><br>The Committee received an update on the STP Financial Planning Process for information.<br><br>This item was not discussed.<br><br>**Action**<br>**The Committee noted the ongoing work within the STP.** | |
| 039/18 | **Choice of Pathology Network**<br><br>Dr Joel Newman, Consultant Haematologist/Specialty Lead for | |

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| | Pathology, and Mr Rod Smith, Project Director, Sustainabilty, were welcomed to the meeting to present the paper on the choice of Pathology Network.<br><br>The papers were taken as read, and Dr Newman was invited to introduce the topic for discussion using a short Powerpoint Presentation.<br><br>Dr Newman introduced the topic, explaining the background to the Lord Carter initiative, and describing the progress that has already been achieved by the Trust resulting in improved efficiency and service quality. Committee members appreciated that the creation of 29 Networks was the next step of the Lord Carter initiative and it had been suggested that the Trust join Network 7, but Trusts had discretion to choose the most appropriate network. The Trust had, with agreement from all parties, explored the options to work with either Viapath or Frontier Pathology (with Frontier being the operationalisation of Network 7 in Sussex). Proposals from both organisations had been received and reviewed, and the outcome of this review was provided to the Committee.<br><br>The Committee discussed the proposals in detail, and noted the importance of establishing the right approach for both the Trust and the STP – the Trust would not wish to adversely impact the implementation of Network 7 which was developing within Sussex through its decisions.<br><br>The Committee supported the recommendation to choose the proposal received from Viapath. The next steps would be to inform NHSI and colleagues within Network 7 that the Trust was provisionally intended to join the Viapath network and that it would be working up the SLA contract arrangements quickly. However, the Committee noted that if terms were presented that were unacceptable, the Trust would withdraw from that decision.<br><br>It was agreed that Mr Smith and Dr Bull would follow up the implementation of this proposal and that Mr Smith, Dr Bull, Mr Newman and Mr Reid would meet with the Senior Executive Team of Viapath, at an early stage, as part of establishing the relationship and developing these proposals together.<br><br>Mr Newman and Mr Smith were thanked for the time they had put into this very important piece of work.<br><br>**Action**<br>**The Finance and Investment Committee supported the recommendation to choose the proposal received from Viapath, noted the requirement for a Board level decision choosing between two proposals by the end of February, and noted the next steps.** | **RS** |

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| 040/18 | **Energy Performance Contract**<br><br>Mr Reid reported that this business case will be presented to the March Finance & Investment Committee. It was noted that he had received a draft business case from the Estates Department; however the balance sheet proposition would need to be reviewed before this is presented to the Committee.<br><br>**Action**<br>**The Committee noted that this will be presented to the March Finance & Investment Committee.** | |
| 041/18 | **Fire Compartmentalisation**<br><br>Mr Reid reported that this Business Case would be presented to the Finance & Investment Committee in March.<br><br>**Action**<br>**The Committee noted that this business case would be presented to the Committee in March.** | |
| 042/18 | **2017/18 Work Programme**<br><br>The Committee received the 2017/18 work programme and a draft 2018/19 work programme.<br><br>**Action**<br>**The Work Programmes for 2017/18 and 2018/19 were noted.** | |
| 043/18 | **Minutes to note**<br><br>There were no minutes to note this month. | |
| 044/87 | **Date of Next Meeting**<br><br>The next meeting is scheduled to take place on Wednesday 27 March 2018 at 8.30am – 11.30am in St Mary's Board Room at Eastbourne DGH. | |

**EAST SUSSEX HEALTHCARE NHS TRUST**

**PEOPLE & ORGANISATIONAL DEVELOPMENT (POD) COMMITTEE**

**Minutes of the People & Organisational Development (POD) Committee meeting held on Wednesday 17th January 2018 15:00 – 17:00 John Cook Room, Post Grad Centre, EDGH with v/c to Chairman's Office, Conquest**

**Present:**
Mrs Miranda Kavanagh, Non-Executive Director (MK) – Chair
Dr Adrian Bull, Chief Executive (AB)
Mrs Dawn Urqhuart, Assistant Director HR, Education (DU)
Mrs Jackie Churchward-Cardiff, Non-Executive Director (JCC)
Mrs Jan Humber, Staff Side Chair (JH)
Mrs Joe Chadwick-Bell, Chief Operating Officer (JCB)
Mrs Lesley Houston, Deputy General Manager – Medicine (LH)
Mrs Lorraine Mason, Assistant Director of HR - OD (LM)
Mrs Lynette Wells, Director of Corporate Affairs (LW)
Mrs Moira Tenney, Deputy Director of HR (MT)
Ms Monica Green, Director of HR (MG)
Ms Vikki Carruth, Director of Nursing (VC)

**In Attendance:** Mrs Nicky Hughes, PA to Director of HR (NH) (minutes)

| No. | Item | Action |
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| 1) | **Welcome, introductions and apologies for absence**<br>The Chair welcomed all to the meeting and noted a quorum was present.<br><br>Apologies for absence were received from:<br>Dr David Walker, Medical Director<br>Mr Jamal Zaidi, Associate Medical Director – Workforce<br>Mrs Kim Novis, Equality & Human Rights Lead | |
| 2) | **2.1 Minutes of the last meeting held on 28th September 2017**<br>The minutes were reviewed and agreed as an accurate reflection of the meeting.<br><br>**2.2 Review of Action Tracker:**<br>The outstanding items on the Action Tracker were reviewed:<br><br><u>Annual Work Plan</u><br>MG reported that the Annual Work Plan had been circulated with the previous minutes for review. | |

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| | • Work plan to be amended in that Employee Relations Report to be changed to May and September 2018 agendas. (MT)<br>• Recruitment update to be added March 2018 agenda. (MT)<br>• New roles to be added to March 2018 agenda. (MT/DU)<br>• Retention Strategy to be added to May agenda. (LM)<br><br><u>Education Steering Group – Doctors Assistants</u><br>MT reported that Doctors Assistants within the Emergency Department would be included within the Workforce Plan 18/19.<br><br><u>Succession Planning/Talent Management update</u><br>To be discussed as Agenda Item within this meeting.<br><br><u>WRES 2016-17 – BME</u><br>MK reported that a conversation would be arranged with David Clayton-Smith prior to the next meeting to discuss the percentage of BME membership on the Board. MK to feedback at March 2018 meeting.<br><br><u>Medical Engagement</u><br>LM confirmed that robust arrangements had been put in place regarding medical engagement. Further update at July 2018 meeting. | **MK**<br><br>**LM** |
| **3)** | **HEE National Workforce Strategy**<br>MG provided an overview of 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 would be open until the end of March 2018 with the final strategy to be published in June/July 2018.<br><br>A comparison was made of data since 2012 up to the current time. Key issues highlighted were:<br>• The population had grown by 2.1m (4%) since 2012<br>• The population was ageing and the demand for healthcare increasing, in terms of numbers and complexity of need.<br>• 5k more nurses left the NHS other than for retirement in 2017 than 2012; if retention had remained the same there would be16k more nurses today<br>• 40k NHS clinical vacancies, 92% covered by Agency/Bank.<br><br>Plan for the future:<br>• 25% more clinical placements funded for future new nurses.<br>• Medical Student places to grow by 25%<br>• 4k people on clinical Return to Practice courses<br>• Without change the NHS would require 190k new staff by 2027. | |

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| | The draft strategy proposed six principles to make better workforce planning and policy decisions:<br>• Securing the supply of staff<br>• Training, educating and investing in the workforce<br>• Providing career pathways<br>• Widening participation in NHS jobs<br>• Ensuring the NHS are model modern employers<br>• Ensuring that in future service, financial and workforce planning are properly joined up.<br><br>JCC reported that the strategy does not refer to generic workers across health and social care, new roles, apprenticeships and funding for trainees.<br><br>MT referred to turnover of staff and suggested looking at the data of nurses transferring to other health providers. MT also stated the Trust should be looking at a longer term planning approach working on recruitment and retention of staff.<br><br>It was agreed that a response would be written to address points focussing on issues that would make a difference to ESHT. MG to write response and share with the Committee at the 14 March 2018 meeting. | **MG** |
| **4)** | **HR Incident Report**<br>MT provided an overview of the HR Incident Report and highlighted the key issues:<br>• All cases for 2015/16 and 2016/17 had been closed; some had been longstanding and difficult to resolve.<br>• The data presented fewer incidents to be investigated so far this year, although the estimate would suggest the same as last year by the end of the year<br>• 5 cases had gone to hearings, 5 dismissals had been reinstated on appeal, 4 gone to hearings with no case to answer.<br><br>For the future it was agreed to look at how investigations were being completed, the preparation as well as reviewing of cases. MT confirmed that when a case arises, a timetable would be set along with a plan of events. A nominated “keeping in touch” person would make contact every 3 to 4 weeks. This was an objective as part of work undertaken with NHS Elect.<br><br>It was noted that there were currently 3 ongoing employment tribunals. Discussions took place regarding safeguarding concerns and consequences for individuals and the Trust and settlement agreements for individuals. | |

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| | MT stated that the aim was to increase mediation within the trust as it was felt that staff would feel more engaged in the process. The grievance procedure had been reviewed to amend the language i.e. the procedure used words such as hearings and respondents; change to a more informal language. | |
| **5)** | **Review of "Well-Led" - CQC**<br>LW provided an overview of the "Well Led" document. The Trust would be assessed against 8 key lines of enquiry:<br>• Leadership capacity and capability<br>• Vision and strategy<br>• Culture of the organisation<br>• Governance and management<br>• Management of risk and performance<br>• Management of information<br>• Engagement and involvement<br>• Learning, improvement and innovation<br><br>Good progress had been made since the previous CQC visit, some areas identified were:<br>• The Trust had been able to identify a vast amount of data, particularly around innovation<br>• Experienced senior leadership team in place<br>• Developing new ways of working<br>• Speak Up Guardian in place<br>• Health and wellbeing for staff<br>• Training<br>• Refreshed ESHT 2020 document<br><br>MK referred to the weakness around the management of information and asked how this was being addressed. LW stated that it was the volume of information e.g. the volume of committee papers had been questioned; ongoing improvement work in place.<br><br>Challenges for the Trust; explanation required of each area and actions to be in place to address them:<br>• Staff shortages<br>• Trust financial and cash position<br>• Ageing estate and backlog maintenance<br>• Never Events<br>• Initiative overload<br><br>A discussion took place regarding communicating to staff about the positives/challenges of CQC requirements. LM stated that communication would be included within the Leadership Programmes and that she was working with the Communications lead and Director of Strategy for formal briefings to take place. | |

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| **6)** | **Succession Planning/Talent Management update**<br>LM provided an overview of the "Succession Planning and Talent Management" document. This was part of the "Well Led" domain; the CQC would be looking at the process as well as a succession plan in place at Board level.<br><br>LM stated that ESHT require a Talent Management process in place that would be consistent and available to all staff. This would be linked into the appraisal process assessing both performance and potential. Discussions had been undertaken with other Trusts and ESHT were looking at a tool to be used as a pilot within the divisions; pilot to be in place by the end of March 2018.<br><br>AB referred to a discussion that had taken place at the BME Network whereby it was noted that talent management seemed to refer to a small group of talented people but felt that the Trust should be referring to the management and development of all staff.<br><br>A further discussion took place regarding succession planning within the divisions. It was agreed that the Executive team would review and agree critical roles within the Trust.<br><br>JCC stated that the Trust should also recognise the need for the employment of external people. | |
| **7)** | **Items for information:**<br>Feedback from sub-groups:<br><br><u>7.1 – Engagement & OD Group</u><br>Item noted.<br><br><u>7.2 Education Steering Group</u><br>It was noted that an Education Steering Group meeting had not been held; update at next meeting.<br><br>DU reported that she had attended the 2nd Educators Forum Group, which had been excellently facilitated, key priorities:<br>• More robust communication – pathway of communication externally for college students<br>• Educational Governance – how we collate information and deliver in a meaningful way.<br><br><u>7.3 – Workforce Resourcing Group</u><br>JCC referred to the vacancy rates on page 3 of the report and queried Scientific Therapeutic and Technical and Additional Clinical Services rates that seemed to be higher within these 2 groups. JCC asked if targeted actions were in place. AB referred to the Scientific Therapeutic and Technical group and stated that this was a very | |

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| | challenged area and discussions had been undertaken regarding training opportunities. MT referred to Additional Clinical Services and stated that this group was impacted by some of the ESBT work; mainly Health Care Assistants and Community Support Workers.<br><br>A discussion took place regarding budgets and vacancies within the divisions. It was noted that the Estates division do not have a budget to cover sickness and annual leave so therefore they do not recruit to some of their vacancies. MT reported that future planning would involve gaining a clearer picture of vacancies and re-sizing of budgets. The Strategic Workforce Group was being reviewed in terms of function and remit to include specific sub-groups to aid the delivery of the Strategic Plan.<br><br><u>7.4 – HR Quality & Standards Group</u><br>Item noted. | |
| **8)** | **Any other business**<br><u>Workforce Challenges</u><br>VC referred to workforce challenges and work to be undertaken in terms of grip and control and rostering.<br><br>It was noted that this would link in with the work around Safer Staffing Rates; an agenda item for 14 March 2018 meeting. | |
| **9)** | **The next meeting of the Committee will take place on:**<br><br>**Wednesday 14th March 2018**<br>**15:00 – 17:00**<br>**St Mary's Boardroom, EDGH** | |

East Sussex Healthcare NHS
NHS Trust

**Minutes of the Quality and Safety Committee Meeting**

**Wednesday 24 January 2018**
**Room 2 Ed Centre, CQ vc to John Cook Room, EDGH**

Present:
Sue Bernhauser, Non-Executive Director - Chair
Jackie Churchward-Cardiff, Non- Executive Director
David Walker, Medical Director
Vikki Carruth, Director of Nursing
Lynette Wells, Executive Director, Corporate Affairs
Ashley Parrott, Associate Director of Governance
Catherine Ashton, Director of Strategy, Innovation and Planning
Korron Spence, Hospital Director (for Joe Chadwick-Bell)

In attendance:
Paul Young, Associate Director, Strategy, Improvement and Planning
Sue Lyne, Frailty Practitioner
Sharon Ball, Service Manager, Ophthalmology
Hazel Tonge, Deputy Director of Nursing
Jo Shayler, Clinical Service Manager, Maternity
Lisa Flindall, Matron, Folkington Ward, EDGH
Jo Byers, Sister, Folkington Ward, EDGH
Emma Tate, Head of Clinical Improvement
Strategy Improvement and Planning

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
Sarah Wilmer, Acting Assistant Director of Nursing, Medicine

It was noted that the Terms of Reference had been reviewed and that due to agenda length future meetings would be extended to two and a half hours.

## 2.0 Patient Story

Sue Lyne – presented a patient story which demonstrated End of Life Care being delivered in a positive and effective way.

The story involved ‘Den’, 90 years old, who had chronic renal failure and was cared for, at home, by his wife who had a diagnosis of Dementia. Den had experienced increasing episodes of falling. He had recognised that he was in the End of Life phase and had declined dialysis, but continuing hospital appointments and reviews had proved confusing to him and his family.

The frailty service had completed a comprehensive geriatric assessment and an action plan had been put in place.
The success of the intervention was that the patient received the right care, from the right professionals at the right time. Den had been cared for at home and died at home, peacefully and with dignity, with all his care needs met. A plaudit had been received from Den's daughter – paying tribute to the service and the social care professionals who had been involved.

The story illustrated the importance of recognizing frailty in older people and being responsive at End of Life. A key worker, and a single point of contact was important and work was ongoing to achieve this.

The Committee commended the engagement of the team and the development of the frailty nurse service.

**3.1 Minutes of the Previous Meeting**

The minutes of the 22 November 2017 meeting were approved.

**3.2 Matters Arising**

**Action Log**

**QSC 73** – Radiology – plain film backlog. A verbal update was on the agenda. See Action 111. Action closed.

**QSC 87** – Deep Dive – Pressure Ulcers – Item on the agenda. Action closed.

**QSC 90** - Joe Chadwick-Bell to review the wording of the risks relating to the Divisions. Joe to be asked for wording suggestion. Vikki Carruth and Lynette Wells to follow up. Action remained open.

**QSC 97 -** Ashley Parrott to discuss assurance around the investigation of incidents (Action 2A) with Urgent Care. It was reported that closing the loop reports demonstrated a reasonable assurance of actions being done. Jackie Churchward-Cardiff questioned whether the system in place was robust. Ashley Parrott said that sessions were being arranged for colleagues on each site to work out the challenges to ownership of actions resulting from the reporting of incidents. Urgent Care was not seen as a specific outlier – other Divisions experienced similar challenges. There had been a system change that had shown some improvement, but not enough yet to assure the Board. Ashley Parrott would follow up with Urgent Care to check that the 'Must Dos' and 'Should Dos' that had been identified had been done and to report back to the next meeting. Action remained open.

**QSC 100 -** Ashley Parrott to include an update on follow up of abnormal investigation reports in the next Clinical Governance Report in November 2017. Specification written by Ashley Parrott and shared with David Walker who was taking this forward with Justin Harris. Action closed.

**QSC 101 –** Joe Chadwick-Bell to confirm accountability/responsibility for the Joint Community Rehabilitation Service. Ashley Parrott reported that CQC registration is with

Adult Social Care and reporting of incidents was now going through the ASC system. Action closed.

**QSC 102** – Vikki Carruth and David Walker to discuss the way forward for Ophthalmology with Adrian Bull. David Walker and Sue Bernhauser agreed that this action was in fact to invite the team to attend the QSC meeting to update on actions being taken. Item on the agenda. Action closed.

**QSC 103 -** Item on the agenda. Action closed.

**QSC 104 –** Ashley Parrott to discuss with Jonathan Reid how to resolve the capture of the risk. Risk reworded as requested. Action closed.

**QSC 105 –** Sarah Blanchard-Stow to provide an update on CTG monitoring at the next meeting in January 2018. Item on the agenda. Action closed.

**QSC 106 -** Jo Brandt to be invited to the membership of the Patient Safety and Quality Group**.** Ashley Parrott reported that the Terms of Reference had been updated to include a Senior Finance Team member. Action closed.

**QSC 107 -** Ashley Parrott to arrange for the score of Risk 1660 – Cyber Attack to be amended to 15. Ashley Parrott confirmed the amendment of the risk to 15. Action closed.

**QSC 108 –** Ashley Parrott to ensure presentation and the example of work being done on Folkington Ward is presented at the next meeting in January 2018. Item on the agenda. Action closed.

**QSC 109** - Ashley Parrott to investigate the reason for the higher rate of complaints against activity in the Women and Children Division and update to the next meeting. Ashley Parrott reported that numbers were steady and related mainly to the gynaecology service. A better breakdown would be done for the next meeting then Division to respond. Action remained open.

**QSC 110 -** Vikki Carruth to update on the validity of 'night move' data at the next meeting. Vikki Carruth reported that there was a lack of assurance that the information on the Patient Administration System was in real time. Ward clerks updated the systems in the mornings leading to moves appearing to have been at night. Vikki was due to attend the next Ward Clerks' meeting to discuss this. Vikki Carruth to follow up with Sarah Goldsack (Knowledge Management) and update the next meeting. Action remained open.

**QSC 111 –** Justin Harris to be asked to provide data on the latest plain film backlog figures and improvement trajectory. Item on the agenda. Justin Harris updated the meeting as follows:

- A significant proportion of the total backlog were unreported clinic films which were on the risk register. An agreement had been made previously with referring clinicians to review these films in clinic.
- Original 5 year (Jan 2012 to Dec 2016) search performed at the beginning of 2017 revealed around 172,000 unreported studies. Around 50,000 were studies that should be auto reported such as obstetric ultrasound. Those in 2012 - 2013 were on the old Agfa PACS system and were being investigated separately by Dr Harris.

This part of the 5 year audit had been very time consuming as it involved searching multiple databases for report data. The priorities were cxr and abdo plain films, mammography, CT and MRI. So far a large majority had been found to be reported but reports were not on the current PACS system.

- The unreported studies on the new PACS system which started in Sept 2013 had proved easier to trace. PACS IT had been instructed to perform a full search of all studies listed as unreported from Sept 2013 to Dec 2017. This data would be available before the end of the month for interrogation.

It was noted that the scale of the backlog needed to be confirmed

**Action – Justin Harris to present a position paper at a modified, extraordinary meeting of the Quality and Safety Committee in February.**

**QSC 112 -** Results of CQC IRMER Report to be presented to a future meeting. Lynette Wells reported that a letter (as opposed to a report) had been sent. The CQC had been happy with the progress being made and would not be revisiting. Action closed.

**QSC 113 -** Action plan to be emailed out by Karen Salt when available. No update – Karen Salt to follow up. Action remained open.

**Compliance and Risk**

**4.1 – Patient Safety and Quality – Board Assurance Framework**

Lynette Wells presented the report which was taken as read. There were no additions, deletions or changes to gradings. One area (Finance) was scoring red and a risk to the organisation. It was noted that prioritisinjg and delay to payments was causing issues for suppliers. There was also an ongoing dispute with the CCG over income.

**Action – Vikki Carruth to formally escalate to Jonathan Reid, Director of Finance, concerns from the Committee regarding the impact of finance issues on quality in the organisation.**

**4.2 – Patient Safety and Quality – High Level Risk Register**

Ashley Parrott presented the report which was taken as read.

In response to a question from Jackie Churchward-Cardiff JCC it was noted that Ophthalmology, as a service, was on the risk register.

Further points were noted as follows:
Risk 1642 – Management of the Trust when it is at Full Capacity – had not been updated despite two requests (Oct 17 and Jan 18). Korron Spence confirmed that the Full Capacity Protocol had been uploaded to the Extranet. Vikki Carruth suggested that more input was needed as clinical escalation/de-escalation process and exclusion/inclusion criteria had not been included. It was noted that a risk assessment had been done at EDGH.

**Action – Korron Spence to share Risk Assessment conducted at EDGH.**

**Action – Korron Spence to arrange to update the risk register.**

**4.3 – CQC Progress Report – December 2017**

Lynette Wells presented the report which was taken as read. The Trust had since been advised that the next inspection would be announced and take place on 6/7 March. This would be a core service review and would cover Medicine; Surgery; Urgent Care; Maternity Conquest;
Out Patients' Department EDGH and would include community services. End of Life Care was not expected to be covered specifically but as part of the Medicine Review.

The 'Well Led' inspection would take place on 21 and 22 March 2017 and would include the use of resources.

The CQC Preparation Group was meeting regularly and Alan Thorne, Improvement Director, was looking at various areas of the Trust – feedback had been positive with some examples of outstanding practice being seen.

**4.4 – ESHT 2020 Improvement Programme (including notes of QISG)**

This item was withdrawn from the agenda following consideration at the Quality Improvement Steering Group where it had been identified that some changes to the governance reporting process were needed.

**4.5 – Improvement Group Exception Report**

Catherine Ashton presented the report which was taken as read. The Improvement Matrix showed a significant number of pieces of work (over 70) were classified as improvement work.

**Safety and Quality**

**5.1 – Governance Quality Report (including PSQG Report)**

Ashley Parrott presented the report which was taken as read. It was noted that a series of breakfast meetings was being planned to address some of the challenges around The key achievements, progress and challenges were noted and the following highlighted:

- A series of breakfast meetings was planned to address issues around ownership of actions from Serious and Amber incidents within the Divisions.
- Ophthalmology and Gynaecology were flagging with issues and challenges.

There was a discussion about how to manage services where there were significant issues. It was noted that gynaecology and ophthalmology had some of the longer waiting lists.

**Action – Vikki Carruth to arrange for a discussion at the Executive Directors' meeting about how to manage/escalate troubled services.**

**5.2 – Quality and Safety Strategy Progress Report**

The report was taken as read with no questions arising.

**5.3 – Excellence in Care – Early Adopters' Report**

Lisa Flindall, Matron and Jo Byers, Sister of Folkington Ward joined the meeting for this agenda item.

Ashley Parrott presented the Excellence in Care programme which aimed to reduce variation in reporting and in standards on wards.
Folkington Ward had volunteered to pilot the Quality and Safety Work Stream. Leadership and Culture would follow in January/February 2018 and the aim was to roll Excellence in Care out to 6 more wards in March 2018. It was noted that the indicators had been developed by the ward based on what the team had considered to be important. Results were available quickly and drivers could be changed/amended as necessary.

Folkington Ward had spent some time helping other wards – sharing experience and best practice with a multi-disciplinary approach.

Lisa Flindall explained that the whole team had engaged and had ownership of the programme which aimed to support wards with improvement work and provide evidence of success. A staff survey relating to Leadership had been conducted and would be used as a tool going forward with an annual survey being planned.

The Committee noted the presentation and commended the work on the programme.

**5.4 – Quality Section of the Integrated Performance Report Month 8**

The Committee noted the report with no questions arising.

**5.5 – Quality Account – High Level Timeline for Production**

The Committee noted the report with no questions arising.

**5.6 – CTG Monitoring Report**

The Committee noted the report. It was agreed that detail of dates and timescales were needed along with evidence of a clear plan.

**Action – Sarah Blanchard-Stow to update the report to provide further information on actions and timescales for CTG monitoring.**

**5.7 – Quality Walk Round Feedback (Non-Executive) – verbal**

Due to time constraints this item was not presented.

**5.8 – Ophthalmology Update**

Sharon Ball presented the report noting that the service had experienced significant changes and challenges in the past 8 months. There had also been a Never Event in 17/18. Key points were noted as follows:

- The existing and new follow up backlog was being addressed with external support which had started in December 2017 and would continue until March 2018.
- A plan was in place to address existing follow up appointments.
- The current new patient wait time was 21 weeks – but expected to reduce to 11 weeks by the end of March 2018.
- New to follow up ratio was 1:6 and this was on the risk register. 2383 patients should have had an appointment and were still waiting. The 18 Week Support Company would only be able to address some of these.
- The main areas with capacity issues were glaucoma and AMD, both conditions that could impact on sight. A business case for more AMD consultants was being developed
- A Get It Right First Time visit was taking place on 12 March 2018.
- A meeting was taking place on 24 January to look at different ways of working.

David Walker highlighted that the depletion of administrative support was one of the reasons for the issues being experienced, in particular in the AMD service. Two Serious Incidents had resulted from patients not being seen in a timely manner.

**Action – Business case for additional consultants to be presented to Executive Directors' meeting as soon as possible and before the end of the financial year.**

**Action – Sharon Ball to advise Vikki Carruth and David Walker what support was needed following the meeting due to take place on the evening of 24 Jan 18.**

**Action – Ashley Parrott to meet with Sharon Ball to link the two risks.**

**6.0 - Deep Dive – Pressure Ulcers**

The Deep Dive was taken as read and the improvements noted.

**7.0 – Papers for noting**

There were no papers for noting.

**8.0 – Deep Dive for next meeting**

**9.0 - AOB**

**Director of Infection Prevention and Control –** It was noted that Vikki Carruth would take on the role of Director of Infection Prevention and Control. Umer Shanker had agreed take the Lead Microbiologist role. David Walker and Vikki Carruth were working to support the team.

**HSDU** – Vikki Carruth reported that Estates and Facilities colleagues had been asked to submit a plan to address environmental issues in HSDU. The team was working in difficult conditions and colleagues were not being kept informed of timescales for resolution.

# Use of Trust Seal

| Meeting information: | | | |
|---|---|---|---|
| Date of Meeting: | 17th April 2018 | Agenda Item: | 20 |
| 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.

**7th March 2018** – Lease Agreement with Overnmill Limited relating to 1066 Bakery and Café at the Conquest Hospital.

**7th March 2018** – Deed of Agreement with Overnmill Limited relating to 1066 Bakery and Café at the Conquest Hospital.

### 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.