EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 5th June 2018, commencing at 09:30 in St Mary's Boardroom, EDGH

	AGENDA		Lead:	Time:
1.	1.1 Chair's opening remarks 1.2 Apologies for absence 1.3 Monthly award winner(s)		Chair	0930 - 1015
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 17th April 2018	A		
4.	Matters arising	B		
5	Quality Walks Board Feedback	C	Chair	
6	Board Committee Feedback • Audit Committee Annual Report • Q&S Committee Annual Report	D	Comm Chairs	
7	Board Assurance Framework	E	DCA	
8	Chief Executive's Report	F	CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
9	Integrated Performance Report Month 1 (April) 1. Quality & Safety 2. Access & Responsiveness 3. Sustainability 4. Leadership & Culture	Assurance	G	DN/MD COO HRD	1015 - 1100
	BREAK				1100 - 1115
10	Learning From Deaths (Quarter 3)	Assurance	H	MD	1115 - 1125
11	Quality Improvement Priorities 2018/19	Approval	I	DN	

STRATEGY

					Time:
12	ESBT Update	Assurance	J	DS	1125 - 1130

GOVERNANCE AND ASSURANCE

					Time:
13	Six month update on EPRR Standards	Assurance	K	COO	1130 - 1200
14	CNST maternity incentive scheme	Approval	L	DN	
15	Delegation of approval of Quality Account 2017/18	Assurance		DCA	
16	Health and Safety at Work Policy	Assurance	M	DN	
17	Board sub-committee minutes: 17.1 Audit Committee 17.2 Finance & Investment Committee 17.3 POD Committee	Assurance	N	Comm Chairs	

ITEMS FOR INFORMATION

				Time:
18	Use of Trust Seal	O	Chair	1200 - 1215
19	Questions from members of the public (15 minutes maximum)		Chair	
20	Date of Next Meeting & AGM: Tuesday 7th August 2018, St Mary's Boardroom, EDGH		Chair	

David Clayton-Smith

David Clayton-Smith

Chairman

18th April 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, 17th April 2018 at 09:30 in the St Mark's Church Hall, Little Common.

Present:
Mr David Clayton-Smith, Chairman
Mr Barry Nealon, Vice Chairman
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Mrs Miranda Kavanagh, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Dr Adrian Bull, Chief Executive
Ms Vikki Carruth, Director of Nursing
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:
Miss Jan Humber, Joint Staff Committee Chairman
Mrs Ruth Agg, Speak Up Guardian (for item 023/2018 only)
Mr Christopher Langley (NHSI- Financial Improvement Director)
Mrs Angela Ambler (observing)
Mr Pete Palmer, Assistant Company Secretary (minutes)

019/2018 **Welcome**

1. Chair's Opening Remarks
Mr Clayton-Smith welcomed everyone to the meeting of the Trust Board held in public. He particularly welcomed Eileen Hardwick, introduced Angela Ambler, part of the NExT Director scheme which supported prospective non-executive directors, and Christopher Langley, working with the Trust as Financial Improvement Director.

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

Ms Catherine Ashton, Director of Strategy
Mrs Sue Bernhauser, Non-Executive Director

3. Monthly Award Winners
Mr Clayton-Smith reported that the monthly award winner for January had been Sara Parham, Deputy Lead Practitioner in Theatres at the Conquest. February's winner was Penny Nicholls, Physiotherapist at Amberstone outpatient physiotherapy department who attended the Board to receive her prize. March's winners were Specialist Nurse Liz Lipsham and the flu team.

020/2018 **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.

021/2018 **Minutes**
The minutes of the Trust Board meeting held on 6th February 2018 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.

022/2018 **Matters Arising**
010/2018 – IPR Month 9 - Leadership & Culture
Miss Green confirmed that an update on plans to improve appraisal rates had been presented to the People and Organisational Development (POD) Committee on 14th March 2018. She reported that in the future pay awards would be linked to the appraisal process, noting the importance to the development and wellbeing of staff in ensuring that appraisals took place regardless of any pay implications.

Mrs Kavanagh noted that the Trust's appraisal performance in comparison to other Trusts was good, and that the staff survey had provided positive evidence about the quality of appraisals being carried out. Dr Bull explained that appraisal figures reflected the number of staff being appraised within twelve months of their previous appraisal and emphasised that the majority of staff received appraisals.

023/2018 **Speak Up Guardian's Report**
Mrs Agg reported that the Trust had undertaken work to develop a culture where staff felt safe in coming forward to raise concerns, where their concerns were listened to and where appropriate action was taken. Recent staff surveys had provided evidence that this work had been successful. Mrs Agg thanked the Board for their support for the Speak Up Guardian role, noting that she continued to hold regular meetings with Dr Bull.

She reported that she continued to work to ensure that the Trust values were well known and understood by staff. Low risk incidents were reviewed with feedback given to staff, difficult behaviours were managed and incidents of violence and aggression reviewed.

Mrs Agg reported that Freedom to Speak Up ambassadors would be introduced into the organisation, offering staff a variety of pathways for raising concerns.

A new Freedom to Speak Up job description had been introduced, and this would be reviewed with Dr Bull. A number of recommendations had emerged following national reviews, and benchmarking against these was being undertaken. The Trust were already compliant in a number of aspects and would work towards full compliance with the recommendations.

Mr Clayton-Smith asked how Mrs Agg's role had changed during her time in the role. Mrs Agg explained that she felt that staff had greater confidence in her ability to resolve issues by working alongside staff and leaders. Dr Bull noted that the Speak Up Guardian role combined being outside of the management hierarchy who people could approach with issues, with being a champion for a

culture of openness and being able to speak up. Miss Green noted the importance of encouraging staff to raise their concerns.

Mrs Churchward-Cardiff asked whether any specific issues had led to the increase in reporting in quarter four of 2017/18. Mrs Agg explained that she felt that winter pressures and the resulting movement of staff had led to the increase and that discussions had taken about place about how the organisation could better manage pressure, communication and the feelings of staff during these periods.

Mr Stevens noted that only 50% of staff felt able to make a complaint and asked if more could be done to raise confidence. Mrs Agg explained that this level was above the national average, but that work would continue and data from the staff survey would be reviewed to identify areas of focus. She explained that information about the Speak Up Guardian was incorporated into staff mandatory training and inductions to raise awareness of the various routes for raising concerns.

024/2018 **Quality Walks**

Miss Green reported that she had recently visited the Health Records team at Apex Way. She explained that the team had been through a difficult time during the previous couple of years, and she had been very encouraged to see the way that they were now manged, with very effective systems in place. Electronic scanning was working well, and staff felt that they were involved, were well supported by mangers and received good communication.

She reported that she had also visited the Jubilee Eye Suite at EDGH. This was a very busy area and she had been very encouraged by the patient information that had been available, ensuring patients knew exactly what to expect when they came in for an operation. Miss Green explained that she had been very impressed by the matron on the ward, who communicated well with her team, and really understood the financial and operational aspects of her department.

She had also visited Hailsham 3 at EDGH, a ward where matron's assistants and clinical orderlies had been introduced. She explained that the ward provided an outstanding example of an area identifying new roles that were needed in order to support innovative ways of working.

025/2018 **Board Committees' Feedback**

1. Audit Committee

Mr Stevens reported that Internal Audit provided the Audit Committee with assurance about working practices within the Trust. The Trust regularly asked the auditors to look at areas which were known to be problematic, reflected in the fact that four reports had recently been issued with three providing limited assurance.

Mr Clayton-Smith asked whether there were common themes between the three limited assurances that had been received. Mr Stevens explained that as the audits had reviewed very different areas there had been little commonality.

Mr Reid praised the quality of Internal Audit that was carried out, and confirmed that auditors were directed towards areas which were seen as high risk. He

explained that doing this helped the organisation to continually improve by identifying issues that needed to be resolved.

2. Finance and Investment Committee

Mr Nealon updated that the Finance and Investment (F&I) Committee had recently focussed on year end outturns and budgets. He reported that the Trust's deficit for 2017/18 would be £57.4m, £20m adrift of the control total set at the start of the year. The Committee had reviewed plans for 2018/19 in detail, culminating in a very successful seminar where divisional business plans for 2018/19 were presented to the Board.

He explained that the Trust's ambition was to identify Cost Improvement Programmes (CIPs) totalling £28m, and deliver a minimum of £23m of these CIPs. £12m of deliverable CIPs had already been identified and work continued to identify additional CIPs. The target of £28m CIPs was challenging and it was important that a realistic control total and budget for 2018/19 was agreed.

Mr Nealon reported that a £47.8m deficit had been approved by the Board for 2018/19, with an aspiration to exceed this. He praised the support that divisions had shown for plans and the tremendous energy for improvement that was evident within the organisation.

Mr Langley added that a formal meeting had taken place between the Trust and NHSI the previous week. Helpful conversations had taken place, and the Trust had set out an ambition to reach £23m CIPs by the end of May. He asked whether Mr Nealon thought that this was achievable. Mr Nealon replied that he was not assured that £23m of CIPs would be identified. He felt that a deficit of £48m was a deliverable budget, but that doing so would rely on CIPs delivering within identified timescales.

Mr Reid explained that the budget had been discussed in detail at the previous week's Board Seminar and it had been agreed that the target of £23m of CIPs was ambitious but a lot of work was being undertaken to support identification and delivery of savings. An update would be provided to the F&I Committee the following week where assurance levels about identified CIPs would be retested.

3. People and Organisational Development Committee

Mrs Kavanagh reported that the POD Committee was now meeting on a bi-monthly basis, and felt that this allowed items to be looked at in more depth than had previously been possible. The draft health and workforce strategy had been approved and would be uploaded to the Trust's website.

She reported that the role of physician associates had been discussed by the Committee and Miss Green confirmed that these roles would be introduced to the Trust.

4. Quality and Safety Committee

Mrs Churchward-Cardiff reported that the Quality and Safety (Q&S) Committee had clear sight on quality development within the organisation and understood where issues existed. She explained that work needed to be undertaken to ensure that actions identified following incidents were appropriately followed up, noting the work being undertaken by the governance teams to provide evidence of these processes.

She reported that the Trust's complaints processes had improved hugely during the previous couple of years. She explained that work was being undertaken to prevent Never Events and was reassured that plans have been developed for areas where there had been issues.

Ms Carruth noted that actions following incidents were regularly completed, but that the recording of these actions could be poor. She explained that detailed investigations were undertaken following never events, and learning from these was shared across the organisation.

The Board noted the Committee Reports.

026/2018 **Board Assurance Framework**

Mrs Wells reported that 16 gaps in assurance were highlighted on the Board Assurance Framework (BAF). The BAF had been reviewed in detail by both the Q&S and Audit Committees who had proposed that four gaps should be removed as they had entered business as usual and considerable assurance about progress was available

Emergency Department Reconfiguration

Mrs Chadwick-Bell explained that a number of actions, including primary care streaming and the development of ambulatory care units, had been undertaken. Sustained improvements in A&E performance reflected the success of the changes that had been introduced.

The Board approved the removal of Emergency Department Reconfiguration from the BAF

Patient Flow

Mrs Chadwick-Bell explained that patient flow would continue to be effected by winter pressures and summer peaks, but felt that appropriate processes were in place to measure and monitor these fluctuations. Improving patient flow remained a key priority for the organisation, but it no longer needed to be included on the BAF.

Dr Bull added that patient flow was a key risk for the organisation and that a significant number of plans for the upcoming year were dependant on achieving patient flow targets. He felt that while appropriate controls had been introduced, more work needed to be done and asked whether the issue should remain on the BAF.

Mr Clayton-Smith noted that the wording of the risk on the BAF was specifically about the introduction of robust controls for patient flow. Executives were very assured that these controls had been introduced. He reported that the BAF was due to be reviewed by the Board during July's Board Seminar, and consideration could be given about whether a risk about capacity and management of downsizing should be added to the BAF.

The Board approved the removal of Patient Flow from the BAF

Mandatory Training

Miss Green reported that improvements in mandatory training rates had been sustained and that compliance and performance was regularly monitored via divisional IPRs and by the POD Committee.

The Board approved the removal of Mandatory Training from the BAF

Clinical Leadership
Dr Walker explained that a major Clinical Leadership training programme had been introduced, Clinical Leadership had been refreshed, and he was assured about the progress that was being made. A recent Medical Engagement Survey for leaders had produced extremely positive results and Dr Walker felt that the Trust now had motivated and effective clinical leadership.
The Board approved the removal of Clinical Leadership from the BAF

Mrs Churchward-Cardiff asked for an update concerning assessment of young people with mental health and deliberate self-harm diagnoses. She noted that this was not an issue that the Trust was able to solve alone, explaining that she was concerned that March's update did not provide sufficient assurance about the response being offered by the system. Dr Bull reported that Sussex Partnership Foundation Trust had recognised the issue and were developing a business case to address the issues of resources and capacity.

Mr Clayton-Smith explained that further discussions would take place during the upcoming Board Seminar about risks, and particularly about how the Trust would receive assurance for risks that were controlled by partner organisations that the Trust could not resolve.

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.

027/2018 **Chief Executive's Report**
Dr Bull reported that the Trust had recently been inspected by the CQC and had received brief, high level and encouraging informal feedback. The lead inspector had remarked that the Trust was on or ahead of its trajectory to reach outstanding by 2020. Dr Bull explained that the CQC had clarified that they would be very clear if they were recommending that the Trust should come out of quality special measures, but that the Trust would remain in special measures for financial reasons. A draft report was expected in May, with publication in June.

The Trust's NHS staff survey results had been received which provided a key insight into how staff felt about the organisation at the end of 2017. The results in 2016 had showed that Trust was one of the most improved in the country. 2017's survey had seen improved response rates from staff, and performance had been maintained with a number of areas of improvement and no areas which had deteriorated. Dr Bull explained that the result was encouraging and that review at service level was being undertaken and an action plan would be developed in response to the findings.

The financial outturn for 2017/18 was disappointing, but had led to the Trust having greater clarification and understanding of the underlying financial position of the organisation. The Trust remained committed to its three year plan to reach financial sustainability and Dr Bull felt that measures introduced during the previous year would provide the foundations for improvement in the future.

Mr Clayton-Smith noted that recent consultant interviews had been very positive, highlighting the benefit of the Trust's improving reputation. Miss Green reported that consultant vacancy levels had reduced form 14% to 5%

and anticipated that this would lead to a reduction in locum costs.

028/2018 **QUALITY, SAFETY AND PERFORMANCE**

Integrated Performance Report Month 11 (February)

Access and Responsiveness
Mrs Chadwick-Bell reported that four hour performance in February had been 86.8% in February, maintaining the performance seen in December and January. This represented an improvement in performance of 10% compared to the previous year despite increased attendances. System wide performance, including that of walk-in centres, had been 90% during February.

Attendances to A&E during February had increased by 8.8% on the previous year and work was being undertaken to fully understand this increase as it was greater than in other regions. The average length of stay had reduced by 1.5 days compared to the previous year.

March had seen 140 admissions requiring isolation as a result of flu compared to 10 the previous year. Ambulance handover times had reduced significantly, but remained challenging at EDGH. Primary care streaming had been started but additional work was still required with further recruitment of GPs being undertaken in order to increase the number of hours offered by the service.

Referral to Treatment performance had been sustained at 90%, and while this was below the target of 92% performance was good in comparison to other Trusts. A significant decrease in delayed transfers of care from 7.6% in February 2017 to 2% in February 2018 had been realised, making the Trust a positive national outlier. The Trust would be focussing on improving stranded patient performance as there was a direct correlation between this and four hour performance.

Mrs Chadwick-Bell reported that while diagnostic performance had improved to 1.4% in March, it was still above the 1% target. Work had been commissioned to look at diagnostic capacity and demand in order to fully understand issues that existed. Achieving diagnostic improvements would positively impact on pathways throughout the organisation.

Cancer performance remained a key priority for the Trust and had improved from 65% in January to 78% in March. Short and medium term recovery plans had been commenced. Mrs Chadwick-Bell explained that she reviewed every cancer breach, sharing learning with Cancer Consultants and Clinical Nurse Specialists. She explained that she was confident that the position would be recovered over the next few months.

Mr Clayton-Smith asked about the effect that admission avoidance teams had had on referrals. Mrs Chadwick-Bell explained that since being established a year before, processes had been improved and the team now also supported the discharge to assess program. She agreed to include data about admission avoidance in the next IPR. **JCB**

Ms Kavanagh asked whether detailed information about 62 day breaches would be provided to the Board and Mrs Chadwick-Bell agreed that this should **JCB**

be added to the Q&S Committee agenda as a standing item to ensure appropriate scrutiny.

Mrs Churchward-Cardiff noted that two week wait referrals had increased by 6%, and asked about the reasons for the increase. Mrs Chadwick-Bell explained that while GPs were referring greater numbers of patients, the percentage identified as having cancer was reducing. The CCG were addressing the issue.

Mrs Churchward-Cardiff asked about readmission rates for patients seen by crisis response teams. The data showed that 92% of patients were discharged to a home destination with 27% being readmitted within 30 days. Mrs Chadwick-Bell agreed to verify if the data was correct, explaining that it was a concern if so. **JCB**

Ms Carruth noted the importance of closely monitoring increases in work for community nurses; discussions about this had been held with the division during IPR meetings. Staff were managing the increased work by ensuring that robust processes were in place and managers were being very supportive of staff. Mrs Chadwick-Bell added that a review of activity was being undertaken to identify activity that wasn't contracted.

<u>Quality & Safety</u>
Ms Carruth noted that she was very encouraged by the continued reduction in falls within the organisation. At the end of 2017/18 the Trust was under the limit for c. diff infections with no lapses in care leading to a c. diff infection identified since August 2017. Zero preventable MRSA infections had been reported. Pressure ulcer rates were being maintained and a deep dive on grade 2 ulcers was being undertaken.

She reported that work was being undertaken to provide support to divisions in closing the loop on Serious Incidents. The Emergency Departments were working to improve response rates to Friends and Family testing with staff being encouraged to seek feedback from patients. She explained that there was no nationally agreed benchmark for response rates.

Issues with discharge from the Trust had been raised within the results of the National Inpatient Survey and a Task and Finish group would be formed to look improving discharge, reporting into the Q&S Committee.

Ms Carruth explained that recent changes to mixed sex reporting had led to an anticipated increase in breaches being identified. The main challenge that existed was within critical care and in moving patients to other wards in a timely fashion. Work would be undertaken with NHSI to look at what actions could be taken to mitigate the issues.

A deep dive had been undertaken to identify why the Women and Children's division received more complaints in comparison to other divisions, and an action plan would be presented to the Q&S Committee.

Dr Walker noted that there had been a slight reduction in Venous Thromboembolism compliance and improving this measure would be a focus. He reported that the RAMI had continued to reduce, although anticipated a slight increase in winter. The SHMI had begun to reduce and was at 1.07. He noted a significant fall in mortality from septicaemia following recent focus.

Leadership & Culture

Miss Green reported that workforce remained a key challenge for the Trust. Use of agency staff continued to decrease and a concomitant increase in the use of bank staff was being realised. The Trust's nursing vacancy rate had reduced from 10% at start of year to 8%, with recruitment both in the UK and overseas. Staff retention would be a focus during 2017/18, and the Trust was taking part in the NHS employers retention programme.

Mr Clayton-Smith asked whether Brexit had impacted on recruitment. Miss Green explained that nurses were mainly recruited from either the UK or the Philippines and as a result there had been little impact from Brexit.

Mrs Churchward-Cardiff said that she felt that the Trust's Allied Health Professionals (AHP) were a real strength and expressed concern that their turnover rate was now the second highest having steadily increased over the past year. Miss Green explained that staff were leaving to progress, and that a review of the AHP career structure would be undertaken by the POD Committee.

Ms Kavanagh asked what actions were taken for training and appraisal metrics rated as amber. Miss Green explained that they were reviewed in detail during IPRs with divisions. Meetings were also held with managers and individual members of staff were automatically reminded when they needed to renew mandatory training.

Mr Nealon noted his concern that the Trust had increased numbers of staff by 300 since February 2016 but had seen no decrease in frontline vacancies. He explained that he was concerned that money was being spent on back-office functions and asked if a detailed breakdown of recruitment could be provided. Mr Clayton-Smith asked that a breakdown of recruitment during 2017/18 be presented at an upcoming Committee meeting. **JR/MG**

Finance

Mr Reid explained that the Trust's forecast outturn including STF funding for 2017/18 had improved slightly to £56.1m. The CCG had confirmed that the Trust would receive CQUIN funding of over £1m. During March the Trust had received cash from the Department of Health which had allowed it to improve its position with creditors significantly.

Mr Clayton-Smith asked why bank spending was not showing an anticipated saving when compared to agency spending. Mr Reid explained that a review of standard bank rates for staff was being undertaken in order to reduce spending in this area. Mr Stevens noted that incentives had been offered in order to encourage staff to join the bank during the previous year which had added to the expense.

Mr Nealon asked whether the cost of Out of Hospital work was accurately reflected in the Trust's block contract. Mr Reid explained that the full year value of East Sussex Better Together (ESBT) investment was just over £5m, which was in principle beneficial to the Trust. However, increased activity during the year had led to the contracts becoming loss making.

The Board noted the IPR Report for Month 11.

029/2018 **Financial Plan 2018/19**

Mr Reid explained that the Financial Plan had been reviewed by the Board and Divisions in detail at the previous week's Board Seminar. There were three key components to the plan:

- Unrecovered income of £15m
- Sustainable Transformation Funding of £13m
- A balance of £30m to be addressed via efficiencies and service reconfiguration

A key variable to the plan was the level of CIPs identified, and a minimum of £18m CIPs would need to be delivered in order to reach the agreed deficit. The Board had expressed a determination to reach £23m of CIPs, with an ambition of realising £28m. Confirm and challenge sessions were being held with divisions to ensure that CIPs were realistic and deliverable, and regular review was undertaken by the F&I Committee.

Mr Langley reported that NHSI had not accepted the planned £47.8m deficit proposed by the Trust and had asked for a more ambitious target to be set. Mr Clayton-Smith explained that the Board were determined to reach a minimum deficit of £47.8m with the ambition of surpassing this. Further discussions about financial plans were due to be held with NHSI on 11th May.

Mr Langley noted that the Trust had set a target of a £36m deficit in 2017/18 and not achieved this. He hoped that the excellent progress seen in other areas of the organisation could be replicated in improving the finances of the Trust. He noted that if CIPs of £28m could be identified, with delivery of £23m of these, then the Trust could reach a deficit of £40m for the year. He asked that the Board ensured that it had a realistic plan for improvement, and then delivered it during the coming year.

030/2018 **Nursing Establishment Review**

Ms Carruth reported the Trust's Nursing Establishment was reviewed every six months and had been discussed and challenged in detail by the F&I Committee. If the proposals within the review were approved by the Board then an implementation plan would be developed.

Mr Clayton-Smith asked whether the review had focussed on nurse numbers or nurse skill mix. Ms Carruth explained that the Trust didn't always have sufficient registered nurses available, and saw a high use of special nurses. The review recognised that additional nurses were required in A&E, in addition to requesting additional HCAs, in order to drive down expensive last minute use of agency and special nurses.

Mr Reid confirmed that the financial implications of the review were reflected in the Trust's financial plans for 2018/19. Ms Carruth noted that further reviews of the nursing establishment would be undertaken on a regular basis and whenever was needed.

The Board approved the Nursing Establishment Review

031/2018 **Developing and Delivering Safe and Sustainable Services**

Mr Reid reported that the Trust was undertaking a systematic review of

specialities in order to fully understand the future shape of services. He explained that the final review would be presented to the Board. Dr Bull added that the aim of the review was to create a model based on assumptions, looking at staffing, the bed base and priority site rationalisations. The review would set up a framework for how this could be achieved.

Ms Kavanagh emphasised the importance of ensuring that the interests of patients were considered when decisions about services were made. Mr Clayton-Smith agreed, explaining that decisions would be made looking at the entire system to ensure that financial, clinical and patient interests were all considered.

032/2018 **Staff Survey Results**

Miss Green presented the results of 2017/18's Staff Survey to the Board. She reported that response rates had improved from 46% to 49% from the previous year's survey, putting the Trust above the national average. A mix of paper and on-line surveys had been used for the first time. The Trust had seen no key findings that had significantly declined since the previous year. Six key findings remained below the national average although all had shown improvement since 2016/17.

Miss Green explained that detailed plans would be developed with divisions to address any issues highlighted within the report. Trust priorities for the next year had been identified and would be a focus:

- Values based behaviour
- Support for stressed staff
- Support staff to improve and deliver excellence

033/2018 **Clinical Excellence Awards 2017**

Miss Green explained that Clinical Excellence Awards for Consultants were considered by a panel on an annual basis, and were approved by the Remuneration Committee before coming to the Board for ratification. She explained that the panel had recommended that 26 Consultants be awarded one point, and that one outstanding candidate be awarded two points.

Mr Clayton-Smith noted that he chaired the award panel and that a strict process was followed when reaching decisions about awards. Dr Walker explained that consultants received the awards for excelling in their work, and for going above and beyond their normal duties.

The Board approved the recommendations for Clinical Excellence Awards 2017

034/2018 **Minimising Mixed Sex Accommodation Declaration**

Ms Carruth reported that recent changes to the way in which mixed sex breaches were monitored and reported had led to an expected increase in the number of cases being declared. She explained that the declaration being presented to the Board would be displayed on the Trust's website and set out the Trust's ambitions in relation to mixed set accommodation.

Miss Green asked what position the Trust took on patients identifying as a different gender. Ms Carruth explained that the NHS had yet to agree on a national position for the issue. She explained that the Trust dealt with cases on an individual basis and that local processes would be developed until national

guidance was released.

035/2018 **Delegation of Approval of Annual Report and Accounts 2016/17**
Mrs Wells sought approval for the Audit Committee to approve the Annual Report and Accounts on 24th May 2018, and for Mr Reid to be given delegated authority to sign off the documents which would be received by Board at the AGM in September.

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

036/2018 **Annual Self-Certification**
Mrs Wells explained that Trusts were required to self-certify that they could meet the obligations set out in the NHS provider licence and that they had complied with governance requirements. She sought confirmation that the Board was happy with the statements of compliance, explaining that she would arrange for the certificate to be signed and put onto the Trust's website.

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

037/2018 **Board Subcommittee Minutes**

The following sub-committee minutes were reviewed and noted:

- Audit Committee 31st January 2018
- F&I Committee 17th January 2018
- F&I Committee 31st January 2018
- F&I Committee 28th February 2018
- POD Committee 17th January 2018
- Q&S Committee 24th January 2018

The Minutes were received by the Board

038/2018 **Use of Trust Seal**
Mrs Wells noted that the Trust Seal had been used to seal a Lease Agreement and a Deed Agreement with Ovenmill Limited relating to 1066 Bakery and Café at the Conquest Hospital on 7th March 2018.

039/2018 **Questions from Members of the Public**

Mr Clayton-Smith explained that two questions had been received via email from Mrs Liz Walke in advance of the meeting.

<u>East Sussex Maternity Survey</u>
"Referring to the recent East Sussex Maternity Survey carried out by Eastbourne Borough Council, what steps are being taken to establish there is no link between increased risk to unborn baby and/or mother and distance to travel to nearest Maternity unit?"

The Trust responded:

Thank you for your request in relation to the maternity services for the ESHT board meeting. We can confirm that the message in relation to this was fully discussed at the Health Overview Scrutiny Committee at which it is understood

that you were present. This message hasn't changed and the Trust can reassure you further that this work continues to be monitored; ensuring safety and that quality of care given to women and families is maintained remains high on our agenda.

Litigation Claims
"What is the total current value of litigation claims allowed for in the ESHT Balance Sheet, what proportionately relates to Maternity and how many cases does it involve, and please could these figures be provided for 2011-2017?"

The Trust responded by asking Mrs Walke to submit a formal Freedom of Information request for this information.

A letter was passed to Mr Clayton-Smith by Mr Peter Reed, a member of the public, for the attention of Dr Bull.

040/2018 **Date of Next Meeting**

Tuesday, 5th June 2018, in the St Mary's Boardroom, EDGH

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 17th April 2018 Trust Board Meeting

Agenda item	Action	Lead	Progress
028/2018 – IPR Month 11 - Access and Responsiveness	Mrs Chadwick-Bell agreed to include data about admission avoidance in the IPR.	**JCB**	Data included within IPR
028/2018 – IPR Month 11 - Access and Responsiveness	Mrs Chadwick-Bell agreed to add 62 day cancer breaches as a standing item for the Q&S Committee.	**JCB**	Added to agenda for Q&S Committee
028/2018 – IPR Month 11 - Access and Responsiveness	Mrs Chadwick-Bell agreed to verify whether data about admission rates for patients seen by crisis response teams was correct.	**JCB**	Verbal update to be provided at Board meeting
028/2018 – IPR Month 11 – Leadership and Culture	A breakdown of recruitment during 2017/18 be presented at an upcoming Committee meeting.	**JR/MG**	Recruitment was discussed in detail by the POD Committee on 09.05.18

Quality Walks July - October 2017

Meeting information:			
Date of Meeting:	5th June 2018	Agenda Item:	5
Meeting:	Trust Board	Reporting Officer:	Lynette Wells

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

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

Executive Summary:

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

31 services or departments have received visits as part of the Quality Walk programme by Board members between 1st November 2017 and 30th April 2018. In addition to the formal programme the Chief Executive has also visited over 20 wards or departments and staff groups. A summary of the observations and findings noted are detailed in the attached report.

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

None

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

The Board are asked to note the report.

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

Analysis of Key Issues and Discussion Points Raised by the Report
The following services or departments were visited as part of the Quality Walk programme by the Executive Team between 1st November 2017 and 30th April 2018 as detailed below. The Chief Executive also visited several departments and staff groups in addition to the formal programme.

Date	Service/Ward/Department	Site	Visit by
17.11.17	Pevensey Ward	EDGH	Sue Bernhauser
22.11.17	Facilities Department	EDGH	Jonathan Reid
22.11.17	Hailsham 2 Ward	EDGH	Barry Nealon
6.12.17	District Nursing Team	Westfield	Sue Bernhauser
20.12.17	Diabetes and Endocrinology Department	EDGH	Mike Stevens
21.12.17	Kipling Ward	Conquest	Jackie Churchward-Cardiff
28.12.17	DeCham Ward	Conquest	Monica Green
4.1.18	Outpatients Main Area	EDGH	David Walker
12.1.18	Health Records Department	Apex Way	Monica Green
24.1.18	Emergency Department	EDGH	Korron Spence
29.1.18	Medical Division Management Meeting	EDGH	Barry Nealon
7.2.18	Dietetics Department	EDGH	Jonathan Reid
22.2.18	Folkington Ward	EDGH	Jonathan Reid
8.3.18	Health Visitors	Seaford	Jonathan Reid
14.3.18	Friston Short Stay Paed Assessment Unit	EDGH	Catherine Ashton
19.3.18	McCartney Unit	Conquest	Jonathan Reid
19.3.18	Housekeeping Teams	Conquest	Sue Bernhauser
19.3.18	Special Care Baby Unit	Conquest	Sue Bernhauser
21.3.18	Sleep Studies Unit	Conquest	Miranda Kavanagh
21.3.18	Benson Ward	Conquest	Miranda Kavanagh
23.3.18	Clinical Admin - Booked Admission Team	EDGH	Sue Bernhauser
26.3.18	Jubilee Eye Suite	EDGH	Monica Green
28.3.18	Hailsham 3 Ward	EDGH	Monica Green
11.4.18	Pathology Department	Conquest	Sue Bernhauser
11.4.18	Litlington Ward	EDGH	Jackie Churchward-Cardiff
11.4.18	Frailty Practitioner Service	EDGH	Catherine Ashton
18.4.18	Sexual Health Department	Eastbourne	Miranda Kavanagh
25.4.18	Newington Ward	Conquest	Mike Stevens
25.4.18	Acute Admissions Unit	Conquest	Mike Stevens
30.4.18	Podiatry Department	Avenue House	Lynette Wells
30.4.18	Cookson Devas Ward	Conquest	David Walker

The majority of these visits were pre-arranged and the Ward or Unit Manager notified in advance to expect the visit, other adhoc visits may also have taken place. Where feedback has been received this has been passed on to the relevant managers for information.

Key Themes and Observations

Communication and Engagement

- Most areas reported that they felt there was good communication structures in place to ensure that staff had regular briefings relating to both the clinical areas and Trust wide issues; however some staff felt that engagement and involvement from service/operational management was not always good and they felt uninformed and rarely involved in service changes.

- There was evidence noted of a number of more senior staff supporting junior colleagues and providing teaching.

- A community team reported that they felt there had been an improvement in communication from senior members of the organisation and particularly the regular briefings from the Chief Executive. They felt that lines of communication to the acute services can be challenging, with phone calls often being referred wrongly, this became evident when a member of staff joined the team who had previously worked in the acute setting and used their knowledge and contacts to assist with communication.

Incidents Risks and Safety Issues

- No major issues identified.

Environment, Equipment and IT

- Community staff reported that they continue to have difficulties with IT equipment which takes up valuable time due to limited reception in some areas. The value of SystmOne was recognised but they struggle to see it as a helpful tool. Lack of IT was also sighted as a problem in some of the ward environments in terms of the numbers of PCs available and the speed of systems.

- The Sleep Studies unit is currently housed in an environment that was not totally suited for purpose and this was reflected in patient feedback, however there are plans for the unit to move but the staff were not sure how long that would be.

- Some areas felt the effect of being in financial special measures was impacting on the delay of obtaining some of the consumables they required, and the replacement of equipment.

Staffing

- Some areas felt that considerable flexibility was required by staff as they often found themselves moved to help other wards that were under pressure, they said they found this stressful when they did not know which ward they would be covering at the start of their shift.

- In the Community staffing was reported as becoming more challenging due to higher patient acuity and dependency and an increasing expectation about what can be delivered in the home environment. Staff also felt that due to the development of new roles e.g. Frailty Nurses/crisis response teams etc. this has led to anomalies in the Clinical Grades and an erosion particularly of the DN roles who find their work more challenging by the complex management and communication with different practitioners, and although the roles are valued and required there have been situations where more than one practitioner has gone to see the same patient.

- The establishment of the Matrons Assistant has been a very positive appointment, however it was noted that the role is evolving and staff feel they are required to work to a higher level (B3) which may be a factor in future retention.

- The Housekeeping Service reported facing a number of challenges which include managing staff absences and sickness (long term) and this is compounded by the number of vacancies they have and delays in recruitment.

- There were good examples noted of positive leadership and staff reported feeling supported by senior staff.

- The Special Care Baby Unit reported a lack of Qualified in Specialty (QIS) nursing staff, as it is very difficult to recruit these staff and a real challenge to 'grow your own' as training is 'on the job' which requires a long placement outside the Unit with another Trust. There is a similar challenge with recruiting scientists for the pathology department.

- Litlington have a stable and committed team with a low turnover of staff which they felt was down to a number of staff working part-time and the flexible approach they had to shifts which works well for the team and the ward organisation.

Good Practice / Service redesign

- Pevensey ward are developing a 2 day pathway for the assessment of new patients and the administration of chemotherapy and other treatments, and there are plans being developed to standardise practices between the Pevensey Unit and Judy Beard Unit at the Conquest Hospital.

- The Clinical Administration Booking team ring all patients to agree dates for surgery, and they are planning further developments to include electronic waiting list cards.

- The Housekeeping service is involved in implementing Phase 2 of Housekeeping Modernisation Productive Cleaning which is proceeding well.

Patient feedback

- Positive feedback was given by the patients that were spoken to with comments about how well informed they were about their treatment and how they felt their families had been included in discussions about their care in a positive way.

- Evidence was observed of very positive feedback from Friends and Family Test results and many plaudits displayed on notice boards.

Other Issues

- Good cleaning scores were noted which staff attributed to the ward orderly role and how it enhances the smooth running of ward areas.

- Some areas remain cluttered due to lack of storage.

Risks and Implications

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

East Sussex Healthcare NHS Trust

Audit Committee

1. Introduction

An Audit Committee was held on 24th May 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. Quality Account Update

The Committee received an update on progress in completing the annual Quality Account. Auditors raised concerns about the quality of data being collected relating to venous thromboembolism and the Committee discussed plans to address the issue.

3. Annual Accounts and Reports

The Trust's external auditors, Grant Thornton, presented their findings following their end of year audit of the annual accounts and reports. They anticipated that an unqualified audit opinion would be issued once a small number of outstanding issues had been resolved. The annual accounts and report were scheduled to be formally submitted to the Department of Health on 29th May 2018 and would be received by the Board at the AGM in August.

4. Audit Committee Annual Report

The Committee approved the Audit Committee's annual report, which would be presented at the Public Board meeting on 5th June 2018.

Mike Stevens
Chair of Audit Committee

25th May 2018

East Sussex Health Care NHS Trust

Audit Committee Annual Report 2017/18

1. Introduction

The purpose of this report is to formally appraise the Board of the work of the Audit Committee during the period 1st April 2017 to 31st March 2018 and to set out how it has met its terms of reference [attached as Appendix A] and priorities.

2. Meetings of the Committee

The Committee is chaired by a non-executive director with a financial background and membership comprises himself and 2 non-executive directors; thus reflecting and meeting the need for independence and objectivity. The Committee convened on 6 occasions throughout the financial year and all meetings were quorate. Meetings were also held with auditors in private session.

Attendance at meetings was as follows:

Mike Stevens, Audit Chair,	6/6
Sue Bernhauser, Non-executive director	4/6
Barry Nealon , Non-executive director	6/6

Mrs Bernhauser is chair of the Quality and Safety Committee and Mr Nealon the Finance and Investment Committee. Their membership of the Audit Committee ensures that matters are triangulated and where required escalated across the Board's committee structure.

3. Governance, risk management and internal control

The Committee reviewed relevant disclosure statements, in particular the Annual Governance Statement together with the Head of Internal Audit opinion, external audit opinion and other appropriate independent assurances and considered that the Annual Governance Statement was consistent with the Committee's view on the Trust's system of internal control. Accordingly, the Committee supported Board approval of the Annual Governance Statement.

The Committee provides assurance as to the adequacy and effectiveness of the organisation's systems and processes for risk management. To facilitate this the Trust's Board Assurance Framework (BAF) and high level Risk Register were presented at each meeting and scrutinised to test assurances and ensure mechanisms were in place to effectively control and mitigate risks. Clinical divisions and corporate representatives attended the Committee on a rotational basis to present their risk registers and clinical audit plans. The number of high level risks has reduced and the articulation of risks has continued improved.

Progress against achieving compliance with the Information Governance Toolkit was monitored throughout the year. The Trust successfully achieved level 2 and this was verified by internal audit who gave the Trust an opinion of 'Reasonable Assurance'

The Committee reviewed the Trust's Annual Quality Account and noted compliance with statutory requirements.

4. Internal audit

The internal audit service was provided by TIAA Limited. The Committee approved the detailed internal audit programme of work and received a report from the internal auditor at

each of its committee meetings which summarised the audit reports issued since the previous meeting. TIAA carried out 27 assurance reviews during the year, which were designed to ascertain the extent to which the internal controls in the system were adequate to ensure that activities and procedures were operating to achieve the Trust's objectives. 8 audits received 'limited assurance', 11 'reasonable assurance' and 3 'substantial assurance'.

Throughout the year the Committee worked effectively with internal audit to strengthen the Trust's internal control processes and ensured there was an improved process for tracking audit actions. The overall annual opinion from TIAA was Reasonable Assurance on the adequacy of the Trust's risk management, control and governance processes with the exception of the Trust's ability to deliver its planned financial control total. This was an improvement from Limited Assurance in the previous year.

5. External audit

Following a competitive procurement exercise, the Trust's external auditors changed to Grant Thornton at the beginning of the year. The Committee approved the External Audit Plan at the start of the financial year and received regular updates on the progress of work. In addition, the Committee received reports and briefings from the external auditors in accordance with the national requirements. These included; the Annual Audit Letter, Final Accounts Memorandum and report on the audit of financial statements, in addition to briefings on specific issues.

6. Counter Fraud Services

Counter fraud services were provided by TIAA Limited and the service continued to enhance the Trust's overall anti- fraud arrangements through the conduct of a range of agreed activities. Fraud awareness training was promoted throughout the Trust and counter fraud education was included in induction training.

The Committee approved and monitored the counter fraud work plan for 2017/18. A counter fraud representative attended each meeting and updated on actions being taken in respect of reactive work and progress of investigations. Proactive work included:

- Fraud check review of corporate credit charge usage
- Dissemination of fraud alerts/intelligence bulleting
- Cyber awareness on line training module
- Reviewed matches from the 2017/18 National Fraud Initiative

The Trust remained compliant with the directions issued by the Secretary of State in 1999, the NHS Standard Contract (2012) and the NHS Counter Fraud and Corruption Manual.

7. Clinical Audit

At each meeting the Committee received a report on progress in implementing the Clinical Audit Forward Plan 2017/18, ensuring that the system in place allowed lessons learnt from clinical audit activity to be shared effectively, and recommendations for improvement to be implemented in a timely manner.

The Committee endorsed the need to move to a position of reducing the number of low level audits and reporting on clinical audit outcomes and learning. A new process was introduced in April 2017 whereby Priority 4 audits were only approved once named auditors and leads were identified for each mandated (Priority 1) audit. This would be continued in 2018/19 as there were sixty nationally mandated audits that needed to be undertaken

The Committee were pleased to note that a long standing issue with non-participation in the National Diabetes was addressed during the year.

8. Management

The Committee challenged the assurance process when appropriate and requested and received assurance reports from Trust management and various other sources both internally and externally throughout the year. This process included calling managers to account when considered necessary to obtain relevant assurance.

The Committee worked closely with the executive directors to ensure that the assurance mechanisms within the Trust were fully effective and that a robust process was in place to ensure that actions falling out of external reviews were implemented and monitored by the Committee. Following an audit it was noted that the review of tenders and waivers was not being presented to the Trust at each meeting and this would be addressed.

9. Financial reporting

The Committee reviewed the annual financial statements before submission to the Board and considered them to be accurate.

10. Review of the effectiveness and impact of the Audit Committee

The Committee performed its duties during the year as delegated by the Trust Board and mandated through governance requirements, ensuring compliance with and further developing good practice through:-

- continuous self assessment and review of its effectiveness; and
- assessing itself against the checklist in the Audit Committee Handbook. This was completed by both committee members and auditors.

There were no areas identified that required improvement.
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11. Audit Committee Chairman's Comments

The Audit Committee fulfilled its remit throughout 2017/18 and I consider that there are adequate and effective internal financial and management control arrangements in place to assure the Board of its corporate governance duties. There are no matters that the Committee is aware of at this time that have not been disclosed appropriately

The Audit Committee continues to develop its contribution to ensuring the continued provision and improvement in Internal Control across the Trust and, in accordance with its Terms of Reference, will seek to maintain this progress.

Mike Stevens
Audit Committee Chair

May 2018

Appendix A

Audit Committee Terms of Reference

East Sussex Healthcare NHS Trust

Audit Committee - Terms of Reference

1. Constitution

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

2. Purpose

The Audit Committee will support the Board by critically reviewing governance and assurance processes on which the Board places reliance. It will seek assurance that financial reporting and internal control principles are applied, and maintain an appropriate relationship with the organisation's auditors, both internal and external. This includes the power to review other committee's work, including in relation to quality, and to provide assurance to the board with regard to the reliability and robustness of internal controls.

The Committee will agree and work to an annual programme that takes into account the need to contribute to the timely sign-off of statutory requirements such as the annual accounts. This programme will be reviewed by the Board. The Committee may be commissioned by the Board to undertake particular studies or investigations, or to focus attention on any matters relating to finance and investment as the Trust Board thinks fit.

3. Membership

The Committee shall be appointed by the Chairman of the Trust Board from amongst the non-executive directors of the Trust and shall consist of not less than three members.

One of the members will be appointed Chair of the Committee by the Trust Board Chairman. One member should also be a member of the Quality and Standards Committee and one member a member of the Finance and Investment Committee.

At least one member of the Committee should have recent and relevant financial experience.

The Chairman of the Trust shall not be a member or act as substitute for a member of the Committee.

Other non-executive directors of the Trust, including any designate non-executive directors, may substitute for members of the Audit Committee in their absence and will form part of the quorum.

4. Attendance

Members of the Committee are expected to attend all meetings; if this is not possible then another non-executive director may substitute as outlined in the preceding paragraph.

The Director of Finance and appropriate Internal and External Audit representatives shall normally attend the meetings.

At least once a year the Committee should meet privately with the internal and external auditors.

The Chief Executive and other executive directors shall be invited to attend particularly when the Committee is discussing areas that are the responsibility of that Director.

The Chief Executive shall be invited to attend, at least annually, to discuss with the Committee the process of assurance that supports the Annual Governance Statement.

The Company Secretary shall attend the meetings to provide appropriate support and advice to the Chairman and committee members.

5. Quorum

A meeting of the Committee shall be quorate if at least two members are present, one of whom shall be the Chairman of the Committee or his delegated nominee. Other non-executive directors of the Trust, including any associate non-executive directors who are substituted for members, may form part of the quorum.

6. Frequency

Meetings shall be held not less than four times a year and at such other times as the Chairman of the Committee shall require. The external auditor or head of internal audit may request a meeting if they consider that one is necessary.

7. Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference and in line with the Committees prime purpose of providing assurance to the Board.

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

8. Duties

8.1 Governance, Risk Management and Internal control

The Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- the board assurance framework, risk management system, Annual Governance Statement together with an accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to discussion by the Board where possible

- the clinical governance system of the Trust, including the clinical audit programme
- the information governance system, including requirements under the NHS Information Governance Toolkit and progress in implementing the General Data Protection Regulations (GDPR)
- the research governance system relating to any research activity the Trust may be engaged with
- the rigour of the processes for producing the quality accounts, in particular whether the information included in the quality account is reported accurately and whether the quality account is representative in its reporting of the services provided and the issues of concern to its stakeholders.
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the Annual Governance Statement
- the policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service
- Standing Financial Instructions (SFIs) and Standing Orders (SOs) on an annual basis.
- the Committee shall report issues in relation to audit, risk or internal control to the Board of Directors on an exception basis in addition to an annual report focused on the effectiveness of the Committee in exercising these duties.
- the Committee will be responsible for forming a panel to procure and appoint both internal and external auditors

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions.

It will also seek reports and assurances from officers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

8.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit Service, the cost of the audit and any questions of resignation and dismissal.

- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that it is consistent with the audit needs of the organisation as identified in the Assurance Framework and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.

- Review of the major findings of Internal Audit work, management's response and the implementation of management action

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.

- An annual review of the effectiveness of internal audit.

8.3 External audit

The Committee shall review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor as far as the rules governing the appointment permit.

- discussion and agreement with the External Auditor, before the audit commences on the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate with other external and internal auditors in the local health economy.

- discussion with the External Auditors of the local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

- review of all external audit reports including agreement of the annual audit letter before submission to the Board for any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

8.4 Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of Counter Fraud work.

8.5 Other assurance functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include but will not be limited to reviews by:

- Department of Health
- Care Quality Commission
- NHS Litigation Authority
- Other regulators and inspectors
- Professional bodies with responsibility for performance of staff or functions including Royal Colleges and accreditation bodies
- The Trust's internal assurance function

In addition, the Committee will review the work of other Committees within the organisation whose work can provide relevant assurance to the Audit Committee's own scope of work; in particular this will include the Quality and Standards Committee and the Finance and Investment Committee. In reviewing the work of the Quality and Standards Committee and issues around clinical risk management, the Audit Committee will wish to satisfy itself that appropriate assurance that can be gained from the clinical audit function and to take the advice of the Quality and Standards Committee on how this function should best be utilised.

8.6 Hosted arrangements

The Committee will review and provide assurance to the Board in respect of any hosted arrangements or services, both those services hosted by the Trust and also those services hosted elsewhere but to which the Trust is a party.

8.8 Management

The Committee shall request and review reports and positive assurances from Directors and Managers on the overall arrangements for governance, risk and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example clinical audit) as they may be relevant to the overall arrangements.

8.9 Financial reporting

The Committee shall monitor the integrity of the financial systems of the Trust and systems of financial control.

The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- changes in and compliance with accounting policies and practices.
- unadjusted mis-statements in the financial statements.
- significant judgments in preparation of the financial statements.
- significant adjustments resulting from the audit.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

9. Reporting arrangements

Minutes of the Committee meetings shall be formally recorded by the Company Secretary, or her nominee, and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness of purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation,

the integration of governance arrangements and compliance with CQC registration standards.

The Committee shall undertake a self assessment of its effectiveness on at least an annual basis and this will be timetabled into the schedule of audit committee business.

This assessment will follow best practice as outlined in the NHS Audit Committee Handbook and may be facilitated by independent advisors if the Committee considers this appropriate or necessary. A copy of the self-assessment and any proposed actions will be reviewed by the Trust Board.

These Terms of Reference shall be reviewed by the Committee and Trust Board at least annually.

East Sussex Health Care NHS Trust
Quality and Safety Annual Report 2017/18

1. Introduction

The Quality and Safety Committee is established under Board delegation with approved terms of reference. The Committee meets bi-monthly and seeks assurance on behalf of the Board that the Trust is providing safe and high quality services to patients supported and informed by effective arrangements for monitoring and continually improving the safety and quality of care.

2. Meetings of the Committee

The Committee met on six occasions throughout the year and all meetings were quorate.

Membership of the Committee comprises both non-executive directors and multi-disciplinary representatives from across the Trust, including the Director of Nursing and Medical Director. Non-executive members were present for all meetings however, attendance from other members was variable during the year. This was strengthened following a review of the Committee's terms of reference and in addition, Associate Director of Nursing from each division were invited to attend meetings.

The patient representative sadly passed away during the year and the Committee will miss her contribution.

Reports from the Committee were tabled at each Board meeting and key matters were flagged for the attention of the Board.

3. Principal review areas

During the year, the Committee provided an objective review of all aspects of quality, safety and standards in support of getting the best clinical outcomes and experience for patients. The Committee assisted the Board in being assured that the Trust was meeting statutory quality and safety requirements and gained insight into issues and risks that could jeopardise the Trust's ability to deliver quality improvement.

The Committee received a patient story at each meeting; this provided a salient reminder of the importance of quality and safety in an NHS organisation.

The Committee reviewed and endorsed the Trust's quality improvement priorities for subsequent publication in the Quality Account.

Key areas considered included:

- Quality improvement – including compliance with CQC recommendations
- Board Assurance Framework and risk registers
- Patient experience and complaints
- Serious Incidents
- End of Life Care
- Infection Control
- Safeguarding
- Mortality and morbidity

"Deep dive" reviews took place in areas highlighted through the risk management process such as such as end of life care, radiology and plan film reporting and pressure ulcers.

The Committee received and reviewed minutes from sub groups, such as the Patient Safety and Quality group.

4. Review of the effectiveness and impact of the Quality and Standards Committee

During the year the Quality and Standards Committee undertook a review of its effectiveness and revised its terms of reference and adapted the work plan accordingly.

Papers received by the Committee were generally of good quality and there is a commitment to reduce their length and ensure there is sufficient analysis to draw out the key issues and demonstrate learning and change in practice.

Committee members demonstrated grip on quality governance through the level of scrutiny, challenge and by seeking assurance on aspects of quality.

5. Chair's remarks

The Committee performed its duties during the year as delegated by the Trust Board. The strengthened membership enables actions and decisions made by the committee to be disseminated and owned by the clinical divisions and departments.

My thanks go to Committee members for their work to ensure we are providing patients with high quality, safe care through our governance structures.

Sue Bernhauser
Non-Executive Director and
Chair Quality and Safety Committee

East Sussex Healthcare NHS Trust

People & Organisational Development (POD) Committee

1. Introduction

Since the Board last met a POD Committee meeting was held on 9th May 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. Nursing Revalidation Annual Report & Medical Revalidation Annual Report 2017/18

The Committee received a verbal overview from the Assistant Director, Revalidation, of the submitted annual reports. Nurses had achieved 100% compliance with completed nursing revalidation submissions in 2017-18 and doctors had achieved 100% appraisal compliance in 2017-18.

It was highlighted that the medical revalidation workload would increase over the next few years as the full five year cycle would need to be completed again; a key challenge for the department.

4. Staff Wellbeing Report

The Committee received a presentation from the Occupational Health Manager and the Health and Wellbeing Lead of the submitted report. The report outlined the improvements within the department, successes: NHS health checks, staff survey and achievement of full payment for CQUINS 2017-18 and future plans.

The Committee commended the good work undertaken by the department and it was highlighted that the staff survey had identified a log of good feedback around health and wellbeing.

5. Recruitment update

The committee received a verbal overview from the Deputy Director of HR of the submitted report. The paper detailed the structure and capacity of the recruitment team, turnover, vacancies/leavers, time to hire, attraction strategy and opportunities. The considerable progress in recruitment was noted particularly in relation to medical staff.

It was highlighted that the turnover rate for AHPs was still increasing. It was agreed for a brief summary of views on the deteriorating retention of AHPs to be provided for the next meeting.

6. HR Incident Report

The Committee received a verbal overview from the Head of Operational HR of the submitted report. The report provided information on the number of formal staff complaints and conduct issues which had been raised, including Employment Tribunal claims during the period 1st January 2018 to 31st March 2018.

It was highlighted that if the Trust lose a tribunal, the Solicitors prepare a “Lessons learned Report” which would be shared with the team and managers and any training/understanding of process would be put in place.

7. Gender Pay Gap

The Committee received a verbal overview from the Deputy Director of HR of the submitted report. The Trust was required to publish statutory calculations every year from March 2017 showing how large the pay gap is between male and female employees. The data would be refreshed for 2018 to present by April next year. A group had been set up, a deep dive analysis to be undertaken and an action plan to be produced.

8. New Roles update

The Committee received a verbal update from the Assistant Director of HR, Education, of new roles, particularly in relation to the introduction of the Physician's Assistant role. The job description was being reviewed and discussions in place to work with divisions who had registered an interest in taking this role forward.

9. Annual Report from the Guardian of Safe Working

The Committee received a verbal overview from the Guardian of Safe Working of the submitted report. The report provided an update following further transition of junior doctors to the new doctor's contract. It identified issues surrounding the recruitment and allocations of junior doctors, the work patterns in some areas and the monies paid to junior doctors and fines attracted due to breaches that were still occurring.

The Deputy Director of Nursing referred to the multi-disciplinary safety huddles and highlighted that doctors were most welcome to join these huddles at any point, which were held on the wards.

10. Apprenticeship update

The Committee received a verbal update from the Assistant Director of HR, Education, on the apprenticeship scheme. A full paper would be submitted at the next meeting.

The key challenge highlighted was the cost pressure for divisions as the levy was unable to be used for backfill and salary support, although there had been a reduction in the number of apprentices joining the schemes.

11. Establishment Review

The Committee received a written report provided for information/assurance.

12. Review of flexible working for nursing staff

The Deputy Director of Nursing explained that a piece of work would be going forward at STP level with HR Directors and Directors of Nursing regarding flexible working. Initial discussions/consultations had taken place and there had been a variety of views and resistance. The Director of HR reassured the meeting that local progress would be encouraged. The driver for this was around nurse recruitment, nurses fit to do their jobs (without being tired), being able to accommodate flexible working shifts.

13. Feedback from Sub Groups

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

Approved minutes of the meeting held on 14th March 2018 are attached for the Board's information.

Miranda Kavanagh
Chair of POD Committee

9th May 2018

Board Assurance Framework

Meeting information:			
Date of Meeting:	5th June 2018	Agenda Item:	7
Meeting:	Trust Board	Reporting Officer:	Lynette Wells, Director of Corporate Affairs

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

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

Other stakeholders please state: ……

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

Executive Summary:

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

Attached is the revised Board Assurance Framework (BAF) with updates shown in red. Following agreement at the last Board meeting four items have been removed in respect of Emergency Department Reconfiguration, Patient Flow, Mandatory Training/Appraisal compliance and Developing and supporting clinical assurance. There are no additions or proposal to move items from the BAF this month.

Discussion took place at the Quality and Safety in respect of whether the gap in control 5.1.1 should be moved to Green/removed from the BAF. It was agreed that it should remain as there are some specialties where recruitment remains very challenging and further assurance is required.

The Women and Children's Division are reviewing the gap in control 2.1.2 related to admissions of young people with mental health conditions and will provide assurance to the next Quality and Safety Committee. A number of actions have been implements and the emphasis of the risk needs to be revised.

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

Quality and Safety Committee – 16th May 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.

Assurance Framework - Key

RAG RATING:

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

Status:

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

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

C indicated Gap in control

A indicates Gap in assurance

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

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/milestone**	**RAG**	**Lead**	**Monitoring Group**
1.1.1	A	Quality improvement programme required to ensure trust is compliant with CQC fundamental standards.	March CQC inspection reports published Sept 15, trust in special measures. Quality Improvement plan developed Improvement Director working with the Trust. May-16 to Sept-16 2020 Quality Improvement Priorities agreed and key metrics developed to support compliance and monitoring. Commenced preparation for Autumn CQC inspection. Mock inspection took place end June, further mock planned end of July. Continued monitoring of QIP and preparation for CQC inspection. Nov-16 CQC inspection took place October - draft report expect Dec 16. Continuing with quality improvement priorities eg end of life care and optimising patient pathways. Jan-17 Draft report expected this month Mar-17 Report published end of Jan 17. Trust rating moved to 'Requires Improvement' Good progress evidenced in a number of areas however 2 must do actions and 34 should do actions to address. Programme of improvements in place. May-17 Good progress in implementing CQC actions. Mock inspections planned for May-17 Jul-17 Action tracker in place and monitored with divisions and at Q&S. New CQC regulatory guidance being reviewed and communication plan developed to ensure Trust can evidence compliance. Sep-17 QIP 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 Nov-17 Inspection anticipated early 2018. Tracker being strengthened and prep group meeting. Community mock planned for Nov. Jan-18 Ongoing preparation for inspection. CQC information request completed Dec 2018. CQC first focus groups also taken place. Mar-18 CQC inspection 6/7 March core services and 20/21 Mar Well Led, expect draft reports by end of May May-18 Draft report received and factual accuracy checks taking place	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: Monthly performance meeting with clinical units Clear ownership of individual targets/priorities Daily performance reports Effective communication channels with commissioners and stakeholders Healthcare Associated Infection (HCAI) monitoring and Root Cause Analysis Single Sex Accommodation (SSA) processes and monitoring Regular audit of cleaning standards Business Continuity and Major Incident Plans Reviewing and responding to national reports and guidance Cleaning controls in place and hand hygiene audited. Bare below the elbow policy in place Monthly audit of national cleaning standards Root Cause Analysis undertaken for all IC outbreaks and SIs and shared learning through governance structure Cancer metric monitoring tool developed and trajectories for delivery identified, part of Trust Board performance report. Clinically led Cancer Partnership Board in place
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Exception reporting on areas requiring Board/high level review Dr Foster/CHKS HSMR/SHMI/RAMI data Performance delivery plan in place Accreditation and peer review visits Level two of Information Governance Toolkit External/Internal Audit reports and opinion Patient Safety Thermometer Cancer - all tumour groups implementing actions following peer review of IOG compliance. Consistent achievement of 2WW and 31 day cancer metrics

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.1.1	C	Effective controls required to support the delivery of cancer metrics and ability to respond to demand and patient choice.	May-Jul 17 Performance of 62 days below trajectory at 69.9% (latest data Feb 17) Greater focus on patient tracking with Guys being set up to run weekly in order to replicate the scrutiny on 38 day transfers currently in place with MTW and BSUH. Refer to monthly IPR for details of ongoing programmes of work to improve cancer metrics. Sep-17 Presentation to Board Seminar in Aug. Continued progress in improving performance particular focus on achieving 62 day performance by end of Sept 17 Nov-17 Meeting 2 week wait target despite continuing increase in referrals. 62 day standard remains a challenging target. Daily telephone conferences held to ensure patients are seen within timescales. New reporting system being developed to provide a live view/dashboard anticipate this monitoring will assist in delivering improvements to cancer performance. Jan-18 Achieving cancer metrics with exception of 62 days 77% Lung, colorectal and urology are highest breaching specialities, although urology have improved significantly. Number of actions in place to improve performance detailed in monthly performance report. 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. May-18 – demand for colorectal, breast and urology 2ww has been exceptional and as such is impacting delivery across all cancer standards in these specialties. Governance systems and actions plans are in place, with demand analysis being undertaken by the CCG and Trust. An additional role is being developed to support the DAS services to take swift actions to ensure patients booked and capacity established. A twice weekly meeting is in place with ADOs and CCGs, with the COO.	end-May 18	◄►	COO	Cancer Operational Board and IPRs

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**
2.1.2	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. Jan-17 -Mar 17 Mental health nurse visits wards daily 9-5 Monday to Friday. Additional mental health training for ESHT nursing staff but need therapeutic intervention from CAMHS. Strategy meeting planned and also meeting SPFT to discuss further support, need sufficiently skilled staff. Hospital Director CQ linking in with SPFT for mental health matters. Jul-17 Ward nurses having mental health training currently as part of away days. Special Observations Policy ratified and specials being requested ad hoc. Paediatric strategic work including mental health in reach plan Sep-17 - Meeting arranged end Sept to review issues. Audit of children admitted to the paediatric ward with mental health diagnosis commenced. Nov-17 Audit complete, will be presented at Nov WCSH audit meeting. SPFT continuing with training and support (particularly from the MH nurse daily) and will meet to review audit results in Nov/Dec Jan-18 Audit presented and confirmed that children with mental health difficulties primarily present after 4pm in the afternoon and so the vast majority cannot be assessed until the following day by the mental health nurse. These children require a hospital bed until the assessment is undertaken. Initial meeting with CAMHS and another planned Feb. 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. May-18 Division are assured adequate controls in place now and are applying for the HEE "we can talk" project to further enhance the skills and competencies of the ward staff. Discussed at Q&S and further assurance being sought.	end May-18	◄►	COO	SLF Q&S
2.1.3	C	Effective controls are required to monitor and formally report on follow up appointments in order to ensure there is no clinical risk to patients suffering a delay.	Mar -17 Inability to formally extract data from Oasis PAS to report on patients follow up by time period. Local systems in place but require Trust wide system for monitoring and analysis. Liaising with supplier regarding options for reporting. May-17 Position resolved with community paediatrics due to data transition to Systm One. Ongoing discussion to find Trustwide solution. Jul-17 All doctors validating Follow Up waiting lists and telephone Follow Ups now taking place. Longest waiter 36 weeks. Sep-17 IT reviewing to develop a follow up waiting list that can be easily complied from existing systems and monitored at a specialty/consultant level for volumes and timeframe for appointments Nov-17 E system still under development but as a mitigation data re non appointed follow ups (within clinically defined timeframes) is sent to all service managers weekly for action. Jan-18 There have been difficulties with resources within the PAS team to take this work forward due to other priorities such as eRS. Mitigation continues as above and an implementation plan, with milestones, is being developed by IT/Operations to be monitored through IPR. 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. May-18 Development of the database sits within Outpatient Improvement Project and has been delayed due to capacity within the PAS team/overlap with PAS Upgrade project. Sheduled for full go live by end August 18. In the interim above arrangement applies and in addition we are also able to run reports on any follow up appointment cancelled by hospital or patients	end Aug-18	◄►	COO	SLF Q&S

Risk 2.2 There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.					
Key controls	Clinical Unit Structure and governance process provide ownership and accountability to Clinical Units Clinicians engaged with clinical strategy and lead on implementation Job planning aligned to Trust aims and objectives Membership of SLF involves Clinical Unit leads Appraisal and revalidation process Implementation of Organisational Development Strategy and Workforce Strategy National Leadership and First Line Managers Programmes Staff engagement programme Regular leadership meetings Succession Planning Mandatory training passport and e-assessments to support competency based local training Additional mandatory sessions and bespoke training on request				
Positive assurances	Effective governance structure in place Evidence based assurance process to test cases for change in place and developed in clinical strategy Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Training and support for those clinicians taking part in consultation and reconfiguration. Outcome of monitoring of safety and performance of reconfigured services to identify unintended consequences Personal Development Plans in place Significant and sustained improvement in appraisal and mandatory training rates				
Gaps in Control (C) or Assurance (A):	**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
No gaps in control or assurance escalated to BAF					

Strategic Objective 3: We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.

Risk 3.1 We are unable to develop and maintain collaborative relationships based on shared aims, objectives and timescales with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.

Risk 3.2 We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.2.1	A	Assurance is required that the Trust will be able to develop a five year integrated business plan aligned to the Challenged Health Economy work.	Mar-17-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. 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. Sep-17- Nov-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. Work is ongoing with commissioners and NHSi to agree and align our long term financial position and operational plan. Planning for 18/19 is progressing with the divisional teams with regular updates provided to FISC Jan-18 Work ongoing to develop long term financial model alongside work to provide assurance on the 18/19 financial and operational plans. The new format of leadership briefing will provide the opportunity for Executive Team to brief the organisation on the progress with our plans. Currently meeting the milestones for 18/19 planning which will feed into the longer term IBP 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. May-18 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. May-18	end June-18	◄►	DS	F&I SLF

Strategic Objective 3: We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.

Risk 3.3 We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we may not be the provider of choice for our local population or commissioners.

Key controls	Development of communications strategy Governance processes support and evidence organisational learning when things go wrong Quality Governance Framework and quality dashboard. Risk assessments Complaint and incident monitoring and shared learning Robust complaints process in place that supports early local resolution External, internal and clinical audit programmes in place Equality strategy and equality impact assessments
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Board receives clear perspective on all aspect of organisation performance and progress towards achieving Trust objectives. Friends and Family feedback and national benchmarking Healthwatch reviews, PLACE audits and patient surveys Dr Foster/CHKS/HSMR/SHMI/RAMI data Audit opinion and reports and external reviews eg Royal College reviews Quality framework in place and priorities agreed, for Quality Account, CQUINs

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.3.1	C	Effective controls are required to ensure the Trust achieves compliance with the four core 7 day service standards by 2020. There is a risk that the Trust may not achieve compliance with three of the four resulting in loss of reputation due to difficulties in funding, staff recruitment to manage increased rota requirements. Standards 5 (access to diagnostic tests), 6 (access to specialist consultant led interventions) and 8 (Patients with high-dependency care needs receive twice or one daily specialist consultant review depending on condition) are those at risk.	Jul-17 7 Day Service Steering Group reporting into Clinical Effectiveness Group and Quality Improvement Steering Group. Project has support from Programme Management Office, with dedicated project lead assigned. Baseline audit being undertaken. Working closely with NHS England and NHS Improvement to gain best practice/lessons learnt from other Trusts Sept-17 Baseline template to be reviewed prior to distribution and gap analysis underway; Discussions with VitalPAC provider taking place. Strategy/Plan for submission to 7DS Steering Group. Project Initiation Document being drafted. Nov-17 Project initiation document being progressed will be considered by 7 day steering group. Jan-18 PID agreed by 7DS steering group. All divisions incorporating 7DS needs into their 2018-19 business planning. Standard 2 New MAU post-take round proforma agreed and incorporated in IPD. Includes ceilings of care and stratification. Work ongoing on recruiting additional AMU consultants. Intermittent weekend additional AMU consultant cover at both acute hospital sites. Standard 5 Guidance for clinical staff on accessing investigations nearly complete. Will be available on intranet and entry points. Standard 6 Work ongoing on changes to GIM rotas to support 24/7 GI bleeding service. Will require changes to consultant job plans Standard 8 Pilot wards (Gastroenterology, Rheumatology) being recruited for electronic recording of patient acuity stratification and daily review delegation (core standard 8). Work ongoing on modifying eSearcher/PAS to incorporate additional stratification /delegation functionality. Project team site visit to Ashford (EKH) to view functionality of Careflow. Careflow to be introduced from 2018-19 Q1, but preparatory work will be undertaken prior to that. 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. 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. May-18 Ongoing programme of work as outlined above.	end Dec-18	◄► **Jul-17**	COO	SLF Q&S

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
4.1.1	C	Ongoing requirement for assurance on the controls in place to deliver the financial plan for 2018/19 and achieve efficiency targets leading to a reduction in deficit for the Trust and exit from financial special measures.	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. Mar-18 – 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. May-18 – Trust has submitted an initial financial plan with a deficit of £47.9m for 2018/19. This has a CIP target of £23.5m, but the Trust has identified a minimum ask of £18.2m and no contingency to deliver the plan. The plan has not been accepted by NHSI who are requiring as a minimum a deficit of £40m for 2018/19. The Trust has identified £28m of pipeline CIP schemes, but to date only £13m are 'green,' leaving a £5m challenge. External support from PA Consulting is in place to bring forward the balance of schemes. The Trust is revisiting the financial plan assumptions to establish options for improving the financial plan. The PSO and programme support arrangements have been refreshed for the new financial year, and the Trust is seeking to appoint a Recovery Director to support the delivery of the programme into 2018/19.	Commenced and on-going review and monitoring to end Mar-19	◄►	DF	F&I

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

Key controls	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Capital plans operational review on a monthly basis by the Capital Review Group, and detailed review by the Finance and Investment Committee, on behalf of the Board, on a monthly basis. Essential work prioritised within Estates, IT and medical equipment plans
Positive assurances	Draft assessment of current estate alignment to PAPs produced Essential work prioritised with Estates, IT and medical equipment plans. Significant investment in estate infrastructure, IT and medical equipment required over and above that included in the Clinical Strategy FBC. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly. Trust achieved its CRL in 2016/17

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. 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. 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. 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 May-18 – The Capital Plan for 2018/19 has been refreshed, with a further iteration being considered at May 2018 Finance and Investment Committee – to be followed by a refresh of the five year financial plan in June 2018.	On-going review and monitoring to end Mar-19	◄►	DF	F&I

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
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 Nov-17 Meeting with ESFRS 6 November. Trust to provide information in respect of balanced risk related to ward decants required to complete fire compartmentation works. Jan-18 Full survey and supporting information provided to ESFRS, a review meeting to be arranged in January. Business case presented at the board seminar in December, resulting amendments to be incorporated. Developing a project to address issues with existing fire compartment walls in the Seaford and Hailsham ward areas. 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. May-18 Business case for fire compartmentation developed, will be reviewed by Board June 18 before submission to NHSi. Fire stopping works are being carried out to reduce the size of the Seaford and Hailsham fire compartments in line with the recommendations by ESFRS. ESFRS visited on the 10th May and were impressed by the standard of work now being completed by third party certified contractors. They will be seeking Trust permission to use ESHT as a best practice model in this subject. Seaford and Hailsham areas are due to be completed by the end of June18.	end Jun-18	Sep 17 ◄►	CEO	Audit Committee

Risk 4.4 We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.	
Key controls	Horizon scanning by Executive team, Board and Business Planning team. Board seminars and development programme Robust governance arrangements to support Board assurance and decision making. Trust is member of FTN network Review of national reports Clear process for handling tenders/gathering business intelligence and mobilisation or demobilisation of resources Participating in system wide development through STP and ESBT Alliance Strategy team monitoring and responding to relevant tender exercises Anti-virus and Anti-malware software Client and server patching NHS Digital CareCert notifications Information Governance Toolkit
Positive assurances	Policy documents and Board reporting reflect external policy Strategic development plans reflect external policy. Board seminar programme in place Business planning team established SESCSG Sussex and East Surrey Cyber Security Group

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
4.4.1	C	Adequate controls are required to minimise the risks of a cyberattack to the Trust's IT systems. Global malware attacks can infect computers and server operating systems and if successful impact on the provision of services and business continuity.	Nov -17 Develop Information security programme of work Staff Training - Phishing Simulation software Formal information security certification for internally provided digital services Jan-18 Action plan published Jan-18. Reviewing IT Security Systems and phishing email simulation software in place. Funding approved by Sussex COIN board to implement DNS security across Sussex COIN. Will require a long term sustained programme of work to deliver assurance that threats from cyber-attacks are adequately controlled. Mar-18 Ongoing development and implementation of action plan, progress presented to IG Steering Group. Phishing simulation being undertaken. May-18 Number of workstreams in place to ensure adequate controls in place. Update paper will go to Audit Committee.	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.

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
5.1.1	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties	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. 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. 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. May-18 Medical workforce vacancy percentage has decreased by 10% over the last twelve months. Medical vacancy percentage for the Trust now at 4.1%.All areas vacancy percentage showing declining run rates. April 2017-March 2018 . UK Nurse Attraction campaign targeting return to practice and OSCE candidates continues with a number of new nurses joining the Trust. International recruitment continuing for Medical and AHP staff groups-27 International Nurses to join the Trust by August 2018. Medacs recruitment agency now due to be on site by mid May 2018. List of 50 difficult to recruit posts to be identified for them to create a pipeline of candidates. Increased promotion of vacancies via Medacs third party agencies.	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.

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
5.2.1	A	The CQC staff surveys provide insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others.	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. Nov-17 Continued work on ensuring that staff feel valued and wellbeing is key priority. Unsung Hero's roadshows and celebration event in Oct . Range of health and wellbeing activities available to staff including: Health Checks for aged 40-70 , flu vaccination in workplace. Staff listening conversations to share views on what we could do better about stress in the workplace which will inform new Stress at Work policy, our physiotherapist in occupational Health is supporting staff with MSK injuries as well as trying to raise the profile of how to prevent MSK injuries. Three very successful Schwartz rounds at EDGH, Conquest and Bexhill hospitals Jan-18 National staff survey response rate 49% - 3% above 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. 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 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 May-18 Staff survey one of the few Trusts nationally to show sustained improvements. Drill down identifies some areas that require further review and this will be locally reviewed and actions developed. Awaiting results of GMC survey.	end May-18	◄►	HRD	POD SLF

Chief Executive's Report

Meeting information:			
Date of Meeting:	5th June 2018	Agenda Item:	8
Meeting:	Trust Board	Reporting Officer:	Dr Adrian Bull

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

Has this paper considered: (Please tick)

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

Other stakeholders please state: ……

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

Executive Summary:

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

The purpose of this report is to provide the Board with a summary update from the CEO's perspective.

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

None

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

The Board is asked to note the contents of the report and receive the update.

1. Introduction

At the time of writing we have received our Care Quality Commission reports following the March 2018 inspection. These reports are draft and for accuracy checking. The CQC's aim is to publish the reports in early June and if this is the case a verbal update on the outcome of the inspection will be given at the Board meeting.

I would like to once again express my thanks to all staff at the Trust, not only those involved in planning the CQC visit and those who met with the inspection teams, including members of this Board.

Our financial position remains challenging and we closed 17/18 with an underlying deficit of £53.6m. We are developing cost improvement plans for 18/19 that will improve efficiency and maintain quality whilst reducing the deficit.

2. Quality and Safety

Patient falls continues to be one of the highest causes of harm in the trust although there has been a reduction in all falls reported and serious harm from falls in 2017/18 compared to 2016/17. The new assessment trial has completed and now a full roll out plan is in place to embed across the trust inpatient areas. New review and challenge sessions are supporting this roll out to check compliance and ensure support to departments.

A task and finish group has been established to improve the quality of information and communication to patients and next of kin during their discharge from the hospital following patient experience feedback.

The management of investigations for moderate harm (Amber) incidents within the Divisions remains a challenge to ensure completed within the timescales and for identified improvement to prevent recurrence to be in place. The Divisions are aware of the challenges and are being tracked for progress through the Integrated Performance Reviews.

We have experienced an improvement in sepsis screening following a dip in February 2018.

The Trust is participating in cohort 3 of the NHSI led national recruitment and retention programme for registered nurses. This work is being led jointly by corporate nursing and human resources and a bespoke action plan to address local underlying factors related to turnover and leavers will be developed.

We are delighted to report that the Trust is an early UK implementer (one of only two Trusts) of the global project to move from subjective UK National Descriptors to International Dysphagia Diet Standardisation Initiative (IDDSI) levels for people who have swallowing difficulties. The aim of the project is to increase safety by bringing all manufacturers and consumers into consistent practice.

Infection control – the Trust has reported 36 cases of CDiff for 2017/18 which is below the limit of 41.

Pressure Ulcers – There has been an increase in category 2 and a snapshot deep dive is being conducted and will report to the Board in June. There were no category 3 or 4 pressure ulcers and there has been a considerable reduction in overdue RCAs for category 3 and 4s.

Mixed Sex Accommodation – the new 'real time' method of reporting continues to result in increased numbers of breaches but the numbers are reducing.

The Maternity Establishment Review and Paediatric Review are underway. Daily reporting on safe staffing is in place and a monthly report has been developed.

Mortality indices remain within the expected range, and much improved on this time last year.

There has been a recent slight fall in the VTE prophylaxis data which we are addressing through the clinical improvement group.

3. People, Leadership and Culture

Recruitment

- A targeted approach to medical vacancies (in particular ED) has seen a reduction to a vacancy rate of 4.1% in M12. This is a reduction from 14.3% in April 2017.
- International recruitment is continuing in the Philippines and Indian sub- continent for Medical and AHP staff groups, including radiographers.
- 27 International Nurses will join the Trust by August 2018.

Workforce Planning

- Skill mix changes and the introduction of new roles continue as part of working with divisions.
- Participating in NHSI Nurse Retention Programme, which includes identifying retention issues and implementation of best practice interventions.
- Continuing implementation of Medical Healthroster and e-Job Planning systems to ensure efficient use of staff within the organisation.

Staff Engagement

- Over 300 nominations received for the Trust Awards.
- Case study published on our approach to Staff Engagement published by NHS employers.
- Leadership masterclass on Personal impact held for 80 leaders across the organisation
- An evening masterclass on Leadership held for SAS doctors with plans for follow up workshops.
- Ongoing work with partners across the system to develop a range of OD interventions – these include a system wide leadership programme, which included our staff from maternity looking at the Better Births Agenda and OD Practitioner course.

Education

- 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

March was challenging, with much of the south east and the rest of the country seeing high levels of demand and patient acuity, coupled with snow. This resulted in the East Sussex and other local systems operating in the highest escalation levels since last year.

However staff managed admirably and we supported by the 4x 4 response service during the snow period to support staff getting to and from work, as well as supporting our community services in reaching our patients.

We saw and increase of 12% additional patients through our emergency departments compared to March last year, 60% more patients treated and discharged through our ambulatory services avoiding overnight stays in hospital and our total non-elective spells increased by almost 25%.

With this additional pressure we delivered a 4 hour performance standard of 89.2% across the East Sussex system and 85.5% within the Trust services; this was a 4.8% improvement on the previous year and puts us within the top 30% of systems nationally.

Our elective waiting list continues to decrease, and although our longer waiting patient numbers have declined we have not been able to sustain our performance at 92%, actions are in place to recover this position, however we have maintained elective surgery for our cancer and urgent cases as well as treating those who have waited the longest. We continue to focus on outpatient and theatre productivity as a key priority to manage demand as efficiently as possible.

Our cancer patients continue to be seen within 2 weeks for their initial appointments; however we have seen an unprecedented and unpredictable demand for urology, breast and colorectal services through March and April, which is affecting our delivery in April and through the start of May. We continue to focus on our 62 day pathway which has improved since the same time last year, the high volume specialties urology and colorectal remain our key priority, although focus continues for all services.

The community teams continue to support patients in their own homes as well as through the bedded rehabilitation services. Length of stay in the intermediate beds has reduced by 4.7%.

5. Finance

External auditors for the Trust are in the process of signing off on our results for 2017/18, with a reported 'accounting' deficit of £56m. The Trust did not deliver its plan in 2017/18 and in preparing for 2018/19; the Executive Team and Board have been clear and consistent in highlighting the importance of agreeing and then delivering a stretching but achievable financial plan for 2018/19. Leaders and teams across the Trust have been preparing for 2018/19 for a number of months, and the initial Month 1 results reported this month are consistent with the budget. Board colleagues reviewed the components of the plan in Seminar before the start of the financial year.

Delivering Month 1 is a good start to the year – we know that recovering from a movement off plan is harder than continuing to deliver a plan. But, there are two priorities for us in the next few weeks. First, we must shift the focus now to delivery – providing support to Clinical and Corporate teams as appropriate, and getting the assurance and escalation processes within the organisation right. Second, we must continue to test the initial financial plan for opportunities for further improvement. NHS Improvement, our regulators, have not accepted the Trust's initial draft plan and, indeed, the Board has indicated that it wishes to go further in reducing the deficit. So, alongside the delivery piece, we must continue to turn our pipeline of CIP schemes from 'green' to 'red.' As at the date of writing, we have £13.8m as 'green – and we have set ourselves a target of £18-23m. Whilst there is a good pipeline of schemes in place, and our Divisional teams have worked hard to identify savings based on the Model Hospital analysis, we will continue to seek further improvement into June. We are reviewing the overall financial plan in more detail later in the meeting today.

At the same time, work continues on our sustainability programme for the Trust. We are out to tender for an analysis of the 'drivers of the deficit' at the Trust, to help us understand the causes of the £50m deficit – and this sits alongside a piece of work which is being undertaken with the Clinical Commissioners and East Sussex County Council looking at the drivers of the 'system deficit.' Our 3+2 Year financial model is taking shape, and has been reviewed at the Finance and Investment Committee – and will come to the Board in July. Our Clinical Strategy is also taking shape, working alongside colleagues in the East Sussex System. Alongside the focus on 2018/19, we are building a clear road map to sustainability over the next two years.

East Sussex Healthcare NHS
NHS Trust

Month 1 – April 2018

TRUST INTEGRATED PERFORMANCE REPORT

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Contents

East Sussex Healthcare NHS
NHS Trust

April 2018

Key Successes

•Performance improved in all the key constitutional standards

Key Issues

•A&E Attendances continue to grow year on year.
•Non-elective and emergency admissions remain higher than planned

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

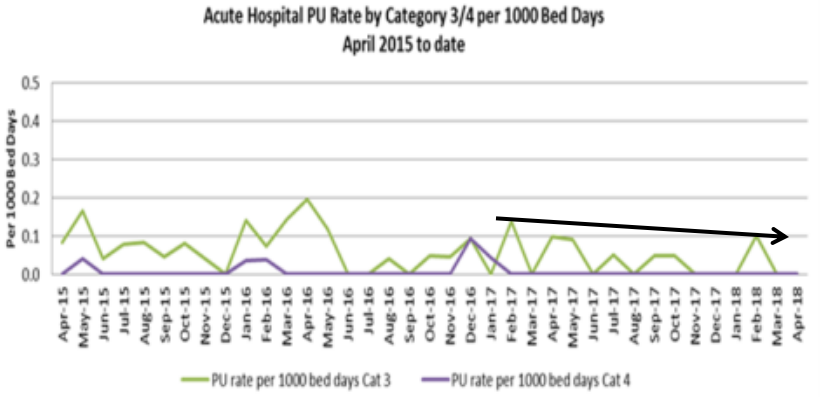
East Sussex Healthcare NHS
NHS Trust

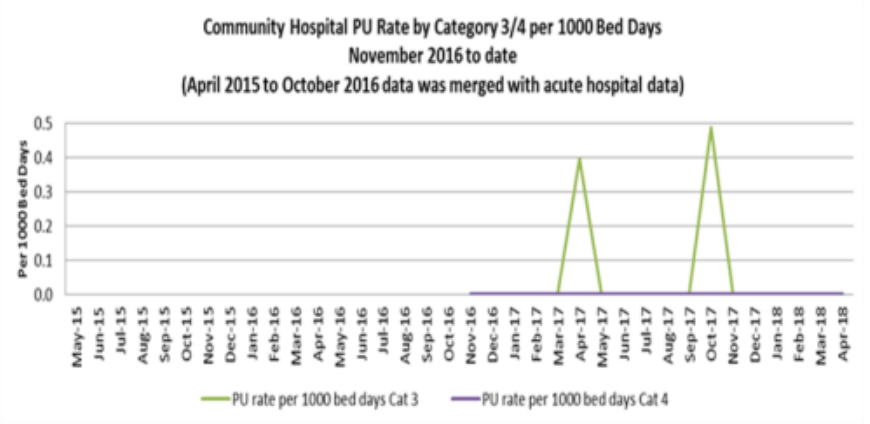
Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-17	Apr-18	Var	2017/18	2018/19	Var		
Total falls	M	136	158	16.2%	136	158	16.2%	136	
All patient falls per 1000 Beddays	5.5	5.7	6.7	1.0	5.7	6.7	0.98	5.6	
All patient falls with harm per 1000 Beddays		1.3	1.5	0.1	1.3	1.5	0.13	1.4	
Total grade 2 to 4 pressure ulcers per 1000 Beddays	M	2.5	2.0	-21.0%	2.5	2.0	-21.7%	2.0	
Safety Thermometer overall score	92.0%	93.2%	93.09%	-0.1%	93.2%	93.1%	-0.1%	92.5%	
VTE Assessment compliance	95.0%	96.7%	95.7%	-1.0%	96.7%	95.7%	-1.0%	95.6%	
Number of MRSA Cases	0	0	0	0	0	0	0	0	
Number of Cdiff cases	4	1	3	2	1	3	2	3	
Number of MSSA cases	M	0	1	1	0	1	1	1	

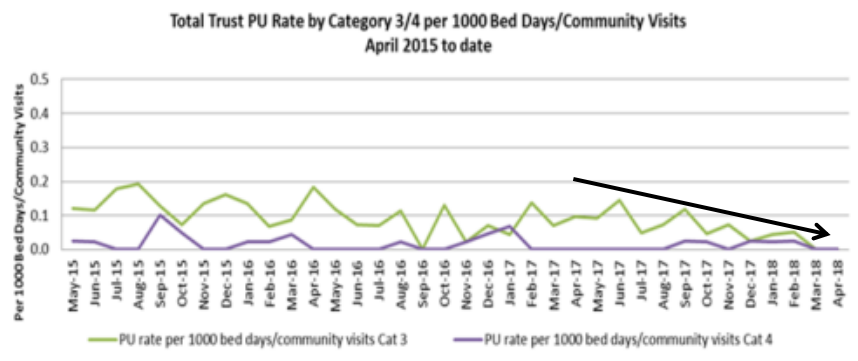
- The percentage of no harm/near miss patient safety incidents is 81% (national figure 73%).
- The number of patient falls reported in April has increased which is well over our recent rate. Two areas higher than others are Acute Medical Unit at EDGH and the Irvine Unit. The wards have been asked to review and provide assurance, via a deep dive to the Quality & Safety Committee, that the assessments and preventative actions were in place.
- Falls review and challenge sessions are now commencing on a weekly basis to ensure the new system is embedded. This will continue alongside the roll out of the new falls assessment.

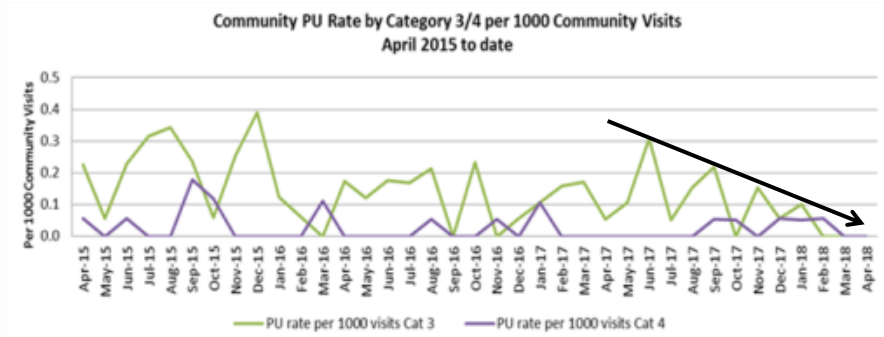
East Sussex Healthcare NHS
NHS Trust

PRESSURE ULCERS









A reduction in total ESHT acquired for April (cat 2s, 3s and 4s) with 42 (61 in March). Snapshot deep dive for grade 2 PU carried out in early May with report to Quality & Safety Committee in June 2018
The graphs above detail the breakdown of category 3 and 4 pressure ulcers for April 18

- Acute hospital acquired - cat 3/4 = 0
- Community acquired - cat 3/4 = 0
- Community hospital acquired - cat 3/4 = 0

Considerable reduction in overdue RCAs for grade 3/4. Two have not yet been received; a further three have been reviewed at PURG but require more information so will be re-submitted and re-reviewed.
RCAs review any lapses, note good practice and consider potential avoidability.

Serious Incidents (SI) reported in april

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-17	Apr-18	Var	2017/18	2018/19	Var		
Number of Serious Incidents reported	M	3	5	2	3	5	2	4	
Never Events	0	0	0	0	0	0	0	0	

There were **5 serious incidents** reported during April 2018 which were:

- 1 x surgical trauma in Gynaecology
- 1 x surgical trauma from caesarean section
- 1 x potentially missed subdual haematoma from imaging report
- 1 x diagnostic treatment delay
- 1 x serious incident has since been downgraded by the Trust and the Clinical Commissioning Group Scrutiny Panel as did not meet the criteria and there was no harm caused during our care.

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

As of the end of April there were 17 open Serious Incidents in the system. 3 are with the CCG awaiting review, 1 has been returned by the CCG with further comments 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 81% informed verbally, 84% followed up in writing and 93% findings shared with patient or family upon completed investigation. This has reduced from previous performance partly due to the delay in completion of the outstanding Amber investigation reports. There are 66 Amber (moderate harm) investigations open in the system over the timescale for completion.

The review of the action plans identified from the 4 never event investigation reports (detailed in the **Closing the Loop** Report reviewed at Patient Safety and Quality Group) found 19 out of 24 actions have been completed with full assurance they are embedded in practice. 3 actions have partial assurance and 1 action remaining for completion.

PATIENT EXPERIENCE

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-17	Apr-18	Var	2017/18	2018/19	Var		
Inpatient FFT response rate	45.0%	30.9%	38.6%	7.7%	30.9%	38.6%	7.7%	40.9%	
Inpatient FFT score	96.0%	97.0%	97.8%	0.8%	97.0%	97.8%	0.8%	97.2%	
A&E FFT response rate	22.0%	8.3%	4.8%	-3.5%	8.3%	4.8%	-3.5%	8.0%	
A&E FFT score	88.0%	90.0%	94.9%	4.9%	90.0%	94.9%	4.9%	89.7%	
Maternity FFT response rate	45.0%	43.3%	0.4%	-42.9%	43.3%	0.4%	-42.9%	27.8%	
Maternity FFT score	96.0%	98.2%	100.0%	1.8%	98.2%	100.0%	1.8%	98.3%	

Patient Experience feedback continues to be an important quality measure in terms of score and response rate.

The A&E response rate has increased slightly from 3.9% to 4.8% with a score of 95% satisfaction.
Inpatient **FFT** response rates are at 37% which is lower than target however we recently changed software provider therefore inputting and recording has not been available each day. This should be rectified for May data.
Maternity response rate is so low as the maternity department did not use the paper system whilst changing service providers.
The response rate is also likely to be affected in May.

NHS Choices

- Overall rating at EDGH = 4 Stars (191 ratings)
- Overall rating at Conquest = 4.5 Stars (208 ratings)

Improvement Project - Discharge

Following patient feedback from the National Inpatient Survey and patient experience questionnaires further improvements can be made to the quality of the discharge process in terms of information provided and how we communicate with patients and relatives. A group is now meeting and working with a ward from each Division to review the process and seek feedback from staff and patients on ideas to improve the quality. Changes will be trialled and adjusted where needed to the pilot sites before rolling out to other areas.

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NHS Trust

MIXED SEX ACCOMMODATION

A new system was implemented in February. Any breaches are recorded on a real time system by the clinical site team. Using the categories provided by the KSS NHI team, only breaches that are not clinically justified are reported to UNIFY.

Examples of clinical justification includes patients in mixed bays in hyperacute beds and patients with infections who are cohorted. Both of these categories are clinically justified, and are captured but not reported to UNIFY.

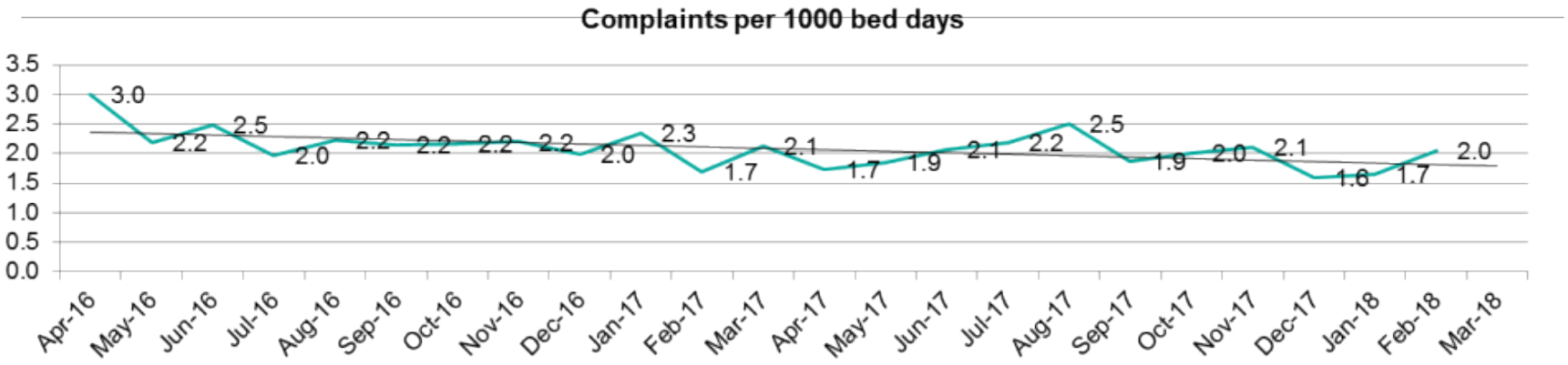
In April, 71 pts were affected in 17 incidents and reported as not clinically justified. There was one breach incident at Conquest whilst the hospital was in 'Black' status, and four at EDGH.

Main areas of challenge were ITU at Conquest and AMU at EDGH.

All steps are taken to move patients as soon as possible and patient feedback is monitored with no complaints of negative comments in April.

Complaints

East Sussex Healthcare NHS
NHS Trust



53 new complaints were received in April and at the end of the month there were no overdue complaints.

Complaints by bed days within each Division in April 2018 are:

- Medicine – 1.4 per 1000 bed days (16 complaints)
- DAS – 3.2 per 1000 bed days (19 complaints)
- Out of Hospital – 3.0 per 1000 bed days (5 complaints)
- Women, Children and sexual Health – 4.6 per 1000 bed days (6 complaints)
- Urgent Care - 7 complaints.

The main themes in complaints is **communication, attitude, lack of diagnosis and problems /complications**.

Parliamentary and Health Service Ombudsman (PHSO);

In April, the Trust received **two contacts from the PHSO**. The first was to ask the Trust to undertake further local resolution on a complaint rather than consider it for investigation at this stage, whilst the second contact was to make an initial line of enquiry about a case referred to them. There were no final case outcomes received in April.

ADNs are now standing members at **Quality & Safety Committee** and will be asked to discuss actions/plans regarding themes.

Nursing and Midwifery Workforce

East Sussex Healthcare NHS
NHS Trust

- Establishment Reviews - The Maternity and Paediatric reviews are due to be received soon following presentation at the appropriate Board committees. Further establishment reviews will be conducted for theatres (underway) and outpatients.

- Safer Staffing governance is being revised to enhance the cross divisional senior nursing ownership building on the daily reporting in place and the new monthly report. Health roster compliance sessions led by the Director of Nursing and the corporate nursing team are identifying themes and cross divisional areas for focus and a Safer Staffing group is being established to drive this agenda forward.

- The Director of Nursing is leading a review to ensure more flexibility in shift length and patterns nursing staff are able to work alongside the most prevalent 11.5 hour shifts in inpatient and intermediate care wards. This is aimed at providing nursing staff with more choice about their working patterns, but needs to be balanced with service needs.

- The Trust is now participating in the NHSI led national recruitment and retention programme focused on registered nurses in line with the Secretary of State's commissioning. A bespoke action plan to address local underlying factors related to turnover and leavers is being developed. This joint work is being led by corporate nursing and human resources.

- The Trust's Strategic Workforce Resourcing Group will be supported by a Nursing Workforce Resourcing Group which will provide a forum for all aspects of workforce profiling and planning to support the Trust's strategy and delivery of clinical services.

Safer Staffing

East Sussex Healthcare NHS
NHS Trust

	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
BEXHILL HOSPITAL -	91.1%	115.3%	86.4%	160.1%
EASTBOURNE DISTR	89.4%	106.6%	93.3%	124.6%
CONQUEST HOSPITA	87.8%	109.7%	88.9%	109.0%
Totals	88.6%	108.7%	90.8%	119.1%

- The Safer Staffing return generally shows that both RN and HCA fill rates are closer to planned rates across all sites. This is an improved position on previous months and reflects, to some extent, the reduced escalation capacity open at present whilst noting that annual leave rates are slightly lower than the last quarter.

- 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. Health roster compliance sessions are in place. There is a focus on use of additional staff ("specials") and ensuring annual leave is actively planned and managed throughout the year and in line with the Trust Policy.

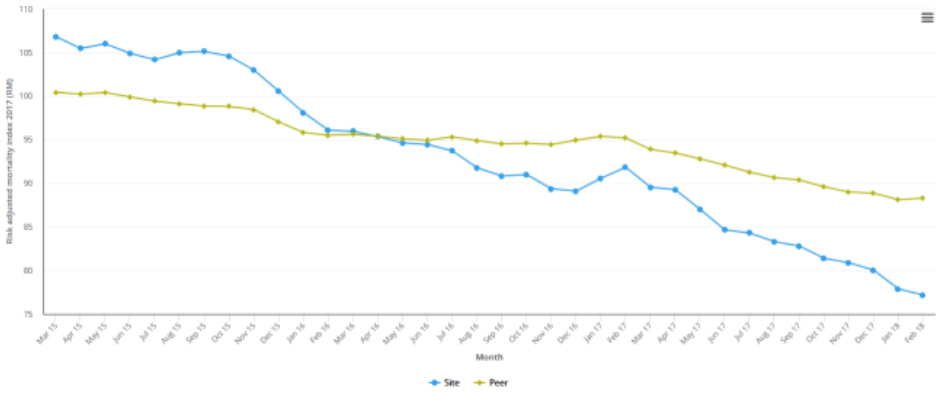
- Daily reporting on demand, fill rate and outstanding shifts continues and is supplemented with a daily report on staff moves and Safe Care compliance following the staffing meetings at each site.

- More detailed reporting has been received at the People and Organisational Development (POD) Committee including breakdown of fill rates and impact by ward.

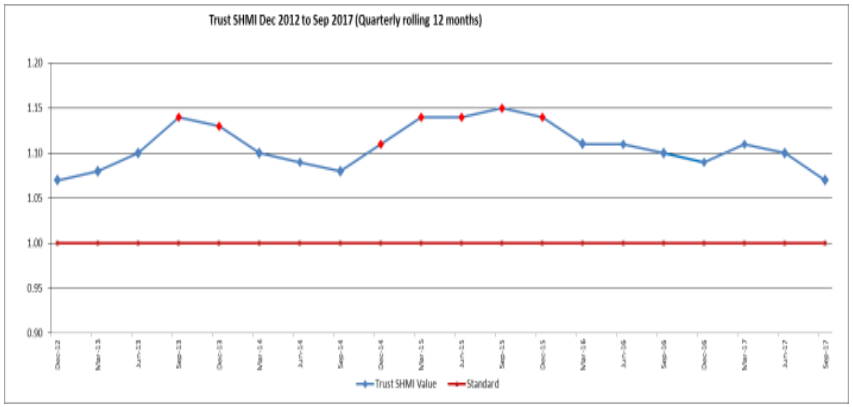
Mortality Metrics

East Sussex Healthcare NHS 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 - March 2017 to February 2018 (rolling 12 months) is **77** compared to 92 for the same period last year (March 2016 to February 2017). February 2017 to January 2017 was 78.

RAMI 17 shows an February position of 91 against a peer value of 99. The January position was also 91 against a peer value of 99.

Crude mortality shows March 2017 to February 2018 at 1.75% compared to 1.91% for March 2016 to February 2017 (an 8.25% reduction)

The percentage of deaths reviewed within 3 months was 71% in January 2018, compared to 65% in December 2017.

Main causes of death during April 2018 (Mortality Database)	
Pneumonia	47
Cancer	25
Sepsis/Septicaemia	15
Heart failure	8
Myocardial Infarction	6
Chronic Obstructive Pulmonary Disease (COPD)	5

RAMI 17 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
		Apr-17	Apr-18	Var	2017/18	2018/19	Var		
Four hour standard	95.0%	80.1%	89.6%	9.4%	80.1%	89.6%	9.4%	88.2%	
A&E Minor Performance	98.0%	93.7%	99.1%	5.4%	93.7%	99.1%	5.4%	98.1%	
Four hour standard (Local System)									
12 Hour DTAs	0	0	1	1	0	1	1	0	
Unplanned re-attendance to Emergency Department	5.0%	3.0%	2.8%	-0.2%	3.0%	2.8%	-0.2%	2.8%	
% Patients waiting less than 15 minutes for assessment in ED	M	80.9%	83.8%	2.9%	80.9%	83.8%	2.9%	83.0%	
% Patients waiting less than 60 minutes for treatment in ED	M	41.1%	49.6%	8.5%	41.1%	49.6%	8.5%	46.9%	
% Patients waiting less than 120 minutes for treatment in ED	M	68.5%	80.8%	12.3%	68.5%	80.8%	12.3%	76.8%	
% Patients that left without being seen in ED	M	1.5%	2.5%	1.0%	1.5%	2.5%	1.0%	1.9%	
% Patients admitted from ED (Conversion rate)	M	26.4%	30.1%	3.7%	26.4%	30.1%	3.7%	29.4%	
Number of ambulatory care admissions with zero length of stay	M	628	1031	403	628	1031	403	852	
% of ambulatory care admissions with zero length of stay	M	54.5%	62.9%	8.5%	54.5%	62.9%	8.5%	56.8%	
Emergency Department attendances	M	9571	10156	6.1%	9571	10156	6.1%	9953	
Ambulance conveyances	M	3211	3119	-2.9%	3211	3119	-2.9%	3220	
Admissions via A&E	M	26.4%	30.1%	3.7%	26.4%	30.1%	3.7%	29.4%	

The Trusts' 4 hour performance was 89.6% for April (9.55% improvement on the previous year)

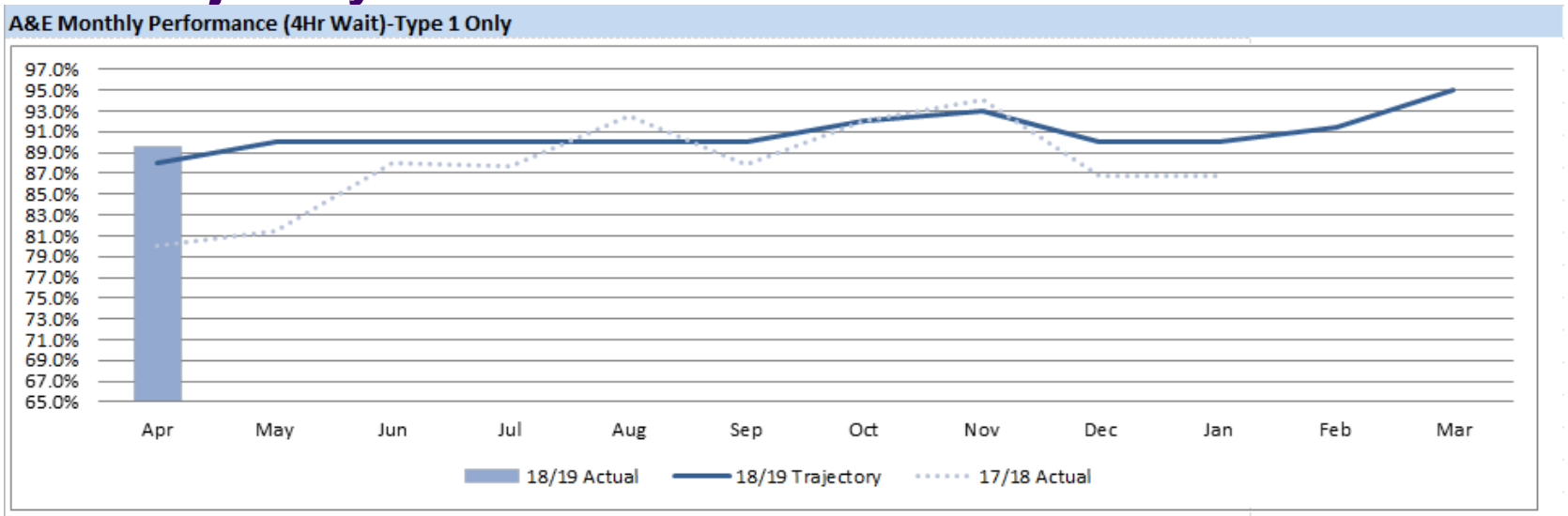
The system, walk in centres and the acute trusts combined performance was 92.25%, March 89.2%, Feb 90% and Jan 91%

Patients being managed through the ambulatory unit and AMU with a 0 day LOS has increased to 62.5%.

Activity continues to increase on the previous year, attendances up 9.4% and on non-elective spells up 17.5%.

A system wide review is being undertaken to assess the causes for the continued increases.

A&E Trajectory



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	88.0%	90.0%	90.0%	90.0%	90.0%	90.0%	92.0%	93.0%	90.0%	90.0%	91.5%	95.0%
18/19 Actual	89.6%											
17/18 Actual	80.1%	81.4%	88.0%	87.7%	92.5%	87.8%	92.1%	94.1%	86.7%	86.7%		

- EDGH – 89.3%
- Conquest – 89.8%

- Minors performance for April is 99.1%

- Attendances in April increased by 6% on the previous year.

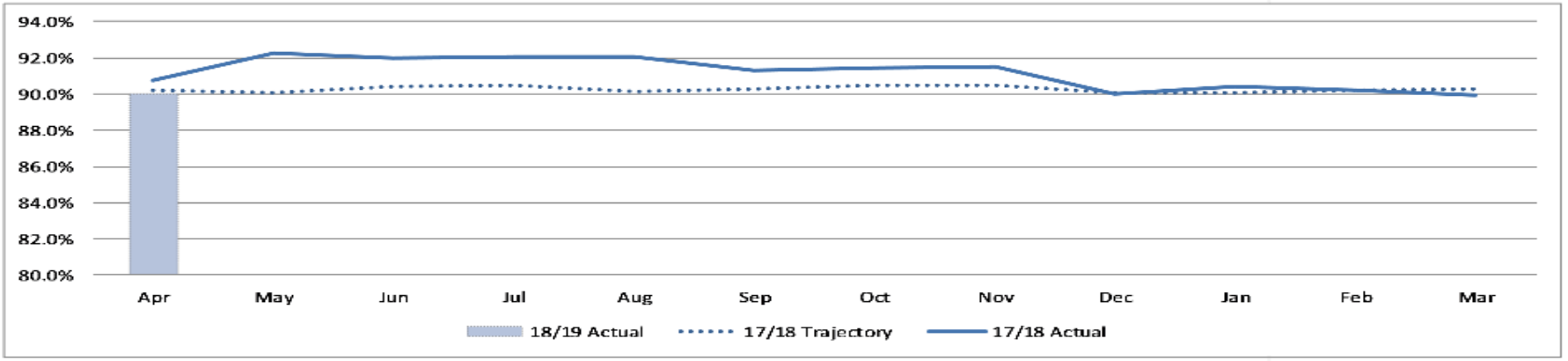
- Ambulance conveyances decreased by 2.9% against April 2017. This may be due to the timing of the Easter holidays affecting variation in both March and April year on year.

East Sussex Healthcare NHS
NHS Trust

RTT

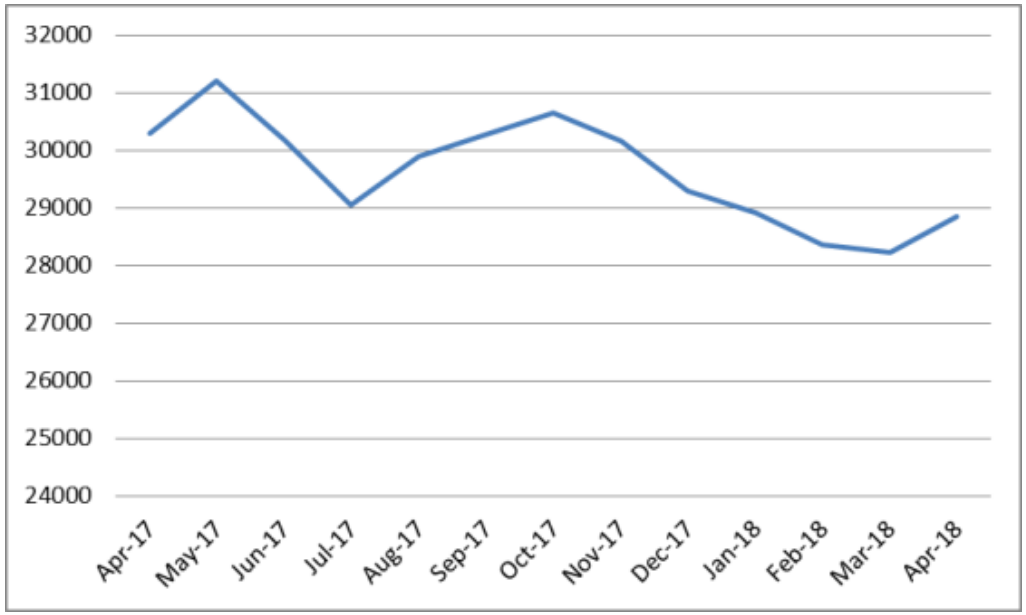
Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-17	Apr-18	Var	2017/18	2018/19	Var		
RTT Incomplete standard	92.0%	90.8%	90.0%	-0.8%	90.8%	90.0%	-0.8%	91.1%	
RTT Backlog (Number of patients waiting over 18 weeks)	M	2794	2886	92	2794	2886	92	2636	
RTT Total Waiting List Size		30284	28853	-1431	30284	28853	-1431	29637	
RTT 52 week waiters	0	0	0	0	0	0	0	0	
RTT 35 week waiters	M	331	186	-43.8%	331	186	-43.8%	188	

RTT (Referral to Treatment 18 Weeks)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18 Trajectory	90.20%	90.03%	90.40%	90.50%	90.10%	90.30%	90.50%	90.50%	90.03%	90.03%	90.20%	90.30%
18/19 Actual	90.0%											
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%	89.9%

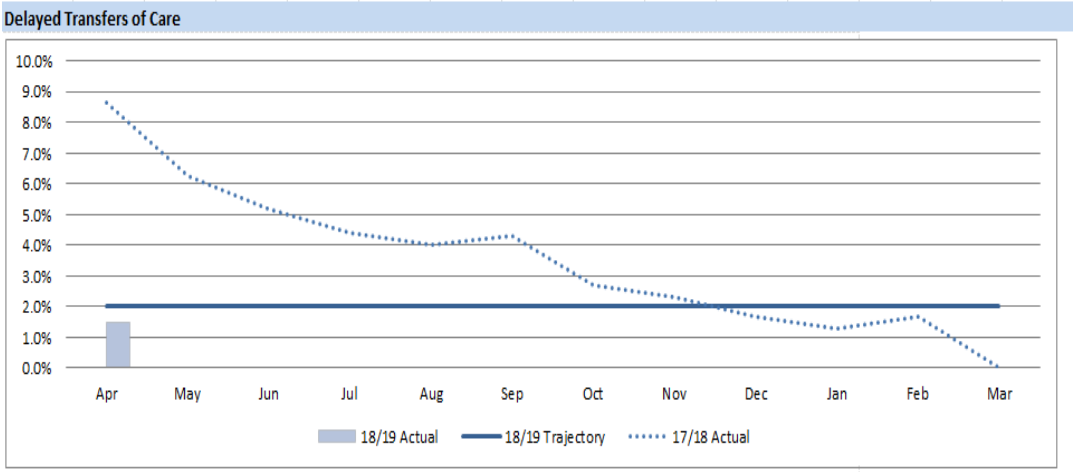
- The Trust performance for April was 90% up from 89.9% in March.
- Elective activity has been maintained through winter, prioritising cancer, urgent and long waiting patients.
- Focusing on out-patient and theatre productivity to better manage demand and capacity without additional costs.



- The waiting list increased marginally in April following a sustained decrease. This trend is seen annually and associated with reduced activity levels over the Easter period.

CANCELLATIONS AND DTC

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-17	Apr-18	Var	2017/18	2018/19	Var		
Delayed transfer of care national standard	3.5%	8.6%	1.5%	-7.1%	8.6%	1.5%	-7.1%	3.2%	
Cancellations									
Urgent operations cancelled for a second time	0	0	0	0	0	0	0	0	
Proportion of last minute cancellations not rebooked within 28 days	0.0%	0.0%			0.0%			98.7%	
Outpatient appointment cancellations <6 weeks	M	51	29	-43.1%	51	29	-43.1%	43	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
18/19 Actual	1.5%											
17/18 Actual	8.6%	6.3%	5.2%	4.4%	4.0%	4.3%	2.7%	2.3%	1.7%	1.3%	1.7%	

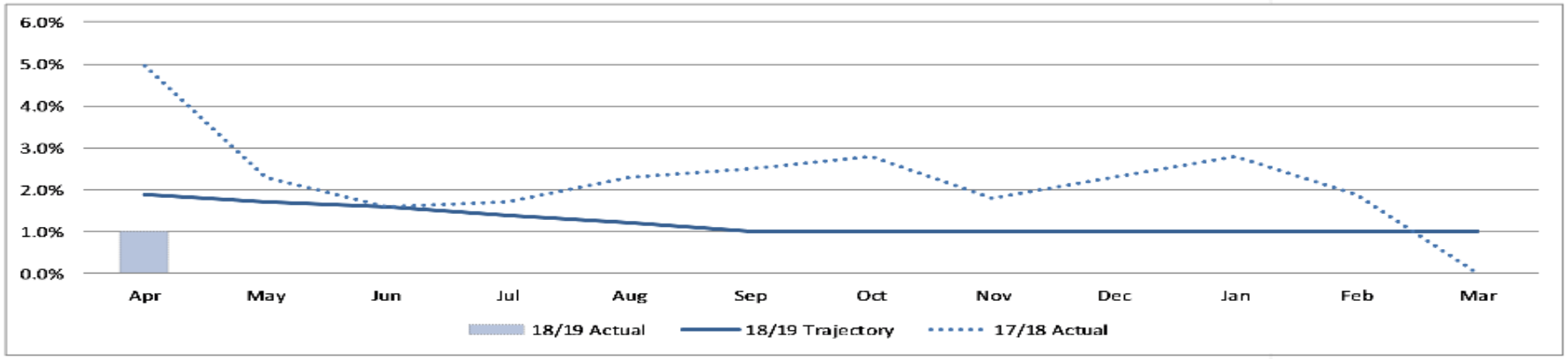
- DTC are currently below the trajectory of 2%. The Trust continues to achieve the national target of being under 3.5%. This has been as a result of continued closer working with social care.
- Despite the increase in activity, non-elective bed days have reduced by 0.4% on April last year and length of stay by 0.7 days supporting the continued elective flow and sustained 4 hour performance.
- Elective LOS has decreased slightly overall in year, April saw an increase of 0.1 days, this is being reveiwed and is a focus moving forwards

Diagnostics

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-17	Apr-18	Var	2017/18	2018/19	Var		
Diagnostic standard (% patients waiting more than 6 weeks)	1.0%	5.0%	1.0%	-3.9%	5.0%	1.0%	-3.9%	2.0%	

Diagnostic waiting times (over 6 weeks)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	1.9%	1.7%	1.6%	1.4%	1.2%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
18/19 Actual	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%	

Diagnostics remains a challenge for the organisation. Performance in April improved to 1.02% up from 1.4% in March.

Further work is required to achieve the <1% target.
Key areas for improvement are radiology (CT) 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.

Breaches 6 weeks and over	Apr-18
Computed Tomography	40
Non-obstetric ultrasound	10
Audiology - Audiology Assessments	4
Colonoscopy	2
Magnetic Resonance Imaging	1
Flexi sigmoidoscopy	1
Cystoscopy	1
Gastroscopy	1

East Sussex Healthcare NHS
NHS Trust

CANCER STANDARDS

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Mar-17	Mar-18	Var	2017/18	2018/19	Var		
Cancer 2WW Standard	93.0%	98.1%	95.2%	-2.9%	96.8%			96.0%	
Cancer 62 day urgent referral standard	85.0%	76.3%	78.0%	1.7%	76.0%			75.9%	
Cancer 2WW Standard (breast symptoms)	93.0%	98.7%	94.9%	-3.7%	96.7%			95.8%	
Cancer 31 day standard	96.0%	97.1%	96.1%	-1.0%	98.1%			97.1%	
Cancer 31 day subsequent drug treatment	98.0%	100.0%	100.0%	0.0%	100.0%			100.0%	
Cancer 31 day subsequent surgery	94.0%	94.1%	100.0%	5.9%	100.0%			98.4%	
Cancer 62 day screening standard	90.0%	85.7%	47.6%	-38.1%	80.0%			66.9%	

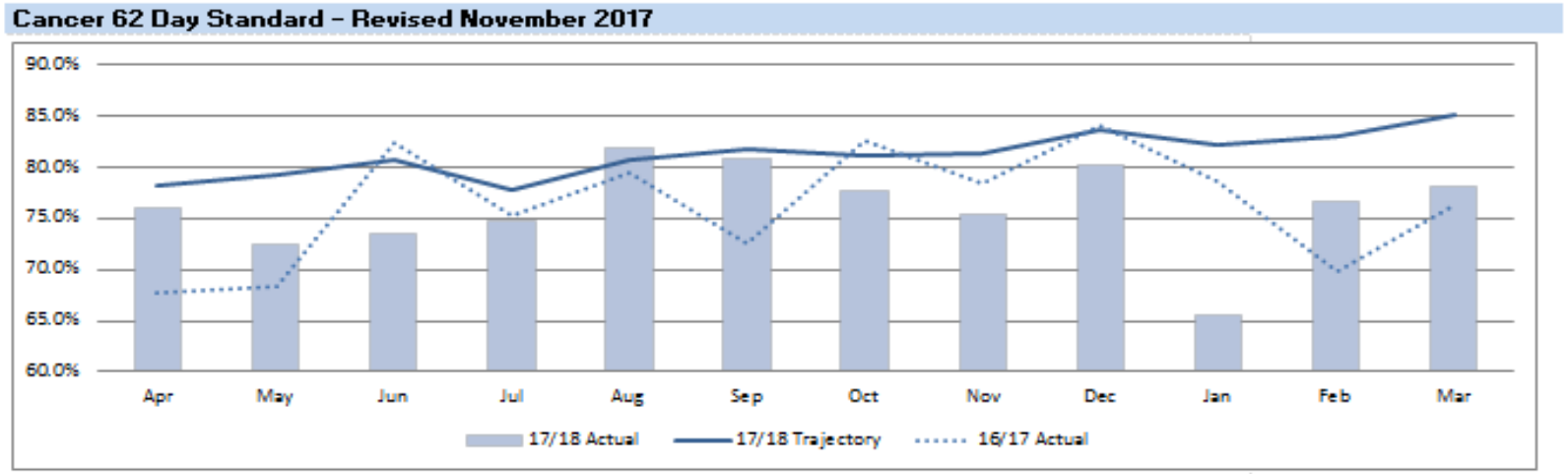
- The cancer data is reported a month in arrears.

- In March the Trust improved the 62 Day urgent referral standard by a further almost 2% showing significant improvement from February towards meeting the 85% target. The 62 day screening standard still requires further improvement. The numbers within this standard are very low and therefore small variances impact on the percentage achievement.

- Cancer 31 day standard continues to meet the standards and met at over 99%. 2ww Standard continues to achieve in March.

Cancer 62 Days

East Sussex Healthcare NHS
NHS Trust



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18 Trajectory	78.2%	79.2%	80.6%	77.8%	80.6%	81.7%	81.0%	81.2%	83.6%	82.1%	83.0%	85.0%
17/18 Actual	76.0%	72.4%	73.4%	74.7%	81.9%	80.8%	77.6%	75.4%	80.2%	65.5%	76.6%	78.0%
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%

Urology, colorectal and Haematology are the highest breaching specialities this month.

Actions to deliver :

- 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

ESHT Cancer Waiting Times Report for March 2018 - Published on 03/05/2018

March 2018 Summary

Standard	Seen/Treated			On Target			Breaches			Compliance			Target
	Conq.	EDGH	All	Conq.	EDGH	All	Conq.	EDGH	All	Conq.	EDGH	All	
Cancer 2WW	692	850	1,542	656	812	1,468	36	38	74	94.8 %	95.5 %	95.2 %	93 %
Symptomatic Breast 2WW	74	84	158	69	81	150	5	3	8	93.2 %	96.4 %	94.9 %	93 %
DDT to First Treatment 31 Days	80	101	181	76	98	174	4	3	7	95.0 %	97.0 %	96.1 %	96 %
ECAD to Subs Surgery 31 Days	7	9	16	7	9	16	0	0	0	100 %	100 %	100 %	94 %
ECAD to Subs Chemo 31 Days	8	11	19	8	11	19	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	50.5	72.0	122.5	40.0	55.5	95.5	10.5	16.5	27.0	79.2 %	77.1 %	78.0 %	85 %
Screening Ref to First Treatment 62 Days	7.0	3.5	10.5	3.5	1.5	5.0	3.5	2.0	5.5	50.0 %	42.9 %	47.6 %	90 %
Upgrade to First Treatment 62 Days	8.5	4.5	13.0	6.0	3.5	9.5	2.5	1.0	3.5	70.6 %	77.8 %	73.1 %	

Q4 2017-18 Summary

Standard	Seen/Treated			On Target			Breaches			Compliance			Target
	Conq.	EDGH	All	Conq.	EDGH	All	Conq.	EDGH	All	Conq.	EDGH	All	
Cancer 2WW	1,804	2,472	4,276	1,718	2,377	4,095	86	95	181	95.2 %	96.2 %	95.8 %	93 %
Symptomatic Breast 2WW	193	220	413	183	212	395	10	8	18	94.8 %	96.4 %	95.6 %	93 %
DDT to First Treatment 31 Days	198	298	496	194	286	480	4	12	16	98.0 %	96.0 %	96.8 %	96 %
ECAD to Subs Surgery 31 Days	19	15	34	19	15	34	0	0	0	100 %	100 %	100 %	94 %
ECAD to Subs Chemo 31 Days	27	34	61	27	34	61	0	0	0	100 %	100 %	100 %	98 %
ECAD to Subs Other 31 Days	4	16	20	4	16	20	0	0	0	100 %	100 %	100 %	
2WW Ref to First Treatment 62 Days	144.0	215.0	359.0	101.5	160.5	262.0	42.5	54.5	97.0	70.5 %	74.7 %	73.0 %	85 %
Screening Ref to First Treatment 62 Days	10.0	8.5	18.5	5.5	3.5	9.0	4.5	5.0	9.5	55.0 %	41.2 %	48.6 %	90 %
Upgrade to First Treatment 62 Days	19.5	15.5	35.0	14.0	13.0	27.0	5.5	2.5	8.0	71.8 %	83.9 %	77.1 %	

Cancer Standards – 31 days (target 96%)

March 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	21	22	43	20	21	41	1	1	2	95.2 %	95.5 %	95.3 %	96 %
Colorectal	15	5	20	14	5	19	1	0	1	93.3 %	100 %	95.0 %	96 %
Gynaecology	6	1	7	6	1	7	0	0	0	100 %	100 %	100 %	96 %
Haematology	3	3	6	3	3	6	0	0	0	100 %	100 %	100 %	96 %
Head & Neck	1	0	1	1	0	1	0	0	0	100 %		100 %	96 %
Lung	10	5	15	10	5	15	0	0	0	100 %	100 %	100 %	96 %
Other	0	1	1	0	1	1	0	0	0		100 %	100 %	96 %
Sarcoma	1	0	1	1	0	1	0	0	0	100 %		100 %	96 %
Skin	7	21	28	6	21	27	1	0	1	85.7 %	100 %	96.4 %	96 %
Upper GI	7	7	14	7	7	14	0	0	0	100 %	100 %	100 %	96 %
Urology	9	36	45	8	34	42	1	2	3	88.9 %	94.4 %	93.3 %	96 %
Total	80	101	181	76	98	174	4	3	7	95.0 %	97.0 %	96.1 %	96 %

Cancer Standards – 62 days (target 85%)

March 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	8.0	10.0	18.0	7.0	9.0	16.0	1.0	1.0	2.0	87.5 %	90.0 %	88.9 %	85 %
Colorectal	10.0	5.0	15.0	6.0	2.0	8.0	4.0	3.0	7.0	60.0 %	40.0 %	53.3 %	85 %
Gynaecology	5.0	3.5	8.5	4.0	3.0	7.0	1.0	0.5	1.5	80.0 %	85.7 %	82.4 %	85 %
Haematology	2.0	2.0	4.0	1.0	1.0	2.0	1.0	1.0	2.0	50.0 %	50.0 %	50.0 %	85 %
Head & Neck	1.0	1.5	2.5	0.5	1.0	1.5	0.5	0.5	1.0	50.0 %	66.7 %	60.0 %	85 %
Lung	3.5	4.0	7.5	2.5	3.0	5.5	1.0	1.0	2.0	71.4 %	75.0 %	73.3 %	85 %
Skin	6.0	20.5	26.5	6.0	19.5	25.5	0.0	1.0	1.0	100 %	95.1 %	96.2 %	85 %
Upper GI	6.0	4.0	10.0	5.0	4.0	9.0	1.0	0.0	1.0	83.3 %	100 %	90.0 %	85 %
Urology	9.0	21.5	30.5	8.0	13.0	21.0	1.0	8.5	9.5	88.9 %	60.5 %	68.9 %	85 %
Total	50.5	72.0	122.5	40.0	55.5	95.5	10.5	16.5	27.0	79.2 %	77.1 %	78.0 %	85 %

Community Nursing and Therapy Services

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-17	Apr-18	Var	2017/18	2018/19	Var		
Community Nursing									
Community nursing referrals	M	3743	3939	196	3743	3939	196	4145	
Community nursing total contacts	M	33274	35305	2031	33274	35305	2031	35506	
Community Nursing face-to-face contacts	M	19152	18877	-275	19152	18877	-275	19639	
Community nursing ALOS	M	20.1	3.2	-17	20.1	3.2	-16.9	14	

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-17	Apr-18	Var	2017/18	2018/19	Var		
% SALT patients waiting less than 13 weeks	M	100.0%			100.0%			100.0%	
Total SALT patients waiting	M	153	0	-153	153	0	-153	129	
% Podiatry patients waiting less than 13 weeks	M	100.0%			100.0%			100.0%	
Total podiatry patients waiting	M	335	0	-335	335	0	-335	220	
% Dietetics patients waiting less than 13 weeks	M	98.6%			98.6%			98.6%	
Total dietetics patients waiting	M	141	0	-141	141	0	-141	52	
% MSK patients waiting less than 13 weeks	M	94.5%			94.5%			68.9%	
Total MSK patients waiting	M	1388	0	-1388	1388	0	-1388	823	

In month 1, the number of referrals dropped marginally from March (4050) but has increased year on year (5.2%)

As noted previously, the Community Nursing service remains under considerable capacity/demand pressure, and these factors combined with long standing staff recruitment and retention difficulties, appear to be having an impact on the KPI targets.

Average wait times continue to improve.

Admission Avoidance Teams

East Sussex Healthcare NHS
NHS Trust

Hospital Intervention Team:
- Merging with CRS as OOHIT interface service as activity continues to grow to maximise capacity and support Discharge.

Frailty Practitioners:
- Waiting list reduced compared to last month – recruitment to Extended Frailty service on pause

Crisis Response:
- referrals and contacts increasing with admission avoidance and expedition of Discharges also taking 2 hour response from CN

Activity

ACTIVITY

Activity Headlines

Whilst the A&E attendances and Non elective activity has decreased marginally from March, activity remains higher than April 2017.

Day cases, Non-Elective and Follow Up activity are all up against plan and last year – breakdowns of this activity are shown later in the report.

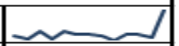
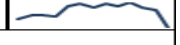
Elective Inpatient activity shows a negative variance of 12% against plan and 15% against last year. Only marginal amounts of activity were outsourced in April 17 and therefore this is mostly a like for like comparison. Key areas of variance are T&O, General Surgery and Gynaecology

First outpatients shows increases against last year's activity (4%) but down against plan (-5%). T&O, Ophthalmology and Maxfax are the largest contributors to the variance

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-17	Apr-18	Var	2017/18	2018/19	Var		
Emergency Department attendances	M	9571	10156	6.1%	9571	10156	6.1%	9953	
Ambulance conveyances	M	3211	3119	-2.9%	3211	3119	-2.9%	3220	
Admissions via A&E	M	26.4%	30.1%	3.7%	26.4%	30.1%	3.7%	29.4%	
Elective spells	M	586	498	-15.0%	586	498	-15.0%	597	
Day Cases	M	3511	3761	7.1%	3511	3761	7.1%	3930	
Elective Beddays	M	1579	1402	-11.2%	1579	1402	-11.2%	1624	
Total Non-Elective Spells	M	3750	4406	17.5%	3750	4406	17.5%	4310	
Number of Emergency spells	M	3106	3830	23.3%	3106	3830	23.3%	3702	
Number of Maternity spells (ante and post partem)	M	357	304	-14.8%	357	304	-14.8%	327	
Number of other non-elective spells (Births/Transfers from other hospitals)	M	287	272	-5.2%	287	272	-5.2%	282	
Non-Elective beddays	M	22149	22064	-0.4%	22149	22064	-0.4%	21937	
LOS									
Elective Average Length of Stay	M	2.7	2.8	0.1	2.7	2.8	0.1	2.7	
Non-Elective Average Length of Stay	M	5.5	4.8	-0.7	5.5	4.8	-0.7	5.1	
Inpatient Average Length of Stay at intermediate care units	M	29.8	30.4	0.6	29.8	30.4	0.6	28.5	

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-17	Apr-18	Var	2017/18	2018/19	Var		
InPatients Total									
Number of Admissions	N/A	77	0	-77.0	1041	1129	88.0	72	
Number of Discharges	25	77	71	-6.0	1055	1020	-35.0	72	
Average Length of Stay	25	29.8	30.4	0.6	27.2	31.6	4.4	28.5	
Occupancy rate	85%	90.2%	93.3%	8.3%					
InPatients Irvine Unit									
Number of Admissions	N/A	34	0	-34.0	385	366	-19.0	23	
Number of Discharges	25	34	19	-15.0	378	367	-11.0	23	
Average Length of Stay	25	24.1	34.7	10.6	24.7	33.3	8.6	28.5	
Occupancy rate	85%	91.1%	94.6%	3.6%					
InPatients Irvine Stroke Unit									
Number of Admissions	N/A	11	0	-11.0	175	262	87.0	11	
Number of Discharges	25	13	9	-4.0	200	155	-45.0	11	
Average Length of Stay	25	37.5	46.2	8.7	37.1	43.7	6.5	28.5	
Occupancy rate	85%	96.3%	97.7%	1.3%					
InPatients Rye Memorial									
Number of Admissions	N/A	13	0	-13.0	225	291	66.0	21	
Number of Discharges	25	12	19	7.0	216	292	76.0	21	
Average Length of Stay	25	36.7	21.3	-15.4	22.3	19.4	-2.9	28.5	
Occupancy rate	85%	93.2%	90.8%	-2.4%					
InPatients Firwood House									
Number of Admissions	N/A	19	0	-19.0	256	210	-46.0	17	
Number of Discharges	25	18	24	6.0	261	206	-55.0	17	
Average Length of Stay	25	33.9	29.0	-5.0	24.7	30.0	5.4	28.5	
Occupancy rate	85%	79.8%	90.0%	10.2%					

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-17	Apr-18	Var	2017/18	2018/19	Var		
Community Nursing									
Number of Referrals	1900	3743	3939	5.2%	3743	3939	5.2%	4145	
Number of Contacts	M	33274	35305	6.1%	33274	35305	6.1%	35506	
Podiatry									
Number of Referrals	M	538	650	20.8%	538	650	20.8%	598	
Number of Contacts	M	9197	10103	9.9%	9197	10103	9.9%	9403	
SALT									
Number of Referrals	M	132	225	70.5%	132	225	70.5%	139	
Number of Contacts	M	642	730	13.7%	642	730	13.7%	668	
MSK West									
Number of Referrals	M	1010	0	-100.0%	978	0	-100.0%	727	
MSK Womens Health									
Number of Referrals	M	172	0	-100.0%	172	0	-100.0%	120	
MSK Neuro Physio									
Number of Referrals	M	83	0	-100.0%	83	0	-100.0%	77	
iMSK									
Number of Referrals	M	107	1228	1047.7%	107	1228	1047.7%	1159	
Dietetics									
Number of Referrals	M	629	702	11.6%	629	702	11.6%	739	
Number of Contacts	M	5544	6806	22.8%	5544	6806	22.8%	6403	
HIT									
Number of Referrals	M	401	0	-100.0%	401	0	-100.0%	537	
Number of Contacts	M	401	0	-100.0%	401	0	-100.0%	791	
JCR									
Number of Referrals	M	790	0	-100.0%	790	0	-100.0%	804	
Number of interventions started	M	580	0	-100.0%	580	0	-100.0%	539	
Frailty									
Number of Referrals	70	106	51	-51.9%	106	51	-51.9%	79	
Number of Contacts	M	552	358	-35.1%	552	358	-35.1%	488	
Crisis Response									
Number of Referrals	M	80	412	415.0%	80	412	415.0%	243	
Number of Contacts	M	809	1773	119.2%	809	1773	119.2%	1548	
Bladder and Bowel Service									
Number of Referrals	M	245	321	31.0%	245	321	31.0%	304	
Number of Contacts	M	2039	2932	43.8%	2039	2932	43.8%	2831	

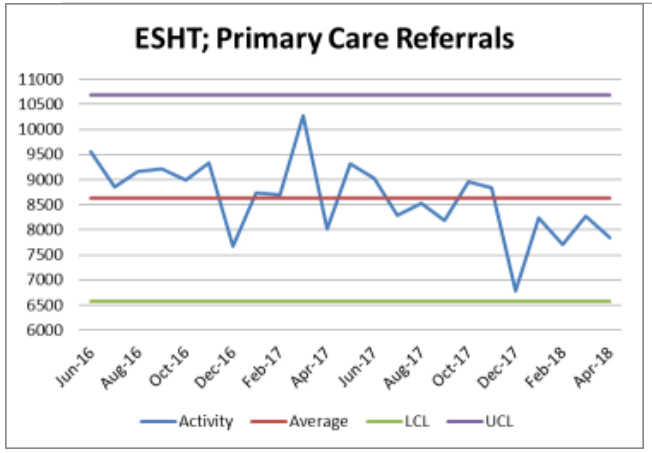
Year End activity is shown in the table below against last year's outturn and against the plan at Year End.

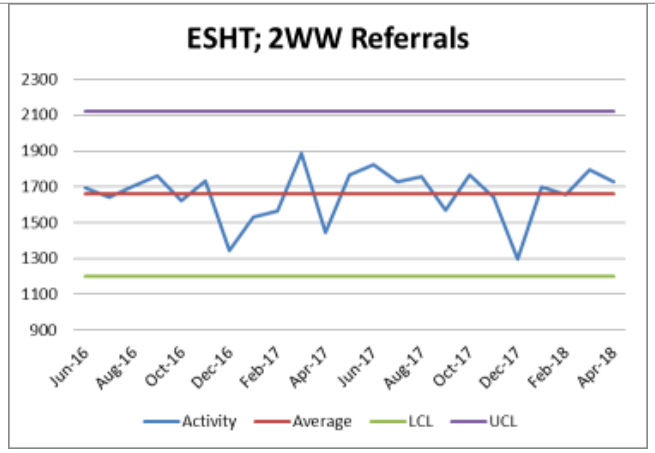
Apr-18	Actual 18/19	Actual 17/18	Plan 18/19	Variance to last year	Variance to plan
Daycase	3,758	3,509	3,672	7%	2%
Inpatient	498	586	567	-15%	-12%
Elective (Total DC/IP)	4,256	4,095	4,239	4%	0%
Non Elective	4,143	3,469	3,863	19%	7%
First OP	8,955	8,652	9,384	4%	-5%
Follow Up OP	23,537	21,406	23,155	10%	2%

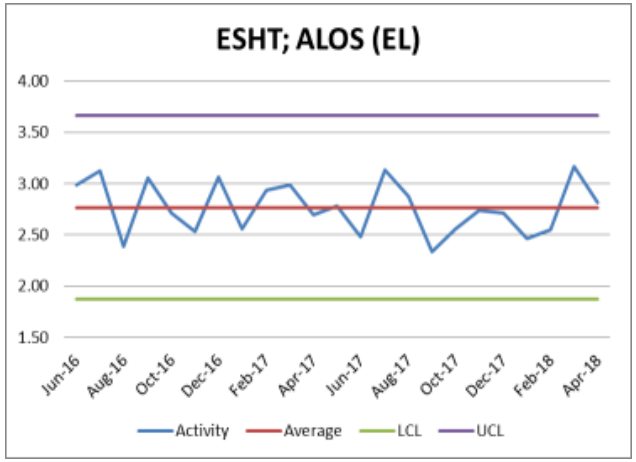
excludes well babies and neonatals

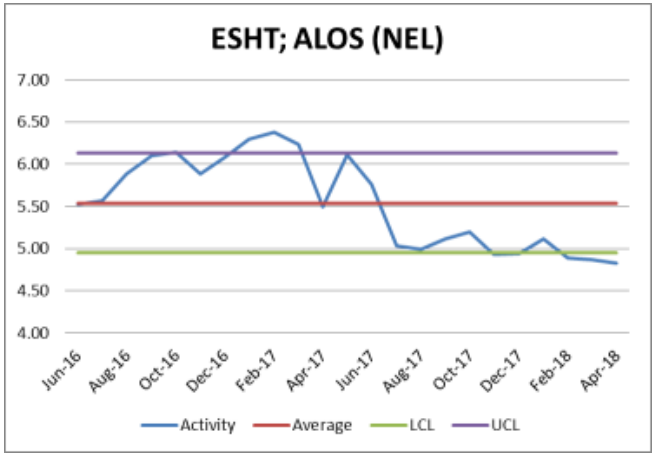
	Year End Plan	Year end forecast	Variance to Year end forecast
Daycase	47,163	47,446	-1%
Inpatient	7,330	6,250	-15%
Elective (Total DC/IP)	54,493	53,696	-2%
Non Elective	45,344	50,407	11%
First OP	121,261	112,385	-7%
Follow Up OP	299,247	295,389	-1%

East Sussex Healthcare NHS
NHS Trust









Primary care referrals have dropped in April after an increase in March. When taken with the increase in consultant to consultant referrals (pathway change) the variance reduces.

The referrals for two week waits increased substantially in March and have seen a very small decrease from this in April. Against Apr-17 they are up by 19.6%.

Non-elective ALoS remains at or below the lower control limit. 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.

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Apr-17	Apr-18	Var	2017/18	2018/19	Var		
Primary Referrals	M	8021	7810	-2.6%	8021	7810	-2.6%	8326	
Consultant to Consultant referrals	M	1472	1781	21.0%	1472	1781	21.0%	1805	
2WW Referrals	M	1443	1726	19.6%	1443	1726	19.6%	1686	

Leadership & Culture

LEADERSHIP & CULTURE

East Sussex Healthcare NHS
NHS Trust

CONTENT

TRUST OVERVIEW

TRUST	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Trend line
WORKFORCE CAPACITY														
Budgeted fte	6,966	6,888	6,904	6,828	6,825	6,893	6,852	6,879	6,873	6,860	6,860	6,859	7,060	
Total fte usage	6,674	6,608	6,679	6,663	6,672	6,695	6,757	6,814	6,847	6,889	6,716	6,876	6,911	
Variance	-292	-280	-225	-164	-152	-198	-95	-66	-27	29	-143	16	-149	
Permanent vacancies	811	785	789	707	706	746	647	622	610	578	537	528	645	
Fill rate	88.3%	88.3%	88.3%	89.4%	89.4%	89.0%	90.4%	90.8%	91.0%	91.4%	92.0%	92.2%	90.5%	
Bank fte usage (as % total fte usage)	8.8%	8.0%	8.9%	8.9%	9.3%	9.3%	9.3%	9.3%	9.7%	9.7%	6.7%	9.1%	10.1%	
Agency fte usage (as % total fte usage)	3.2%	2.9%	2.7%	2.4%	2.2%	2.2%	1.8%	2.1%	1.8%	2.0%	1.9%	1.9%	1.6%	
Turnover rate	11.0%	11.1%	11.0%	11.2%	11.2%	11.6%	11.3%	11.3%	11.3%	11.2%	11.1%	11.0%	10.9%	
Stability rate	92.3%	92.1%	92.0%	91.4%	91.7%	91.1%	91.6%	91.5%	92.1%	92.2%	91.9%	92.7%	92.1%	
SICKNESS ABSENCE														
Annual sickness rate	4.2%	4.2%	4.2%	4.2%	4.3%	4.3%	4.3%	4.3%	4.4%	4.4%	4.5%	4.5%	4.5%	
Monthly sickness rate (%)	3.4%	3.5%	3.8%	4.4%	4.2%	4.3%	4.8%	5.0%	5.3%	5.6%	4.6%	4.1%	3.6%	
Short term sickness (<28 days)	57.4%	62.3%	57.3%	61.8%	59.5%	63.4%	58.6%	61.6%	59.0%	65.4%	48.4%	57.5%	45.9%	
Monthly long term sickness (28 days+)	42.6%	37.7%	42.7%	38.2%	40.5%	36.6%	41.4%	38.4%	41.0%	34.6%	51.6%	42.5%	54.1%	
MANDATORY TRAINING & APPRAISALS														
Appraisal rate	79.3%	81.7%	81.0%	81.5%	81.6%	82.2%	82.3%	81.4%	81.3%	81.8%	81.3%	79.6%	79.5%	
Fire	83.3%	84.4%	84.2%	85.5%	85.9%	85.5%	85.8%	86.0%	85.8%	86.4%	86.5%	86.6%	86.2%	
Moving & Handling	88.7%	89.2%	89.7%	90.2%	90.2%	89.7%	89.1%	89.3%	89.4%	90.4%	90.3%	90.1%	89.4%	
Induction	95.8%	95.1%	95.5%	95.0%	95.0%	94.3%	91.9%	93.5%	92.5%	95.1%	95.1%	94.8%	94.4%	
Infec Control	86.9%	87.6%	88.1%	89.0%	89.6%	89.3%	88.8%	88.8%	88.7%	89.8%	89.9%	90.2%	89.9%	
Info Gov	83.7%	84.3%	84.4%	85.8%	85.3%	85.7%	85.0%	85.8%	84.6%	86.8%	86.5%	86.3%	85.8%	
Health & Safety	87.6%	88.1%	88.8%	89.6%	88.8%	88.1%	87.9%	88.8%	87.9%	88.0%	87.4%	88.0%	88.8%	
MCA	96.0%	96.0%	96.2%	96.5%	96.0%	95.8%	94.8%	94.8%	95.1%	95.0%	95.3%	95.8%	95.8%	
DoLs	98.1%	98.0%	97.8%	98.0%	97.6%	97.5%	95.5%	95.5%	95.8%	95.1%	96.3%	96.4%	96.4%	
Safeguarding Vulnerable Adults	88.2%	88.6%	89.6%	90.3%	90.1%	88.9%	88.0%	87.8%	87.4%	86.2%	85.2%	84.7%	84.2%	
Safeguarding Children Level 2	86.8%	87.1%	87.2%	87.4%	86.4%	86.1%	85.9%	86.0%	85.7%	85.0%	85.4%	85.3%	84.7%	

***Source data**: ESR & Finance Ledger*

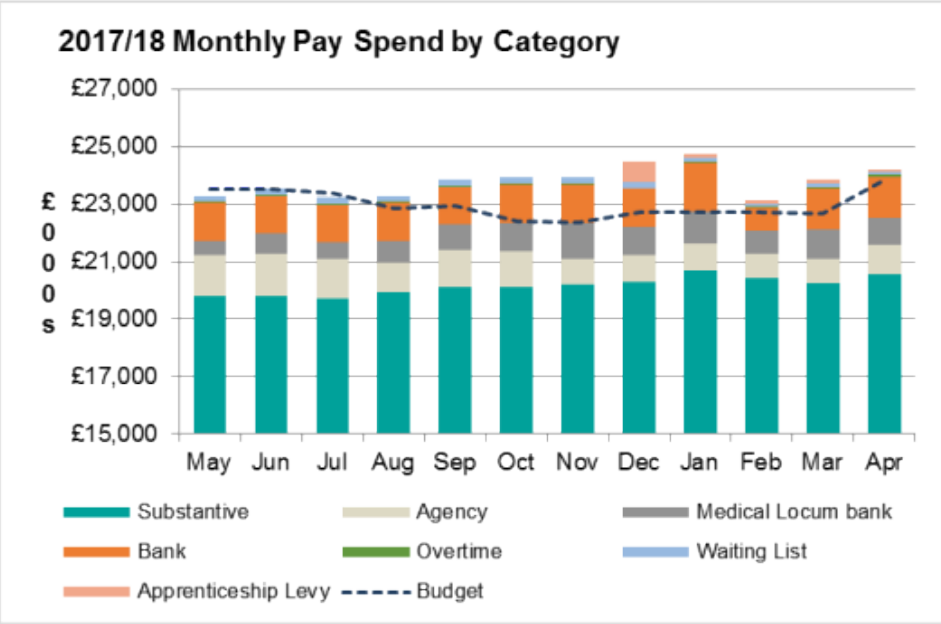
MONTHLY HEADLINES

HEADLINES – APRIL 2018

- Actual workforce utilisation 6,910.5 fte (-149.5 fte below the budgeted establishment)
- Apr '18 monthly budget £23,830k against monthly actual expenditure £24,205k (+£375k)
  - Substantive expenditure £20,540k
  - Temporary staff expenditure £3,571k (14.8% of total pay expenditure) as follows:
    - Bank expenditure £2,362k
    - Agency expenditure £1,053k
    - Overtime £46k
    - Waiting List payments £110K
- Vacancies in April have increased to 644.6 fte (9.5%), this is largely due to the increase in the permanent budgeted fte establishment for the new financial year (+75.1 fte)
- Annual turnover reduced by a further -0.1% to 10.9%, which represents 629.6 fte leavers in the last year
- Annual sickness rate unchanged at 4.5%
- Monthly sickness decreased a further -0.5% against March to 3.6%.
- Mandatory Training rate and Appraisal rates:
  - Mandatory Training down -0.5% to 88.2%. Compliance reduced for all courses with the exception of Health & Safety (+0.8%) whilst Mental Capacity Act & Deprivation of Liberties were unchanged. Appraisal compliance decreased slightly by -0.1% to 79.5%

WORKFORCE EXPENDITURE

Actuals in Month (£000s)													
Category	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Trend line
Budget	£23,504	£23,497	£23,400	£22,825	£22,912	£22,390	£22,366	£22,726	£22,733	£22,733	£22,657	£23,830	
Substantive	**£19,785**	**£19,789**	**£19,725**	**£19,931**	**£20,126**	**£20,096**	**£20,189**	**£20,306**	**£20,679**	**£20,401**	**£20,228**	**£20,540**	
Agency	£1,444	£1,473	£1,342	£1,043	£1,269	£1,269	£889	£907	£929	£848	£863	£1,053	
Medical Locum bank	£498	£696	£609	£745	£909	£968	£1,249	£976	£1,145	£796	£1,014	£911	
Bank	£1,317	£1,299	£1,267	£1,332	£1,268	£1,321	£1,347	£1,329	£1,663	£801	£1,448	£1,451	
Overtime	£25	£33	£38	£39	£45	£44	£32	£31	£31	£45	£34	£46	
Waiting List	£218	£237	£222	£184	£210	£235	£238	£195	£153	£108	£135	£110	
Apprenticeship Levy								£744	£123	£128	£126	£94	
Total Temp Expenditure	**£3,502**	**£3,738**	**£3,478**	**£3,343**	**£3,701**	**£3,837**	**£3,755**	**£3,438**	**£3,921**	**£2,598**	**£3,494**	**£3,571**	
Total Spend	**£23,287**	**£23,527**	**£23,203**	**£23,274**	**£23,827**	**£23,933**	**£23,944**	**£24,488**	**£24,723**	**£23,127**	**£23,848**	**£24,205**	



- Monthly pay budget has increased by £1,173K for the new financial year.
- Agency expenditure increased by £190K compared to March. This includes increases in medical agency usage in Geriatrics, Neurology, Rheumatology & Stroke plus cover for medical vacancies in Radiology, Histology and General Surgery. Agency was also used for additional clinics in Endoscopy and to cover vacancies in Midwifery and Audiology.
- Overtime expenditure increased by £12K this month, primarily due to cover for ancillary staff vacancies and sickness in Diagnostics, Anaesthetics & Surgery and for professional & technical staff cover, in preference to agency usage.

Source: Finance Ledger Month 2 '17/18 to Month 1 '18/19

***Source data**: Finance Ledger*

East Sussex Healthcare NHS
NHS Trust

PLANNED V ACTUAL: SUBSTANTIVE STAFF

- The tables below show the planned substantive FTE changes, taken from the NHSI Workforce Return submission of 30 April 18, compared to actual substantive FTE changes month on month, as the year progresses
- The March 18 outturn planned and actual figures are the same as the Return was compiled after this date.
- In April 18 the variance from plan is just +4.4 ftes.

PLANNED WORKFORCE													
MONTH END	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Prof Scientific and Tech	161.8	163.0	163.0	163.0	163.0	163.0	163.0	165.0	165.0	165.0	165.0	165.0	165.0
Additional Clinical Services	1,892.4	1,869.1	1,868.1	1,842.6	1,842.6	1,842.6	1,842.6	1,842.6	1,842.6	1,842.6	1,842.6	1,842.6	1,842.6
Administrative and Clerical	648.3	641.2	643.2	640.9	640.9	640.9	638.9	635.3	635.3	634.3	634.3	634.3	634.3
Allied Health Professionals	383.0	383.0	383.0	383.0	383.0	387.2	391.2	393.6	394.6	398.2	398.2	398.2	398.2
Estates and Ancillary	511.6	511.6	510.6	510.6	510.6	510.6	510.6	510.6	510.6	510.6	510.6	510.6	510.6
Healthcare Scientists	130.8	132.5	132.5	132.5	132.5	132.5	132.5	132.5	132.5	132.5	132.5	132.5	132.5
Medical & Dental	592.9	594.9	596.9	599.9	600.9	603.9	604.9	607.9	607.9	610.9	610.9	614.9	614.9
Nursing & Midwifery Registered	1,801.1	1,799.9	1,802.0	1,790.2	1,793.4	1,793.4	1,793.4	1,793.4	1,793.4	1,793.4	1,793.4	1,793.4	1,793.4
Planned Substantive Staff	**6,121.9**	**6,095.2**	**6,099.3**	**6,062.7**	**6,066.9**	**6,074.1**	**6,077.1**	**6,080.9**	**6,081.9**	**6,087.5**	**6,087.5**	**6,091.5**	**6,091.5**

ACTUAL WORKFORCE													
BY STAFF GROUP IN POST	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Prof Scientific and Tech	161.8	165.2											
Additional Clinical Services	1,892.4	1,882.2											
Administrative and Clerical	648.3	643.0											
Allied Health Professionals	383.0	384.0											
Estates and Ancillary	511.6	516.0											
Healthcare Scientists	130.8	137.6											
Medical & Dental	592.9	582.8											
Nursing & Midwifery Registered	1,801.1	1,788.9											
Actual Staff in Post	**6,121.9**	**6,099.6**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

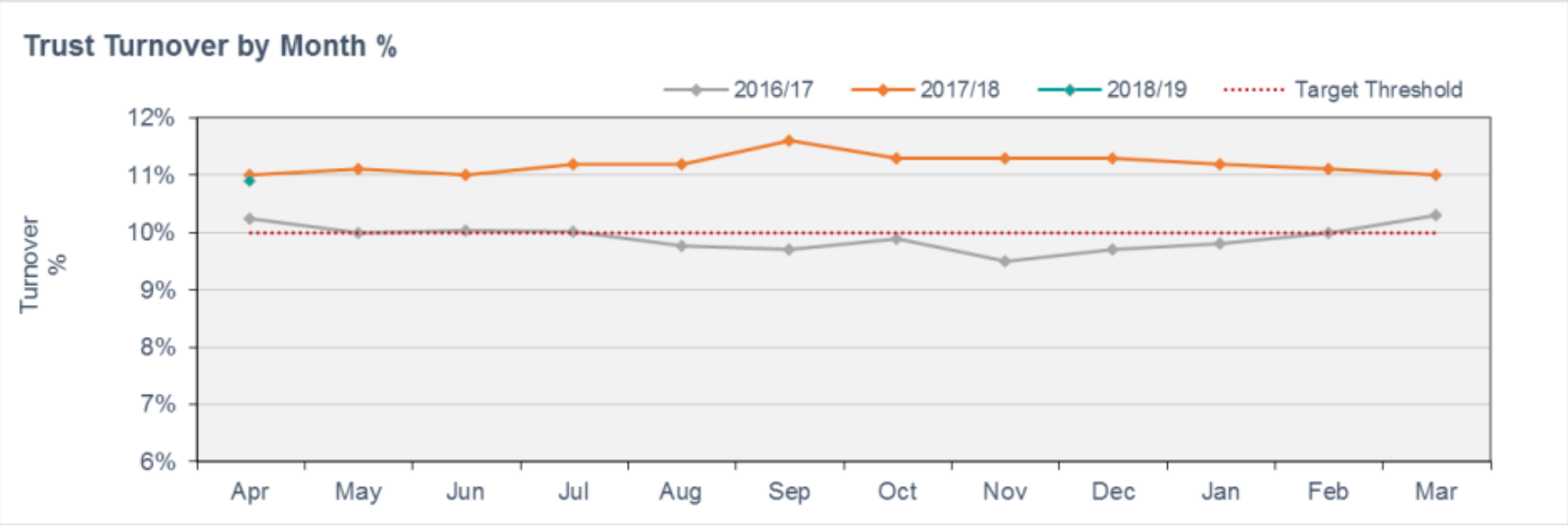
PLANNED V ACTUAL													
BY STAFF GROUP IN POST	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Prof Scientific and Tech	0.0	2.2											
Additional Clinical Services	0.0	13.1											
Administrative and Clerical	0.0	1.8											
Allied Health Professionals	0.0	1.0											
Estates and Ancillary	0.0	4.4											
Healthcare Scientists	0.0	5.1											
Medical & Dental	0.0	-12.1											
Nursing & Midwifery Registered	0.0	-11.0											
Planned v Actual +/-	**0.0**	**4.4**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

***Source data**: NHSI Workforce Planning Return 30 Apr 18; Finance Ledger*

TURNOVER TREND – STAFF GROUP

- Turnover rate of 10.9% in April equates to 629.6fte leavers.
- Fourth consecutive monthly fall in Trust turnover. All staff groups have reduced this month, with the exception of Admin & Clerical

TRUST TURNOVER BY STAFF GROUP (%)												
Year on Year	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Prof Scientific and Tech	11.2%	10.4%	10.2%	10.2%	6.7%	8.2%	8.8%	8.8%	8.3%	9.7%	8.8%	8.7%
Additional Clinical Services	12.6%	12.5%	12.4%	12.8%	13.7%	13.9%	14.5%	13.8%	13.5%	13.5%	13.5%	13.4%
Administrative and Clerical	10.9%	11.0%	11.1%	11.2%	11.5%	11.3%	10.8%	11.1%	11.4%	11.1%	11.3%	11.7%
Allied Health Professionals	10.9%	10.8%	11.5%	11.2%	11.3%	11.0%	11.6%	12.7%	12.7%	12.9%	13.2%	12.1%
Estates and Ancillary	10.2%	9.4%	10.2%	10.7%	11.0%	11.5%	11.4%	10.4%	10.7%	10.3%	9.9%	8.9%
Healthcare Scientists	13.4%	12.7%	9.9%	9.5%	12.0%	11.8%	12.4%	11.0%	9.7%	10.9%	12.1%	11.8%
Medical & Dental	13.2%	12.8%	13.0%	12.1%	11.4%	9.7%	9.4%	10.0%	9.1%	9.7%	10.8%	10.4%
Nursing & Midwifery Registered	10.0%	10.5%	10.8%	10.6%	11.1%	10.3%	10.2%	10.4%	10.2%	10.0%	9.4%	9.2%
TOTAL TRUST TURNOVER	11.1%	11.0%	11.2%	11.2%	11.6%	11.3%	11.3%	11.3%	11.2%	11.1%	11.0%	10.9%



***Source data**: ESR*

East Sussex Healthcare NHS
NHS Trust

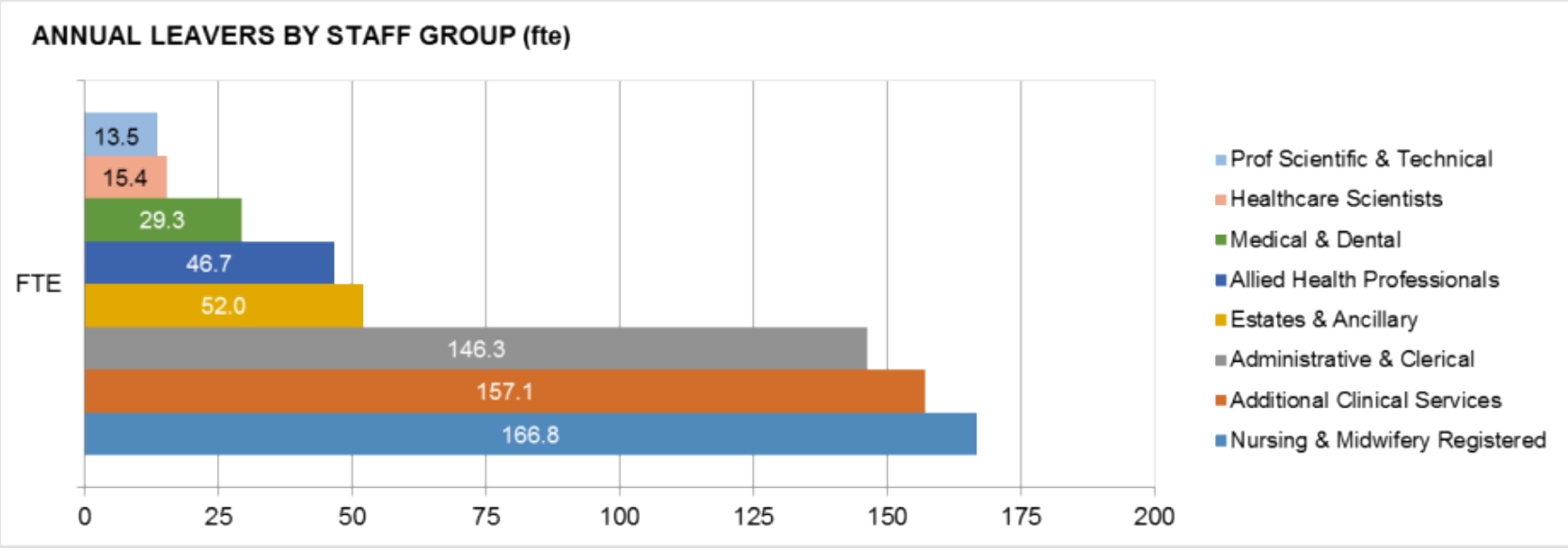
LEAVERS & STABILITY – STAFF GROUP

STAFF GROUPS	STABILITY > 1YR
Medical & Dental	91.4%
Prof Scientific & Technical	95.3%
Administrative & Clerical	93.0%
Nursing & Midwifery Registered	93.1%
Estates & Ancillary	94.2%
Additional Clinical Services	91.0%
Healthcare Scientists	90.2%
Allied Health Professionals	87.5%
TRUST	**92.1%**

Overview

- The Stability Rate measures the number of current staff who have more than 1 year's service with ESHT
- ESHT stability consistently remains >90% for all groups with the exception of Allied Health where specific professions rotate externally eg. Physiotherapy
- Latest available comparisons show stability for NHS organisations at 90.6% and for Kent, Surrey & Sussex Trusts at 87.6% (Feb 2018)

Source: ESR April 2018; NHS Digital iView.

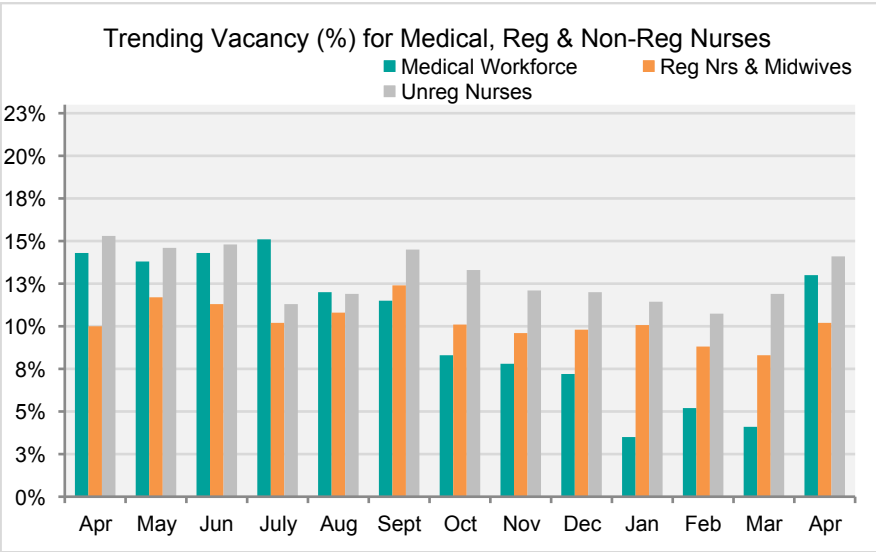


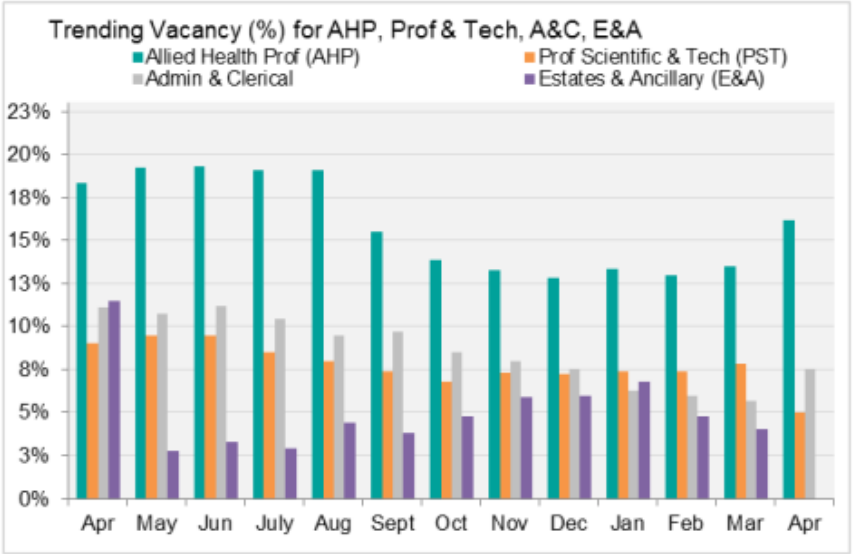
***Source data**: ESR*

RECRUITMENT – TRENDING NET VACANCIES BY STAFF GROUP (%)

- Vacancy rates have increased largely due to additional budgeted establishment at the start of the financial year, including additional posts for junior doctor rotas and approved business cases in Urgent Care and Medicine such as the opening of Ambulatory Emergency Care and increased beds in Acute Medical Unit
- Continued focus on hard to fill posts. Medacs recruitment agency on site by the end of May.

APR 2017 TO APR 2018	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Trend line
Medical Workforce	14.3%	13.8%	14.3%	15.1%	12.0%	11.5%	8.3%	7.8%	7.2%	3.5%	5.2%	4.1%	13.0%	
Reg Nrs & Midwives	10.0%	11.7%	11.3%	10.2%	10.8%	12.4%	10.1%	9.6%	9.8%	10.1%	8.8%	8.3%	10.2%	
Unreg Nurses	15.3%	14.6%	14.8%	11.3%	11.9%	14.5%	13.3%	12.1%	12.0%	11.4%	10.7%	11.9%	14.1%	
Allied Health Prof (AHP)	18.3%	19.2%	19.3%	19.1%	19.1%	15.5%	13.9%	13.3%	12.8%	13.4%	13.0%	13.5%	16.2%	
Prof Scientific & Tech (PST)	9.0%	9.5%	9.5%	8.5%	8.0%	7.4%	6.8%	7.3%	7.2%	7.4%	7.4%	7.8%	5.0%	
Admin & Clerical	11.1%	10.7%	11.2%	10.4%	9.5%	9.7%	8.5%	8.0%	7.5%	6.2%	6.0%	5.7%	7.5%	
Estates & Ancillary (E&A)	11.5%	2.8%	3.3%	2.9%	4.4%	3.8%	4.8%	5.9%	6.0%	6.8%	4.8%	4.0%	-1.5%	
TRUST	**12.0%**	**11.7%**	**11.7%**	**10.6%**	**10.6%**	**11.0%**	**9.6%**	**9.2%**	**9.0%**	**8.6%**	**8.0%**	**7.8%**	**9.5%**	





***Source data**: ESR & Finance Ledger*

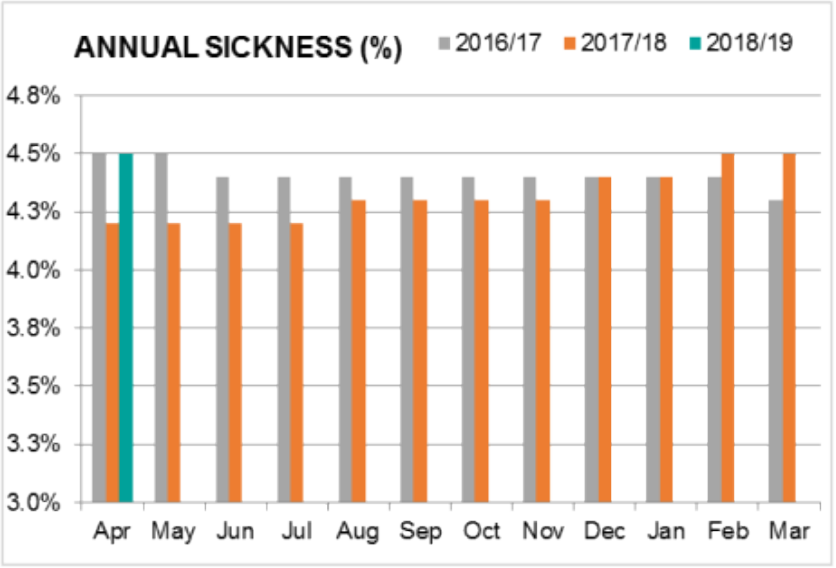
East Sussex Healthcare NHS
NHS Trust

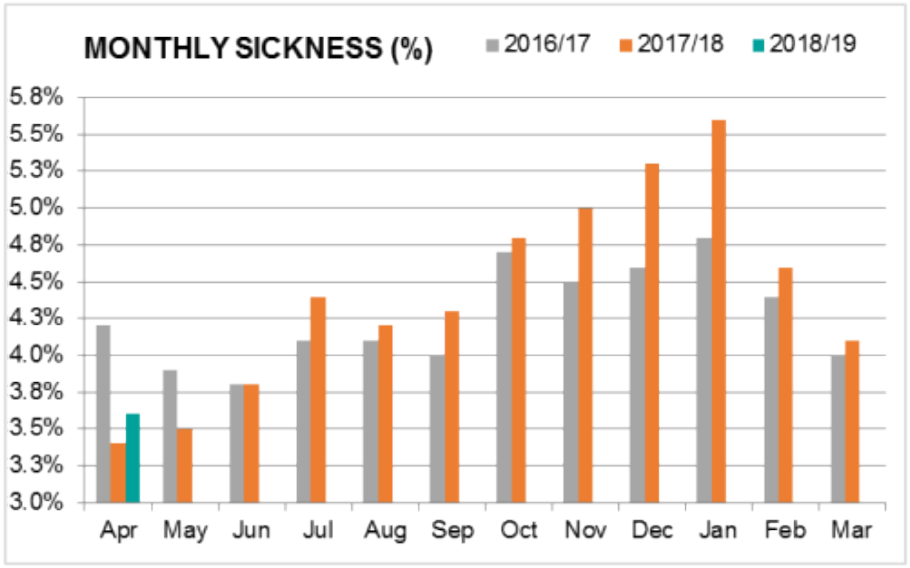
ABSENCE MANAGEMENT – SICKNESS RATES

- The monthly sickness rate has reduced by a further -0.5% to 3.6%, a third consecutive fall since January's high, whilst the annual sickness rate is unchanged at 4.5%
- The staff groups with the highest monthly sickness rates are Estates & Ancillary at 6.4% (increase of +0.1%) and Additional Clinical Services at 4.8% (decrease of -0.2%), Registered Nursing & Midwifery monthly sickness was 3.7% (decrease of -0.2%)

ANNUAL (%)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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%	4.5%	4.5%
2018/19	4.5%											

MONTHLY (%)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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%	4.6%	4.1%
2018/19	3.6%											



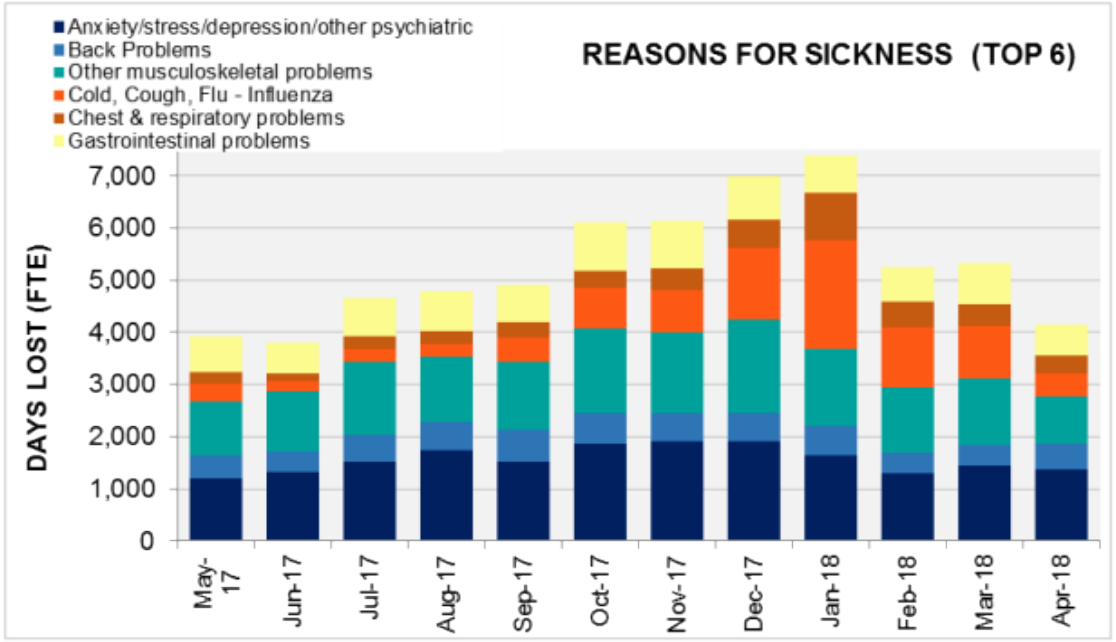


***Source data**: ESR*

ABSENCE MANAGEMENT – SICKNESS REASONS

- Seasonal illnesses continue to fall with Cold/Cough/Flu down by a further -548 fte days lost in month and Chest & Respiratory down -85.6 fte days lost. Overall, fte days lost in April were 6,735 which equates to 224.5 fte staff off sick.

TOP 6	Fte Days Lost by Month												
Reason for sickness	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Trend line
Anxiety/stress/depression/other psychiatric	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	1,299.1	1,433.3	1,376.5	
Back Problems	431.4	406.5	510.4	546.3	611.0	599.0	548.2	532.2	553.9	396.6	415.1	490.1	
Other musculoskeletal problems	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	1,259.0	1,270.8	905.9	
Cold, Cough, Flu - Influenza	347.8	205.4	258.6	260.2	472.3	789.5	829.0	1,360.5	2,070.4	1,139.0	990.8	442.9	
Chest & respiratory problems	222.6	154.7	243.5	248.6	299.4	325.2	409.5	555.1	920.1	499.6	438.6	353.0	
Gastrointestinal problems	680.4	576.5	747.9	747.5	699.8	930.7	895.1	831.8	723.1	647.3	777.1	587.5	



Apr 2018 - Top 10 in descending order (%)		%
1	Anxiety/stress/depression/psychiatric	20.4%
2	Other musculoskeletal problems	13.5%
3	Reason not specified	10.1%
4	Gastrointestinal problems	8.7%
5	Back Problems	7.3%
6	Cold, Cough, Flu - Influenza	6.6%
7	Chest & respiratory problems	5.2%
8	Benign and malignant tumours, cancers	4.8%
9	Headache/Migraine	4.2%
10	Genitourinary & gynae disorders	4.1%
	TOP 10 REASONS	**84.9%**

***Source data**: ESR*

WELLBEING & ENGAGEMENT

HEALTH & WELLBEING

- The Trust continues to focus on creating a healthy and supportive workplace. Feedback from staff in the 2017 National Staff Survey demonstrated improvement above the average sector score

Question/Key Finding	Score 2016	Score 2017	Sector Score
Organisation and management interest in and action on health and wellbeing	**3.61**	**3.69**	**3.63**

- Only 3 of 235 Trusts achieved full payment for the 2017/2018 CQUINS for Health and Wellbeing – ESHT was one of them

	2015	2016	2017	Benchmark for 2018
Does our organisation take positive action on H&W "Yes Definitely"	21%	32%	34%	37%
In the last 12m have you experienced musculoskeletal problems as a result of work activities? "No"	70%	73%	72%	78%
During the last 12m have you felt unwell as a result of work related stress? "No"	60%	64%	64%	69%

STAFF ENGAGEMENT

- Two leadership masterclasses took place in April/ May for over 100 leaders across the Trust, two more are planned for May
- Case study on the ESHT approach to staff engagement has been published on the NHS Employers website
- Organisational Development interventions – facilitation and participation in STP systems leadership programme, facilitation and participation on the OD Practitioner programme (ESBT).

STAFF SURVEY 2017 RESULTS

- ESHT have moved up 16 places in the Staff Survey league table for 2017 and are now number 13 overall
- Staff Engagement, Well Being and Organisational Development team are working with Divisions through May to identify actions for improvement from the Staff Survey
- 11 key findings are significantly better than average

East Sussex Healthcare NHS
NHS Trust

TRAINING & APPRAISAL COMPLIANCE BY DIVISION

MANDATORY TRAINING

- The overall compliance rate for mandatory training is down by -0.5% to 88.2%.
- Learning & Development and the mandatory course trainers are contacting Divisions regarding plans to improve compliance. Additional training dates have been set up for new Healthcare Assistants whilst for existing staff, there is a focus on e-learning to update their training.
- Safeguarding Children Level 3 compliance in Out of Hospital is low as it has only recently been identified that Allied Health Professional staff should undertake this training. Training sessions have been set up and Division are monitoring fortnightly.

APPRAISAL OVERVIEW

- The Trust appraisal rate has reduced by another -0.1% to 79.5%, This is slightly higher than the rate for April 17 (78.3%) but is disappointing that the rate remains below 80%.

DIVISION	APPRAISAL COMPLIANCE
Urgent Care	76.7%
Medicine	80.9%
Out of Hospital	78.2%
Diag/Anaes/Surg	80.7%
Womens, Child, S/Health	80.1%
Estates & Facilities	82.9%
Corporate	80.9%
TRUST	**79.5%**

									SAFEGUARDING		
DIVISION	FIRE SAFETY	MANUAL HANDLING	INDUCTION	INFECTION CONTROL	INFO GOV	HEALTH & SAFETY	MENTAL CAPACITY ACT	DEPRIV OF LIBERTIES	VULNERABLE ADULTS	CHILDREN (LEVEL 2)	CHILDREN (LEVEL 3)
Urgent Care	80.5%	84.9%	93.9%	86.8%	88.8%	92.7%	92.6%	83.1%	81.7%	85.7%	83.3%
Medicine	86.8%	89.9%	95.7%	88.7%	82.9%	87.8%	93.7%	92.2%	83.3%	83.3%	n/a
Out of Hospital	85.9%	89.4%	97.7%	91.9%	81.0%	87.2%	97.3%	99.2%	83.7%	79.0%	3.6%
Diag/Anaes/Surg	83.6%	87.8%	91.0%	86.0%	84.3%	87.3%	97.2%	96.9%	84.5%	86.3%	n/a
Womens, Child, S/Health	87.7%	89.3%	89.2%	90.0%	86.2%	89.0%	95.4%	94.9%	87.4%	91.9%	90.2%
Estates & Facilities	82.1%	82.9%	95.7%	96.0%	93.0%	86.9%	n/a	n/a	n/a	n/a	n/a
Corporate	92.7%	95.9%	95.9%	92.8%	91.3%	94.0%	97.0%	96.4%	78.4%	82.3%	92.3%
TRUST	**86.2%**	**89.4%**	**94.4%**	**89.9%**	**85.8%**	**88.8%**	**95.8%**	**96.4%**	**84.2%**	**84.7%**	**65.6%**

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

***Source data**: ESR*

March 2018

FINANCE

Jonathan Reid, Director of Finance

East Sussex Healthcare NHS
NHS Trust

Finance Report Summary- Month 1

Single Oversight Framework

	Plan YTD	Actual YTD	Plan FOT	Forecast FOT
Capital Service Capacity	4	4	4	4
Liquidity	2	2	2	2
I&E Margin	4	4	4	4
Distance from Financial Plan	4	4	4	4
Agency Spend	1	1	1	1
Finance Rating	3	3	3	3
Rating With Overrides	4	4	4	4

Total Financial Performance vs Plan

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(4,069)	(5,123)	(5,023)	100
Year End Forecast	(54,982)	(47,890)	(47,890)	0

Overall month 1 position reported £0.1m better than planned. Pay overspent by £0.4m; agency costs £0.1m, waiting list payments £0.1m, nursing special observations £0.1m and other pay costs £0.1m. Non pay overspend of £0.2m, risks on CIP £0.1m, COIN costs and drugs overspend offset by underspends on clinical supplies.

Agency Usage

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(1,522)	(977)	(1,053)	(76)
Year End Forecast	(13,799)	(9,468)	(9,468)	0

£0.2m spend on Admin & Clerical agency covering key vacancies, (underspend on permanent A&C offsets)

Income

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	31,004	31,755	32,413	658
Year End Forecast	387,935	391,041	391,041	0

CCG income is £0.1m above plan, with high NEL income offset by low levels of Elective activity (particular in orthopaedics) in April.
Over performance on COIN income of £0.4m offsets additional non pay costs, Pharmacy Manufacturing Unit income £0.1m, ICR income £0.1m above plan.

Operating Costs

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(34,560)	(36,182)	(36,742)	(559)
Year End Forecast	(448,948)	(430,580)	(430,580)	0

£0.4m additional COIN income partly offsets the overspend on non pay. Pay reported an overspend in month 1 against plan with continued waiting list and agency costs. Medicine division reported £0.4m overspend on nursing and medical pay (vacant posts, special observations and additional NEL activity above plan). Pharmacy Manufacturing Unit staff costs in April offset by income above planned.

Cost Improvement Programme

	Plan £k	Actual £k	Variance £k
Year to Date	649	560	(89)
Year End Forecast	23,498	23,498	0

There is £89k shortfall against CIP plan in month 1, this is largely due to Endoscopy scopes. Ongoing work with divisions to identify further CIP opportunities

Cash

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Current Balance	2,100	2,100	3,801	1,701
Year End Forecast	2,100	2,100	2,100	0

Cash balance above minimum balance at month end.

Capital Plan

	Plan £k	Actual £k	Variance £k
Year to Date	3,125	536	(2,590)
Year End Forecast	37,506	13,064	(24,442)

Current CRL is £13.1m to enable the Trust to deliver the planned spend significant external funding will need to be applied for, approved and delivered in year.

BPPC

	Month Volume	Month Value	YTD Volume	YTD Value
Trade Invoices	25.72%	40.02%	25.72%	40.02%
NHS Invoices	90.63%	99.91%	90.63%	99.91%

26% of trade invoices were paid within 28 days which equates to 40% of the total value paid in month.
91% of NHS invoices were paid within contract or within 28 days of receipt which was almost 100% of the total NHS invoices paid.

Divisional Performance

Division	In the Month						Year to Date			Forecast Outturn		
	Plan FTE	Actual FTE	Variance FTE	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k
Diagnostics, Anaesthetics & Surgery	1,864.99	1,807.57	57.42	(1,208)	(1,268)	(60)	(1,208)	(1,268)	(60)	(3,954)	(3,954)	0
Medicine	1,475.14	1,454.41	20.73	2,097	2,005	(92)	2,097	2,005	(92)	29,971	29,971	0
Urgent Care	323.36	301.87	21.49	820	897	76	820	897	76	9,515	9,515	0
Out of Hospital Care	1,047.49	1,027.54	19.95	(490)	(824)	(334)	(490)	(824)	(334)	(2,563)	(2,563)	0
Women's, Children's & Sexual Health	686.43	652.43	34.00	971	1,292	321	971	1,292	321	14,679	14,679	0
Corporate	1,023.51	1,024.92	(1.41)	(4,483)	(4,326)	157	(4,483)	(4,326)	157	(49,692)	(49,692)	0
Estates & Facilities	639.07	641.79	(2.72)	(2,086)	(2,111)	(25)	(2,086)	(2,111)	(25)	(22,629)	(22,629)	0
Central	0.00	0.00	0.00	(744)	(688)	57	(744)	(688)	57	(23,217)	(23,217)	0
Total	**7,059.99**	**6,910.53**	**149.46**	**(5,123)**	**(5,023)**	**100**	**(5,123)**	**(5,023)**	**100**	**(47,890)**	**(47,890)**	**0**

Key Risks

Key Risk 1	Fines and Penalties/ readmissions
Key Risk 2	CIP under delivered against plan
Key Risk 3	Pay overspends in month, £0.1m waiting list and £0.1m agency spend greater than plan

Mitigations

Mitigation 1	Ongoing discussions with CCGs
Mitigation 2	Line by line review of month 1 budget reports and continued confirm and challenge sessions to identify further saving opportunities. Further analysis of drugs spend to understand impact of volume growth.
Mitigation 3	Finance to attend ward HealthRoster compliance sessions and work with HR and divisions to reduce medical overspends (Medacs contract, WLI reduction, etc.)

East Sussex Healthcare NHS
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Income & Expenditure Summary - Month 1

	In Month				Year to Date				Forecast Outturn		
	17/18 Actual (£m)	18/19 Plan (£m)	18/19 Actual (£m)	Variance (£m)	17/18 Actual (£m)	18/19 Plan (£m)	18/19 Actual (£m)	Variance (£m)	18/19 Plan (£m)	18/19 FOT (£m)	Variance (£m)
NHS Patient Income	24.9	26.2	26.4	0.2	24.9	26.2	26.4	0.2	323.1	323.1	0.0
Tariff-Excluded Drugs & Devices	2.4	3.0	2.6	(0.3)	2.4	3.0	2.6	(0.3)	36.1	36.1	0.0
Private Patient / ICR	0.2	0.2	0.3	0.1	0.2	0.2	0.3	0.1	3.1	3.1	0.0
Other Non-Clinical Income	3.0	2.4	3.1	0.7	3.0	2.4	3.1	0.7	30.3	30.3	0.0
Total Income	**30.5**	**31.8**	**32.4**	**0.7**	**30.5**	**31.8**	**32.4**	**0.7**	**392.5**	**392.5**	**0.0**
Pay - Substantive	(19.8)	(20.7)	(20.8)	(0.1)	(19.8)	(20.7)	(20.8)	(0.1)	(249.0)	(249.0)	0.0
Pay - Bank	(1.7)	(2.2)	(2.4)	(0.1)	(1.7)	(2.2)	(2.4)	(0.1)	(23.3)	(23.3)	0.0
Pay - Agency	(1.5)	(1.0)	(1.1)	(0.1)	(1.5)	(1.0)	(1.1)	(0.1)	(9.5)	(9.5)	0.0
Total Pay	**(23.1)**	**(23.9)**	**(24.2)**	**(0.3)**	**(23.1)**	**(23.9)**	**(24.2)**	**(0.3)**	**(281.8)**	**(281.8)**	**0.0**
Drugs	(3.1)	(3.5)	(3.5)	0.1	(3.1)	(3.5)	(3.5)	0.1	(42.2)	(42.2)	0.0
Supplies & Services - Clinical	(2.5)	(2.9)	(2.7)	0.2	(2.5)	(2.9)	(2.7)	0.2	(35.9)	(35.9)	0.0
Supplies & Services - General	(0.4)	(0.3)	(0.4)	(0.0)	(0.4)	(0.3)	(0.4)	(0.0)	(4.8)	(4.8)	0.0
Purchase of Healthcare (non-NHS)	(0.4)	(0.4)	(0.4)	0.0	(0.4)	(0.4)	(0.4)	0.0	(5.8)	(5.8)	0.0
Services from Other NHS Bodies	(0.4)	(0.4)	(0.4)	0.0	(0.4)	(0.4)	(0.4)	0.0	(7.5)	(7.5)	0.0
Consultancy	(0.0)	(0.2)	(0.3)	(0.1)	(0.0)	(0.2)	(0.3)	(0.1)	(0.7)	(0.7)	0.0
Clinical Negligence	(1.2)	(0.9)	(0.9)	0.0	(1.2)	(0.9)	(0.9)	0.0	(10.3)	(10.3)	0.0
Premises	(1.1)	(1.2)	(1.3)	(0.1)	(1.1)	(1.2)	(1.3)	(0.1)	(14.6)	(14.6)	0.0
Depreciation	(1.1)	(1.1)	(1.0)	0.1	(1.1)	(1.1)	(1.0)	0.1	(12.6)	(12.6)	0.0
Other	(1.4)	(1.4)	(1.7)	(0.3)	(1.4)	(1.4)	(1.7)	(0.3)	(14.4)	(14.4)	0.0
Total Non-Pay	**(11.5)**	**(12.4)**	**(12.5)**	**(0.2)**	**(11.5)**	**(12.4)**	**(12.5)**	**(0.2)**	**(148.8)**	**(148.8)**	**0.0**
Total Operating Costs	**(34.6)**	**(36.2)**	**(36.7)**	**(0.5)**	**(34.6)**	**(36.2)**	**(36.7)**	**(0.5)**	**(430.6)**	**(430.6)**	**0.0**
Net Surplus/(Deficit) from Operations	**(4.1)**	**(4.5)**	**(4.3)**	**0.1**	**(4.1)**	**(4.5)**	**(4.3)**	**0.1**	**(38.0)**	**(38.0)**	**0.0**
Financing Costs	(0.5)	(0.7)	(0.7)	0.0	(0.5)	(0.7)	(0.7)	0.0	(7.8)	(7.8)	0.0
Total Non-Operating Costs	**(0.5)**	**(0.7)**	**(0.7)**	**0.0**	**(0.5)**	**(0.7)**	**(0.7)**	**0.0**	**(7.8)**	**(7.8)**	**0.0**
Total Costs	**(35.1)**	**(36.9)**	**(37.4)**	**(0.5)**	**(35.1)**	**(36.9)**	**(37.4)**	**(0.5)**	**(438.4)**	**(438.4)**	**0.0**
Net Surplus/(Deficit)	**(4.6)**	**(5.2)**	**(5.0)**	**0.1**	**(4.6)**	**(5.2)**	**(5.0)**	**0.1**	**(45.8)**	**(45.8)**	**0.0**
Donated Asset/Impairment Adjustment	0.1	0.1	0.1	(0.0)	0.1	0.1	0.1	(0.0)	(2.0)	(2.0)	0.0
Operational Surplus/(Deficit)	**(4.5)**	**(5.1)**	**(4.9)**	**0.1**	**(4.5)**	**(5.1)**	**(4.9)**	**0.1**	**(47.9)**	**(47.9)**	**0.0**
Sustainability & Transformation Fund	0.5	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0
Net Surplus/(Deficit)	**(4.0)**	**(5.1)**	**(4.9)**	**0.1**	**(4.0)**	**(5.1)**	**(4.9)**	**0.1**	**(47.9)**	**(47.9)**	**0.0**

Summary & Next Steps

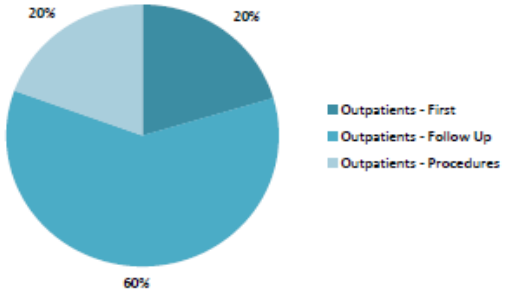
Over performance on non-clinical income of £0.7m, £0.4m relates to COIN (offsets overspend on Other non pay (£0.4m), £0.1m income on Pharmacy Manufacturing Unit, which remained open in April offsetting continued staff and non pay costs, £0.2m income covering additional consultancy costs. ICR income £0.1m above plan in month. Drugs overspend of £0.2m offset by less spend on Tariff Excluded Drugs. Pay overspends due to continued medical agency and waiting list payments to meet cancer referrals and capacity shortfall in certain specialties.

East Sussex Healthcare NHS
NHS Trust

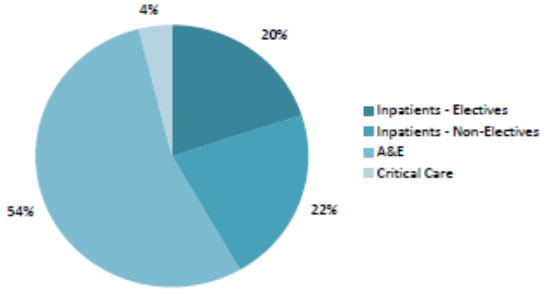
Income & Activity Summary - Month 1

	In Month								Year to Date								Forecast Outturn		
	17/18 Activity Actual	18/19 Activity Plan	18/19 Activity Actual	18/19 Activity Variance	17/18 Actual (£k)	18/19 Plan (£k)	18/19 Actual (£k)	Variance (£k)	17/18 Activity Actual	18/19 Activity Plan	18/19 Activity Actual	18/19 Activity Variance	17/18 Actual (£k)	18/19 Plan (£k)	18/19 Actual (£k)	Variance (£k)	18/19 Plan (£k)	18/19 FOT (£k)	Variance (£k)
Contract Income																			
Inpatients - Electives	3,473	3,750	3,732	(18)	3,855	4,092	3,526	(566)	3,473	3,750	3,732	(18)	3,855	4,092	3,526	(566)			
Inpatients - Non-Electives	3,470	3,780	4,076	296	6,887	8,065	8,714	649	3,470	3,780	4,076	296	6,887	8,065	8,714	649			
Outpatients	28,743	31,971	32,312	341	2,996	3,390	3,584	193	28,743	31,971	32,312	341	2,996	3,390	3,584	193			
A&E	9,649	10,189	10,182	(7)	1,278	1,414	1,375	(39)	9,649	10,189	10,182	(7)	1,278	1,414	1,375	(39)			
CQUIN	0	0	0	0	489	530	582	52	0	0	0	0	489	530	582	52			
Critical Care	776	706	735	29	863	772	817	45	776	706	735	29	863	772	817	45			
Direct Access	7,562	8,229	8,250	21	302	329	325	(4)	7,562	8,229	8,250	21	302	329	325	(4)			
ESBT	0	0	0	0	322	546	546	0	0	0	0	0	322	546	546	0			
Excess Bed Days	1,570	1,377	266	(1,111)	373	331	207	(124)	1,570	1,377	266	(1,111)	373	331	207	(124)			
Tariff Excluded Drugs & Devices	0	0	0	0	2,410	2,966	2,644	(322)	0	0	0	0	2,410	2,966	2,644	(322)			
iMSK	0	0	0	0	11	83	83	(0)	0	0	0	0	11	83	83	(0)			
Maternity Pathway	519	531	570	39	477	542	623	82	519	531	570	39	477	542	623	82			
Other	260,864	293,125	306,498	13,373	6,446	6,085	6,018	(66)	260,864	293,125	306,498	13,373	6,446	6,085	6,018	(66)			
Contract Income Total	316,626	353,657	366,621	12,964	26,709	29,144	29,044	(100)	316,626	353,657	366,621	12,964	26,709	29,144	29,044	(100)	359,165	359,165	0
Divisional Income					3,238	2,611	3,369	758					3,238	2,611	3,369	758	31,876	31,876	0
Total Income	316,626	353,657	366,621	12,964	29,947	31,755	32,413	658	316,626	353,657	366,621	12,964	29,947	31,755	32,413	658	391,041	391,041	0

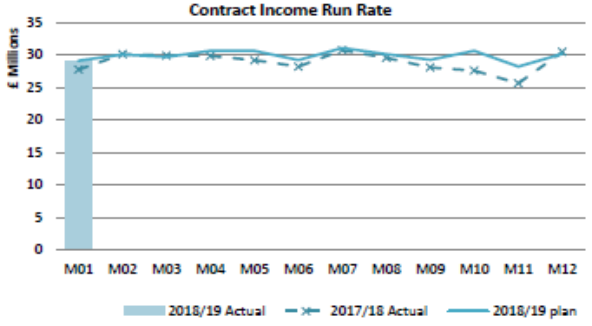
YTD Outpatients Activity by POD



YTD Inpatient and A&E Activity



Contract Income Run Rate



Summary & Next steps

Inpatients - Electives (566)k under plan -13.84%

Trauma and Orthopaedics have under-performed by 130 patients / £429k in April 2018 against plan. This was due to high levels of leave and mandatory training, a reduction in referrals, and a reduced workforce from April 2018.
2018/19 income and activity forecasts for Trauma and Orthopaedics are currently under review.
Ophthalmology also under-performed in April 2018.

Inpatients - Non-Electives 649k over plan 0.01%

Over-performance following a high level of NEL activity. There were 4,076 in April 2018, which is 606 / 17% higher than April 2017.

Exclusions (322)k under plan -10.86%

Under-performance in Tariff-Excluded Drugs of £353k, offset by over-performance in Tariff-Excluded Devices of £30k in April 2018.

Excess Bed Days (124)k under plan -37.49%

Non-Elective Excess Bed Days are lower than planned for April 2018 by £106k and 1,036 activities. This will increase once all the April discharges are fully coded.

Financial Risks

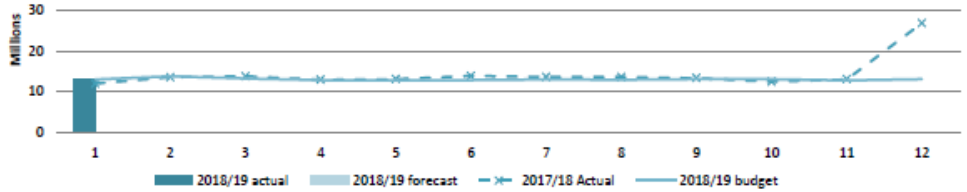
Income has not been reduced in April 2018 for 'Marginal Rate Emergency Thresholds.' This may create a risk in the current financial year.

East Sussex Healthcare NHS
NHS Trust

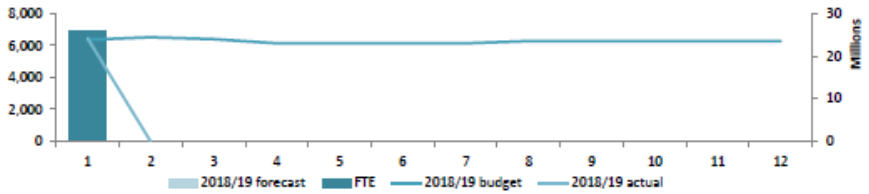
Operating Costs - Month 1

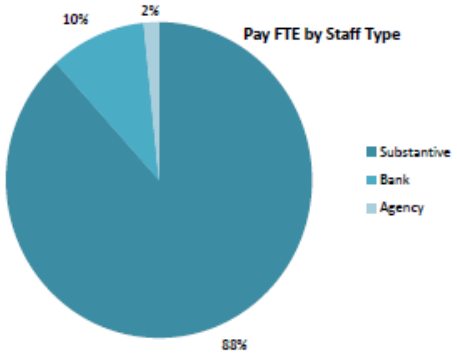
	In Month								Year to Date				Forecast Outturn			
	17/18 WTE Actual	18/19 WTE Plan	18/19 WTE Actual	WTE Variance	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	18/19 Expenditure Variance (£k)	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	18/19 Expenditure Variance (£k)	18/19 Plan (£k)	18/19 FOT (£k)	Variance (£k)	
Administrative & Management	1,313.47	1,392.06	1,341.67	50.39	3,498	3,742	3,681	61	3,498	3,742	3,681	61	44,777	44,777	0	
Ancillary	699.25	707.95	706.75	1.20	1,413	1,429	1,409	19	1,413	1,429	1,409	19	17,135	17,135	0	
Medical	630.31	709.14	671.24	37.90	5,569	5,601	5,816	(216)	5,569	5,601	5,816	(216)	67,146	67,146	0	
Nursing & Midwivery	3,057.51	3,289.12	3,222.84	66.28	9,359	9,790	9,717	72	9,359	9,790	9,717	72	116,838	116,838	0	
Prof, Scientific & Tech	533.62	521.57	518.25	3.32	1,792	1,637	1,723	(86)	1,792	1,637	1,723	(86)	19,650	19,650	0	
Professions Allied to Medicine	421.47	530.37	449.78	80.59	1,431	1,755	1,512	243	1,431	1,755	1,512	243	20,850	20,850	0	
Other	0.00	(90.22)	0.00	(90.22)	13	(123)	345	(468)	13	(123)	345	(468)	(4,170)	(4,170)	0	
Total Pay	**6,655.63**	**7,059.99**	**6,910.53**	**149.46**	**23,074**	**23,830**	**24,205**	**(374)**	**23,074**	**23,830**	**24,205**	**(374)**	**282,226**	**282,226**	**0**	
Services from Other NHS Bodies					358	404	397	8	358	404	397	8	5,766	5,766	0	
Clinical Negligence Premium					1,218	877	877	0	1,218	877	877	0	10,528	10,528	0	
Consultancy					32	182	275	(93)	32	182	275	(93)	861	861	0	
Drugs					920	830	1,130	(300)	920	830	1,130	(300)	9,459	9,459	0	
Drugs - Tariff Excluded					2,210	2,676	2,322	354	2,210	2,676	2,322	354	32,563	32,563	0	
Education and Training					100	114	74	39	100	114	74	39	1,362	1,362	0	
Establishment Expenses					624	508	944	(437)	624	508	944	(437)	6,095	6,095	0	
Premises					1,108	1,238	1,292	(54)	1,108	1,238	1,292	(54)	14,617	14,617	0	
Purchase of Healthcare from Non NHS Bodies					358	404	397	8	358	404	397	8	5,766	5,766	0	
Supplies and Services - Clinical					2,500	2,933	2,734	199	2,500	2,933	2,734	199	35,120	35,120	0	
Supplies and Services - General					354	337	366	(28)	354	337	366	(28)	4,044	4,044	0	
Other Non-Pay					1,704	1,847	1,729	119	1,704	1,847	1,729	119	22,698	22,698	0	
Total Non-Pay					**11,486**	**12,352**	**12,537**	**(185)**	**11,486**	**12,352**	**12,537**	**(185)**	**148,879**	**148,879**	**0**	
Total Expenditure	**6655.63**	**7059.99**	**6910.53**	**149.46**	**34,560**	**36,182**	**36,742**	**(559)**	**34,560**	**36,182**	**36,742**	**(559)**	**431,106**	**431,106**	**0**	

Non-Pay Monthly Run rate



Pay Monthly Run Rate vs FTE





Summary & Next Steps

£0.3m Drugs overspend, further investigation to ensure all high cost tariff excluded drugs have been correctly charged, and identify volume/price variance against plan.
£0.4m Establishment expenses relating to COIN, with additional income received to offset these costs.
£0.1m Consultancy fees are also offset by additional income received from NHSi to support Financial Special measures recovery plan.
£0.1m Medical costs were above planned, continued agency and waiting list cover in addition to annual leave cover over Easter have contributed to this as well as NEL activity being higher than planned.
The finance team are continuing to work with divisions to identify further efficiency saving opportunities and undertake detailed review of month 1 performance against plan.
'Other' pay includes accrual for wage award and apprenticeship levy adjustment.

East Sussex Healthcare NHS
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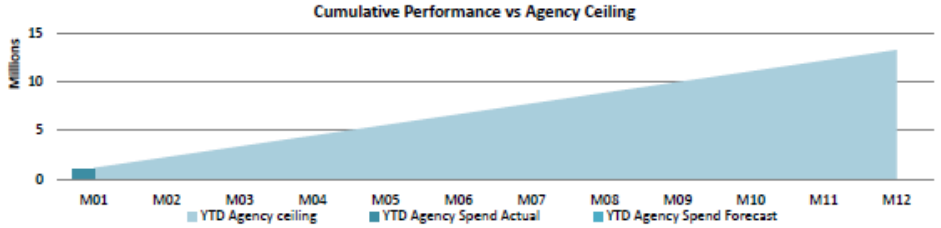
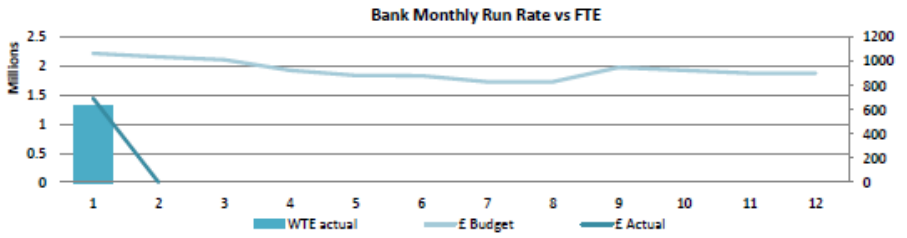
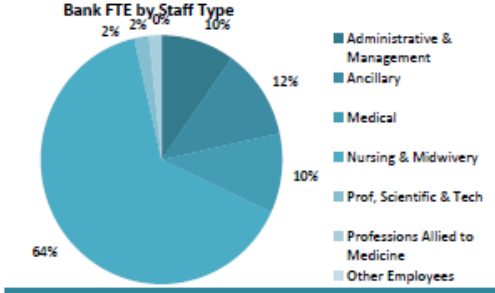
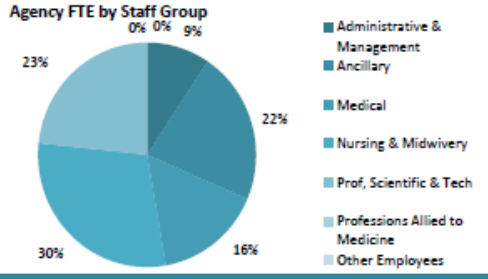
Temporary Workforce Summary - Month 1

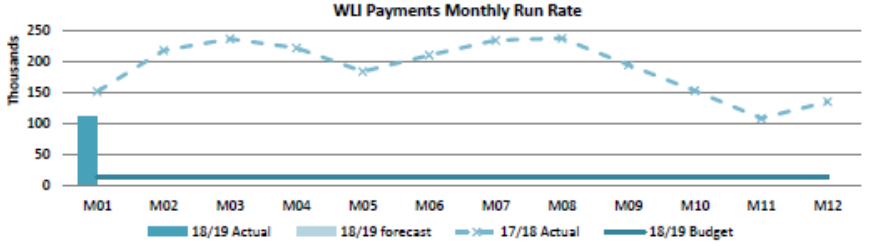
	In Month							Year to Date				Forecast Outturn		
	17/18 WTE Actual	18/19 WTE Plan	18/19 WTE Actual	WTE Variance	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	Expenditure Variance (£k)	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	Expenditure Variance (£k)	18/19 Plan (£k)	18/19 FOT (£k)	Variance (£k)
Agency															
Administrative & Management	7.66	0.00	10.40	(10.40)	77	112	172	(60)	77	112	172	(60)	938	938	0
Ancillary	25.17	0.00	24.51	(24.51)	65	50	47	3	65	50	47	3	781	781	0
Medical	52.39	9.53	17.54	(8.01)	817	345	425	(80)	817	345	425	(80)	3,481	3,481	0
Nursing & Midwivery	75.36	0.00	32.69	(32.69)	239	218	219	(1)	239	218	219	(1)	1,919	1,919	0
Prof, Scientific & Tech	47.20	1.40	25.89	(24.49)	325	106	190	(84)	325	106	190	(84)	540	540	0
Professions Allied to Medicine	0.00	0.00	0.00	0.00	0	146	0	146	0	146	0	146	1,269	1,269	0
Other Employees	0.00	0.00	0.00	0.00	0	0	0	0	0	0	0	0	0	0	0
Total Agency	**207.78**	**10.93**	**111.03**	**(100.10)**	**1,522**	**977**	**1,053**	**(76)**	**1,522**	**977**	**1,053**	**(76)**	**8,928**	**8,928**	**0**
Bank															
Administrative & Management	94.43	6.19	68.71	(62.52)	186	159	134	25	186	159	134	25	1,825	1,825	0
Ancillary	91.38	21.75	82.56	(60.81)	171	146	141	5	171	146	141	5	1,685	1,685	0
Medical	42.42	18.60	71.91	(53.31)	396	708	911	(203)	396	708	911	(203)	6,356	6,356	0
Nursing & Midwivery	342.25	149.88	450.99	(301.11)	919	1,119	1,101	18	919	1,119	1,101	18	5,750	5,750	0
Prof, Scientific & Tech	8.99	0.00	13.78	(13.78)	28	25	38	(13)	28	25	38	(13)	245	245	0
Professions Allied to Medicine	4.14	0.00	11.81	(11.81)	11	33	38	(5)	11	33	38	(5)	396	396	0
Other Employees	0.00	0.00	0.00	(0.00)	0	0	0	0	0	0	0	0	0	0	0
Total Bank/ Locum	**541.19**	**177.82**	**627.85**	**(450.03)**	**1,315**	**1,482**	**1,451**	**31**	**1,315**	**1,482**	**1,451**	**31**	**9,901**	**9,901**	**0**
Total Waiting List Initiative	**15.44**	**0.00**	**9.72**	**(9.72)**	**151**	**14**	**110**	**(97)**	**151**	**14**	**110**	**(97)**	**163**	**163**	**0**
TotalTemporary Workforce	**764.41**	**188.75**	**748.60**	**(559.85)**	**2,989**	**2,473**	**2,614**	**(142)**	**2,989**	**2,473**	**2,614**	**(142)**	**18,992**	**18,992**	**0**











Summary & Next steps

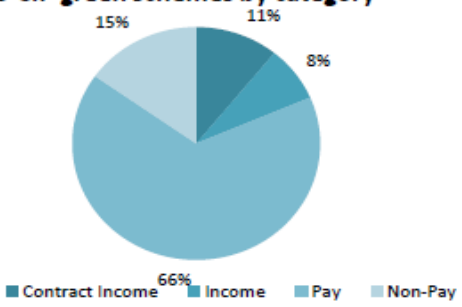
Overall agency costs £1.1m in month 1, which was 31% lower than spend in April 2017. Controls to be reviewed to ensure robust process for the booking of temporary staff, including annual leave and rostering compliance sessions. There is on-going review of the rates paid to locum and agency staff, and medical agency continues to break the NHSi capped rates. Waiting list sessions are continuing to cover vacancies and urgent cancer referalls where demand exceeds capacity to keep waiting list size down. The level of temporary staff costs are expected to reduce through recruitment to vacancies and achievement of CIP.

East Sussex Healthcare NHS
NHS Trust

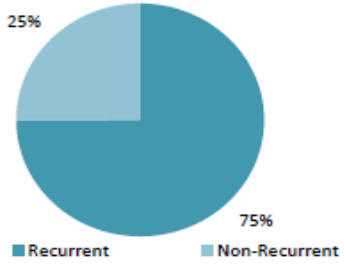
Cost Improvement Programme Summary - Month 1

Category	In Month			Year to Date			Forecast Outturn			YTD Rec (£k)	YTD Non-Rec (£k)
	Plan (£k)	Actual (£k)	Variance (£k)	Plan (£k)	Actual (£k)	Variance (£k)	Plan (£k)	Actual (£k)	Variance (£k)		
Contract Income	73	61	-12	73	61	-12	986	986	0	27	33
Income	36	43	7	36	43	7	540	540	0	43	0
Pay	357	371	14	357	371	14	7,706	7,706	0	264	107
Non-Pay	184	85	-99	184	85	-99	3,936	3,936	0	85	0
Total 'Green' schemes	**649**	**560**	**-89**	**649**	**560**	**-89**	**13,169**	**13,169**	**0**	**420**	**140**
Pipeline/Unidentified	0	0	0	0	0	0	10,329	10,329	0	75%	25%
Total	**649**	**560**	**-89**	**649**	**560**	**-89**	**23,498**	**23,498**	**0**		

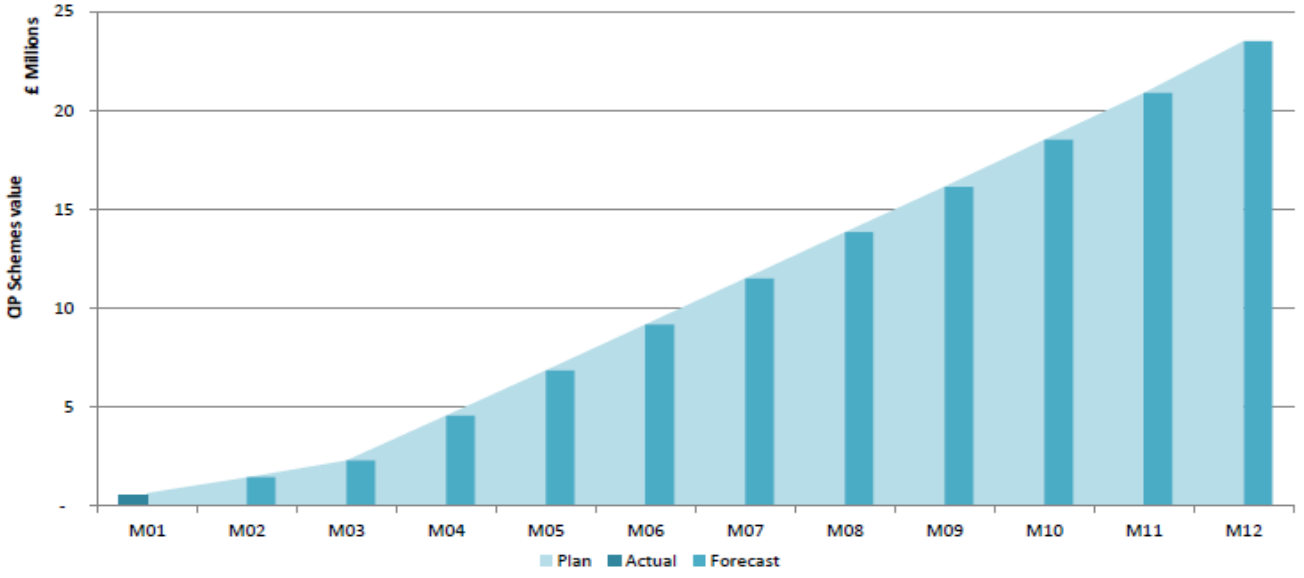
YTD CIP green schemes by category



YTD CIP green schemes recurrent/non-recurrent



CIP Performance



Summary & Next Steps

The Trust is slightly behind the plan for month 1, this is largely associated with the non-delivery of some of the Non-Pay procurement savings in Endoscopy, the Division are currently exploring options to address this and are aware that they will need to recover the shortfall.

The shortfall in contract income is associated with a spend to save scheme unfortunately the staff have not been recruited and as a result we have not incurred the costs either.

The over-performance in pay is made up of non-recurrent savings in Emergency Care, this is mitigating the delay of closing Hailsham 2, initially planned from the start of April and closed mid-April, plus non-delivery against the Theatres Productivity - work is underway to determine if the initial assumptions were correct.

East Sussex Healthcare NHS
NHS Trust

Statement of Financial Position - Month 1

	Year to date				Forecast Outturn			
	17/18 Actual (£k)	18/19 Plan (£k)	18/19 Actual (£k)	Variance (£k)	18/19 Plan (£k)	18/19 FOT (£k)		Variance (£k)
Property, Plant and Equipment	215.7	241.7	215.2	(26.5)	241.7	241.7		0.0
Intangible Assets	1.9	1.9	1.9	(0.0)	1.9	1.9		0.0
Other Assets	1.3	1.3	1.3	(0.0)	1.3	1.3		0.0
Non Current Assets	**219.0**	**245.0**	**218.5**	**(26.5)**	**245.0**	**245.0**		**0.0**
Inventories	7.3	7.3	7.6	0.3	7.3	7.3		0.0
Trade and Other Receivables	35.3	27.8	37.5	9.7	27.8	27.8		0.0
Cash and Cash Equivalents	2.1	2.1	3.8	1.7	2.1	2.1		0.0
Non Current Assets Held for Sale	0.0	0.0	0.0	0.0	0.0	0.0		0.0
Current Assets	**44.7**	**37.2**	**48.8**	**11.7**	**37.2**	**37.2**		**0.0**
Trade and Other Payables	(37.7)	(32.6)	(42.2)	(9.6)	(32.6)	(32.6)		0.0
Borrowings	(35.7)	(0.7)	(35.7)	(35.0)	(0.7)	(0.7)		0.0
Other Financial Liabilities	0.0	0.0	0.0	0.0	0.0	0.0		0.0
Provisions	(0.6)	(0.6)	(0.6)	(0.1)	(0.6)	(0.6)		0.0
Other Liabilities	(1.7)	(1.7)	(2.0)	(0.3)	(1.7)	(1.7)		0.0
Current Liabilities	**(75.7)**	**(35.6)**	**(80.6)**	**(44.9)**	**(35.6)**	**(35.6)**		**0.0**
Borrowings	(121.5)	(218.9)	(125.4)	93.4	(218.9)	(218.9)		0.0
Trade and Other Payables	0.0	0.0	0.0	0.0	0.0	0.0		0.0
Provisions	(2.3)	(2.3)	(2.2)	0.1	(2.3)	(2.3)		0.0
Total Assets Employed	**64.2**	**25.3**	**59.1**	**3.7**	**25.3**	**25.3**		**0.0**
Public Dividend Capital	156	156	156	0	156	156		0
Income & Expenditure Reserve	(187)	(234)	(192)	43	(234)	(234)		0
Revaluation Reserve	94	103	94	(9)	103	103		0
Total Tax Payers Equity	**64.2**	**25.3**	**59.1**	**33.9**	**25.3**	**25.3**		**0.0**

Summary & Next Steps

Month 1 borrowings in line with original plan, cash above minimum balance at month end.

East Sussex Healthcare NHS
NHS Trust

Cashflow & Borrowing Summary - Month 1

Short Term (13 week) Cashflow Forecast

	Actual (£k)				Forecast (£k)								
Week Ending (Friday)	06-Apr	13-Apr	20-Apr	27-Apr	04-May	11-May	18-May	25-May	01-Jun	08-Jun	15-Jun	22-Jun	29-Jun
Balance Brought Forward	**2,100**	**3,165**	**28,714**	**19,056**	**3,692**	**9,511**	**5,175**	**20,709**	**8,049**	**7,845**	**1,381**	**31,471**	**6,140**
Receipts													
WGA Income	1,370	28,174	75	160	9,218	1,164	27,091	2,657	2,486	0	29,147	0	892
Other Income	248	821	252	221	278	1,647	1,481	436	679	424	1,659	424	1,399
External Financing	0	0	3,916	0	0	0	3,916	0	0	0	3,771	0	0
Total Receipts	**1,618**	**28,995**	**4,243**	**381**	**9,496**	**2,811**	**32,488**	**3,092**	**3,166**	**424**	**34,577**	**424**	**2,291**
Payments													
Pay	(371)	(284)	(9,508)	(12,612)	(338)	(252)	(9,670)	(12,752)	(270)	(270)	(270)	(22,152)	(270)
Non-Pay	(185)	(3,032)	(4,140)	(3,037)	(3,255)	(6,486)	(7,184)	(3,000)	(3,100)	(6,618)	(4,216)	(3,100)	(3,100)
Capital Expenditure	0	(129)	(155)	(94)	(83)	(328)	0	0	0	0	0	0	0
PDC Dividend	0	0	0	0	0	0	0	0	0	0	0	0	0
Other payments	3	(1)	(98)	(3)	(1)	(81)	(100)	0	0	0	0	(503)	0
Total Payments	**(553)**	**(3,446)**	**(13,901)**	**(15,745)**	**(3,677)**	**(7,147)**	**(16,954)**	**(15,752)**	**(3,370)**	**(6,888)**	**(4,486)**	**(25,755)**	**(3,370)**
Net Cash Movement	**1,065**	**25,549**	**(9,658)**	**(15,364)**	**5,819**	**(4,337)**	**15,534**	**(12,660)**	**(204)**	**(6,464)**	**30,091**	**(25,331)**	**(1,079)**
Balance Carried Forward	**3,165**	**28,714**	**19,056**	**3,692**	**9,511**	**5,175**	**20,709**	**8,049**	**7,845**	**1,381**	**31,471**	**6,140**	**5,061**

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

Loans

Description	Draw Value £k	Date Drawn	Term	Interest Rate	Value £k	Annual Interest £k
Prior Years						
Capital Loan 1 -Decontamination Cer	1,500	Dec 08	10	3.50%	151	4
Capital Loan 2 - Endoscopy Develop	2,000	Dec 09	20	4.00%	1,167	45
Capital Loan 3 - Endoscopy Develop	2,000	Jun 10	20	3.90%	1,200	46
Capital Loan 4 - Health Records	428	Mar 15	10	1.40%	300	4
Capital Loan 5 - Health Records	441	Mar 15	10	1.40%	309	4
Capital Loan 6 - Ambulatory Care	800	Feb 18	20	1.60%	800	13
Revolving Working Capital	31,300		5	3.50%	31,300	1,096
Interim Loan Agreement	35,218		3	1.50%	35,218	527
Loan Dec 2016	1,619	Dec 16	3	6.00%	1,094	66
Loan Jan 2017	8,925	Jan 17	3	6.00%	8,925	536
Loan Feb 2017	8,000	Feb 17	3	6.00%	8,000	479
Loan Mar 2017	4,600	Mar 17	3	6.00%	4,600	275
Loan Apr 2017	3,214	Apr 17	3	6.00%	3,214	193
Loan May 2017	2,558	May 17	3	6.00%	2,558	153
Loan Jun 2017	5,447	Jun 17	3	6.00%	5,477	329
Loan Jul 2017	2,536	Jul 17	3	6.00%	2,536	152
Loan Aug 2017	3,107	Aug 17	3	3.50%	3,107	108
Loan Sep 2017	5,722	Sep 17	3	3.50%	5,722	200
Loan Nov 2017	1,399	Nov 17	3	3.50%	1,369	47
Loan Dec 2017	3,640	Dec 17	3	3.50%	3,640	130
Loan Jan 2018	11,247	Jan 18	3	3.50%	11,247	397
Loan Feb 2018	4,790	Feb 18	3	3.50%	4,790	170
Loan Mar 2018	20,488	Mar 18	3	3.50%	20,488	729
Prior Years Total	**160,979**				**157,212**	**5,703**
Current Year						
Loan Apr 2018	3,916	Apr 18	3	3.50%	3,916	69
Current Year Total	**3,916**				**3,916**	**69**
Total Loans	**164,895**				**161,128**	**5,772**

Summary & Next steps

1. Opening balance was £2.1m - planned closing balance (March 2019) is £2.1m

2. Maintaining minimum cash balance of £2.1m at month-end

3. Aiming for a minimum cash availability for creditors of £3m per week - currently forecasting over delivery of this during this period

4. Planning assumption is to draw cash equivalent to deficit during 2018/19

5. All existing loans listed here - note the March 2018 value which resulted from the move away from plan in that financial year

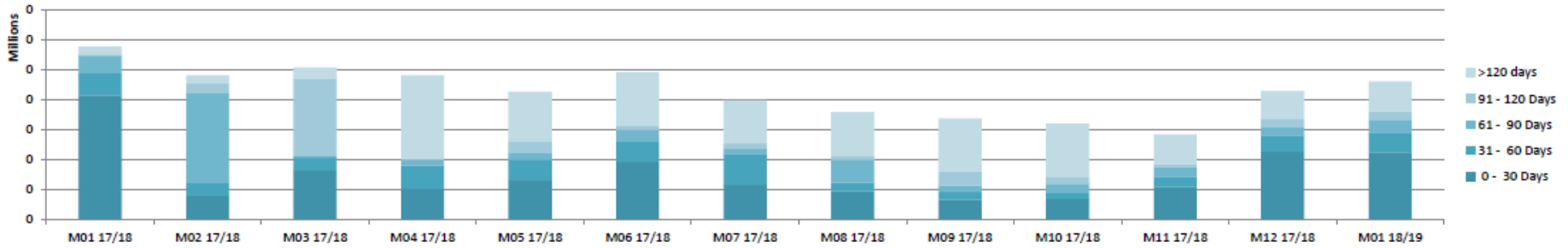
6. The "Interim Loan Agreement" for £35.2m is due to be repaid in February 2019 - discussions will be had with NHSi about this being extended as it is unlikely that the Trust will have generated sufficient cash for this to be repaid

East Sussex Healthcare NHS
NHS Trust

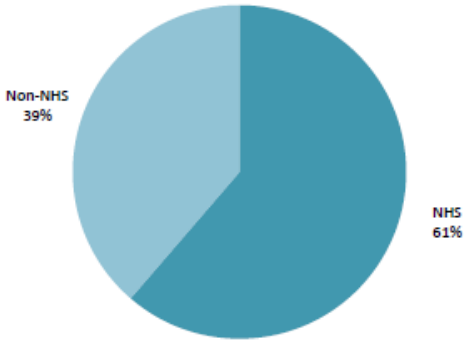
Receivables Summary - Month 1

Receivables Aging Run rate (£k)

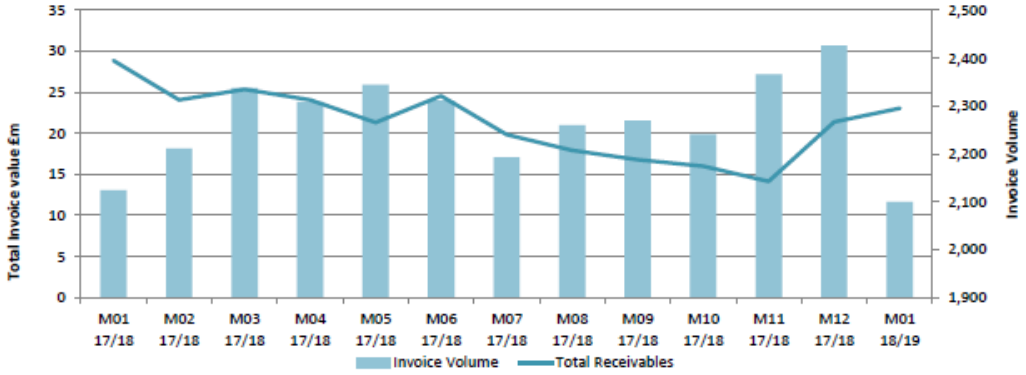
Aging Profile	M01 17/18	M02 17/18	M03 17/18	M04 17/18	M05 17/18	M06 17/18	M07 17/18	M08 17/18	M09 17/18	M10 17/18	M11 17/18	M12 17/18	M01 18/19
0 - 30 Days	20,709	3,924	8,102	5,079	6,448	9,548	5,737	4,648	3,269	3,418	5,379	11,332	11,164
31 - 60 Days	3,686	2,102	2,153	3,871	3,461	3,411	5,217	1,450	1,286	960	1,745	2,686	3,335
61 - 90 Days	2,968	15,136	299	973	1,248	1,938	941	3,850	1,099	1,588	1,573	1,467	2,189
91 - 120 Days	226	1,513	12,894	242	1,920	643	782	583	2,331	1,133	470	1,214	1,316
>120 days	1,284	1,385	1,900	13,908	8,233	9,036	7,179	7,372	8,809	8,897	4,997	4,685	5,048
Total Receivables	**28,873**	**24,061**	**25,348**	**24,074**	**21,309**	**24,576**	**19,856**	**17,903**	**16,794**	**15,996**	**14,164**	**21,384**	**23,053**
Invoice Volume	**2,124**	**2,211**	**2,337**	**2,309**	**2,344**	**2,311**	**2,193**	**2,260**	**2,269**	**2,241**	**2,366**	**2,426**	**2,100**



Current Month % NHS vs Non-NHS by Value



Receivables Invoice Value vs Volume Run Rate



Summary & Next Steps

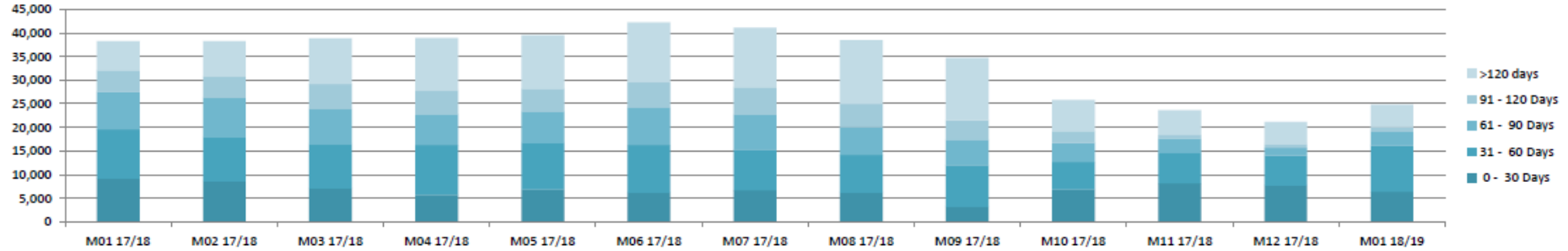
1. Internal plan to bring receivables down to £8m at month-end and to deliver Debtor Day KPI of 18 days
2. Long running dispute with MSK being resolved - approximately £7m aged debtor to be recovered in May/June
3. Improving liquidity means that additional payments being made to "NHS" creditors - improving the likelihood of negotiating additional payments from NHS organisations to us.

East Sussex Healthcare NHS
NHS Trust

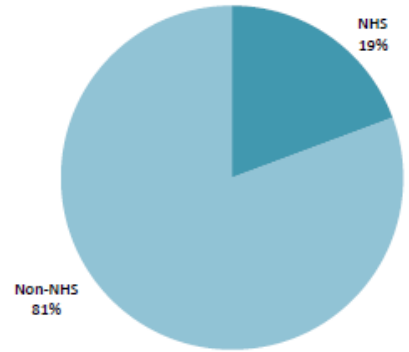
Payables Summary - Month 1

Payables Aging Run rate (£k)

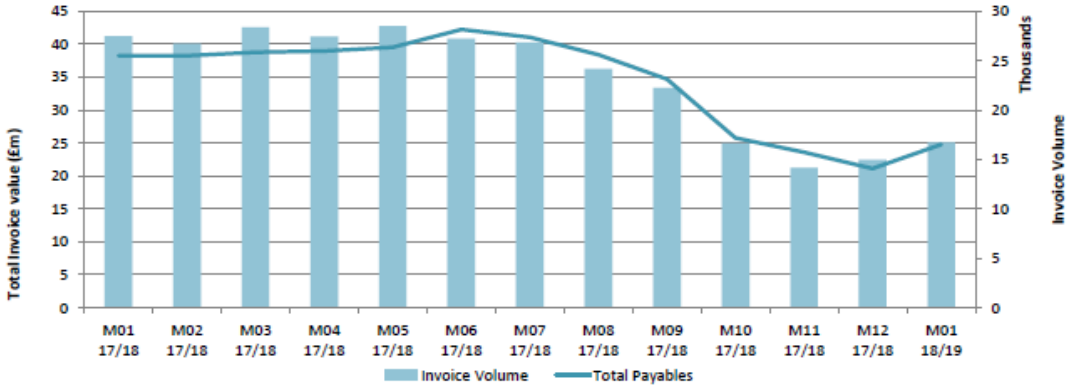
Aging Profile	M01 17/18	M02 17/18	M03 17/18	M04 17/18	M05 17/18	M06 17/18	M07 17/18	M08 17/18	M09 17/18	M10 17/18	M11 17/18	M12 17/18	M01 18/19
0 - 30 Days	9,135	8,521	7,086	5,751	6,799	6,188	6,726	6,227	3,130	6,872	8,184	7,668	6,423
31 - 60 Days	10,447	9,349	9,244	10,518	9,861	10,094	8,620	7,924	8,902	5,760	6,341	6,360	9,679
61 - 90 Days	7,947	8,346	7,536	6,516	6,737	7,883	7,267	5,929	5,430	4,064	3,128	1,681	2,969
91 - 120 Days	4,562	4,536	5,328	4,980	4,792	5,402	5,851	4,875	4,025	2,521	729	655	932
>120 days	6,150	7,493	9,592	11,178	11,353	12,638	12,599	13,449	13,202	6,556	5,220	4,753	4,762
Total Payables	**38,241**	**38,245**	**38,786**	**38,943**	**39,542**	**42,204**	**41,063**	**38,405**	**34,688**	**25,773**	**23,602**	**21,118**	**24,765**
Invoice Volume	**27,500**	**26,728**	**28,386**	**27,428**	**28,488**	**27,245**	**26,840**	**24,162**	**22,223**	**16,609**	**14,182**	**14,954**	**16,715**



Current Month % NHS vs Non-NHS by Value



Payables Invoice Value vs Volume Run Rate



Summary & Next Steps

1. Significant reduction in age and value of payables since the highpoint of last year
2. Prioritisation of invoices not ready to pay (currently £9m)
3. At terms for all creditors where invoices are passed and ready to pay.
4. Internal KPI's to target elimination of registered > 120 days and Creditor days < 60
5. Cash availability short term means we can let the system generate the payment run (for more efficient)

East Sussex Healthcare NHS
NHS Trust

Capital Programme Summary - Month 1

YTD Capital Programme Performance	18/19 Plan (£k)	YTD Actual (£k)	Committed Expenditure (£k)
Brought Forward	**500**	**391**	**528**
External Funding	17,359	0	250
Lease or Alternative Funding	0	0	0
New Business Case	2,570	1	100
Medical Equipment	2,200	13	75
Digital	1,872	3	438
Estates	11,005	4	5,360
Finance	2,000	125	1,500
Total Owned	**37,506**	**536**	**8,251**
Donated	0	300	0
Less donated Income	0	(300)	0
Total	**37,506**	**536**	**8,251**

Capital Resource Limit	Source	£k
Opening Capital Resource Limit		13,064
Closing Capital Resource Limit		13,064

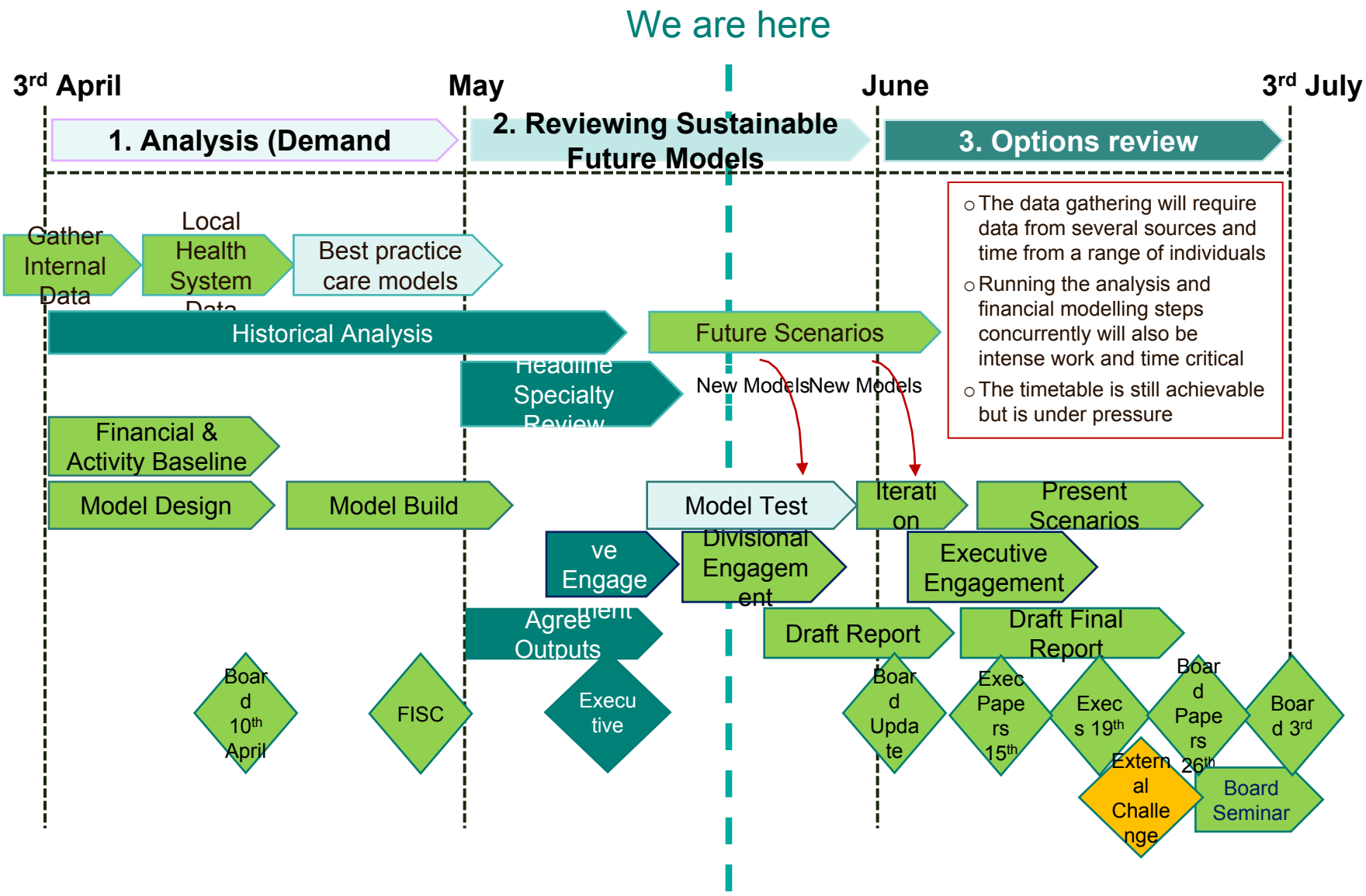
Summary & Next steps

The Capital Resource Group has committed £8.3m of this years Capital Resource Limit (CRL) of £13.1m.
Within the Capital Programme there are schemes where estimated costs amount to £17.4m and where external funding will be explored.
The Capital Programme will deliver the CRL target at year end.
The Trust is actively seeking significant external funding to bring the CRL closer to plan.

Sustainability and Strategy

SUSTAINABILITY

ESHT – Long-term


We are here
3rd April
May
June
3rd July
1. Analysis (Demand
2. Reviewing Sustainable Future Models
3. Options review
The data gathering will require data from several sources and time from a range of individuals
Running the analysis and financial modelling steps concurrently will also be intense work and time critical
The timetable is still achievable but is under pressure
Gather Internal Data
Local Health System Data
Best practice care models
Historical Analysis
Future Scenarios
Headline Specialty Review
New Models
New Models
Financial & Activity Baseline
Model Design
Model Build
Model Test
Iteration
Present Scenarios
ve Engage
Divisional Engagement
Executive Engagement
Agree Outputs
Draft Report
Draft Final Report
Board 10th April
FISC
Executive
Board Update
Exec Papers 15th
Execs 19th
Board Papers 26th
Board 3rd
External Challenge
Board Seminar

Assessing Future Demand – nearing completion

Detailed 5 year Historical trend analysis (by PoD, specialty, age, district)

- Referrals
- First to follow up ratios
- Conversion rates
- A&E attendances & admissio
- 

Explain Historical Patterns and Drivers of the trends

- Population Trends
- Known service changes
- Key initiatives (e.g. MSK)
- Proactive care initiatives
- Urgent care system changes
- 

Develop an *underlying* view of historical demand trends

- Strip out anomalies & non-recurrent trends
- Sense check findings
- 

Identify expected *changes* in drivers of demand

- Population projections
- Recent and new initiatives
- Wider system changes
- 

Agree Assumptions for Future Demand and Activity Projections

- By specialty, point of delivery, site, service category, age

Model Future Demand Scenarios

Translate Future Demand into *resources and key services*

- Acute urgent care, frailty support
- Bed days
- Community Services
- Elective ca

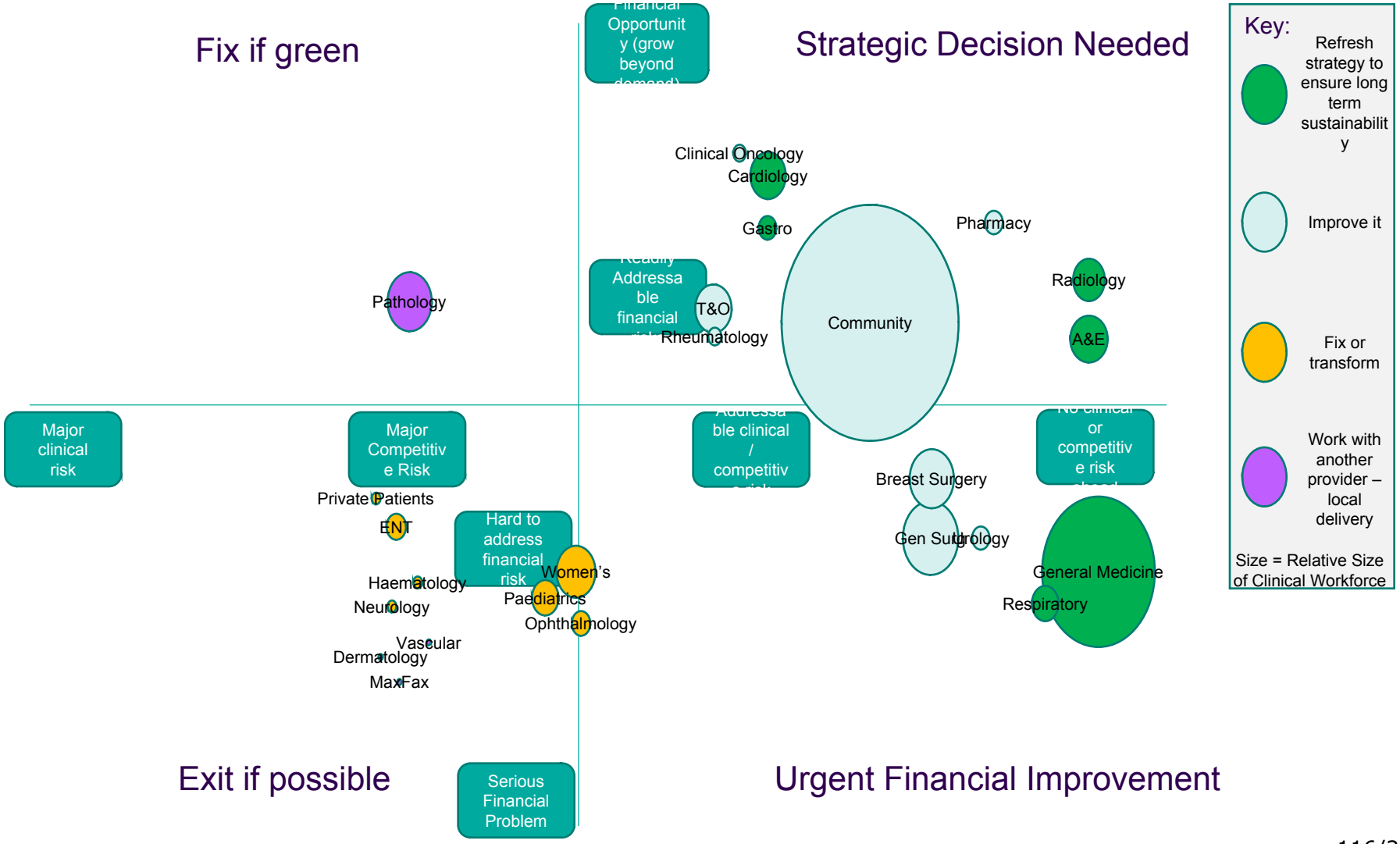
Sense check and challenge assumptions and projections

- Build implications into the financial model – ready for scenario testing

Create findings report that enables strategic discussions in May

Developing these projections now

Emerging strategic assessment of services – still under review



Key Assumptions

Fixed Points

- Appropriate urgent care on both sites
- No capital (or appetite) for New Hospital
- Commissioners (and public) want to keep maternity on both sites

Assumptions

- Our A&E's are not too small
- Growth in over 75 age group in our population will be the main driver of demand growth
- Assuming that historical trends continue unless we have reason to doubt them. If so the defaults are:
  - Population driver
  - Matching national
  - Flat
- That LoS can improve significantly
- That theatre and OP productivity can improve significantly
- That we want to retain and get value from integrated community services
- That BSUH and MTW are not in a position to pick up material excess demand
- That site reconfiguration is requires a clear financial or operational case before it is considered a priority

Key emerging issues & findings

Financial Grip & Operational efficiency is the primary strategic priority

- Meet NHSI requirements, create a platform able to deliver the longer term strategy, shift the discussion from ESHT's inefficiency to how it can help the system

Longer term the most material strategic issues in terms of ESHT and system sustainability

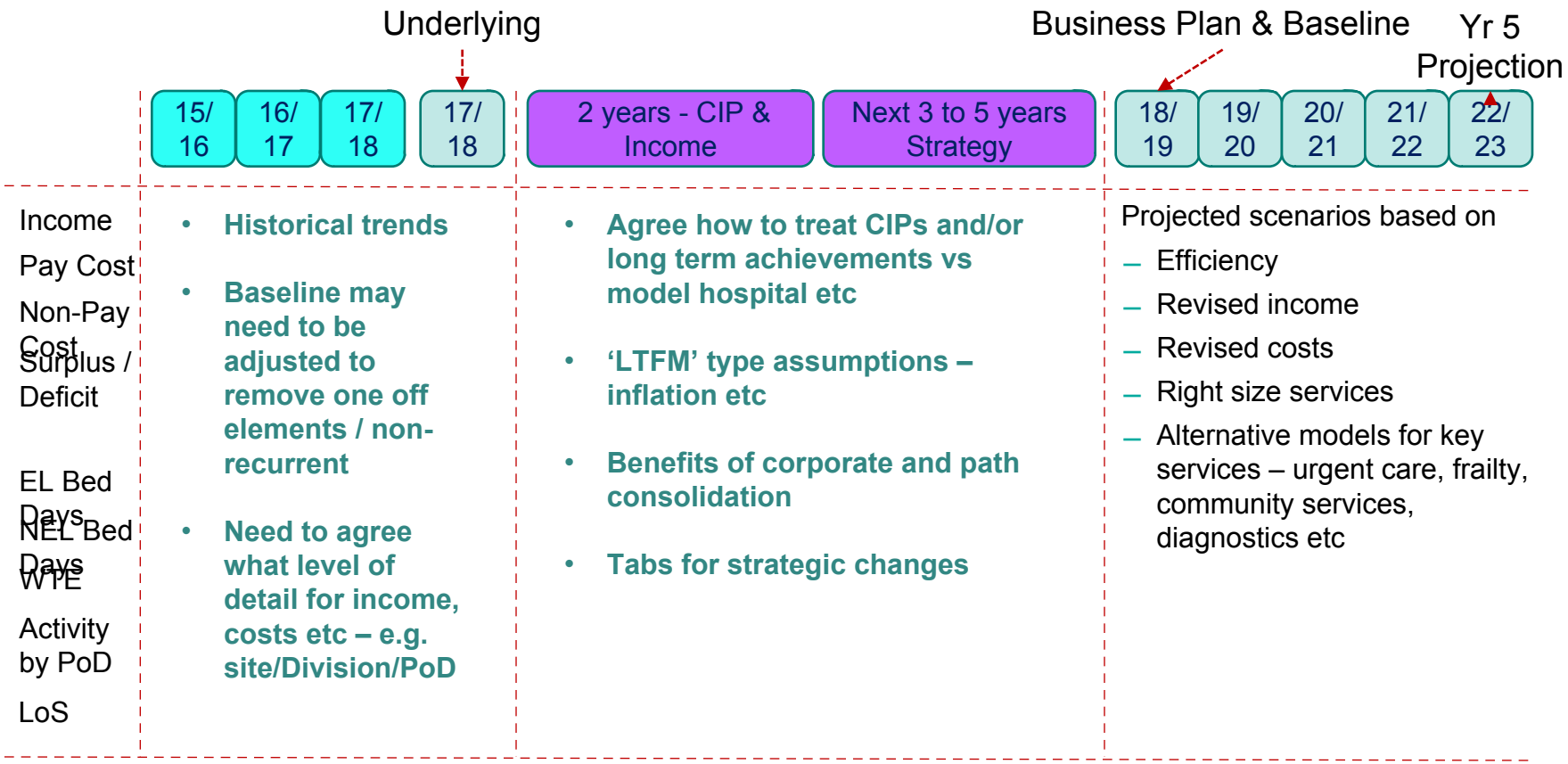
- **Frailty (and vulnerability and co-morbidity)** – 4th oldest profile in A&E attendances and the population growth from 2018 will be highest in over 75s from 2017/18 onwards. At mid-demand growth scenario, ESHT needs top quartile LoS to hold its bed base stable and accommodate non-elective medical admissions
- **Getting value from the Out of hospital Service operating model and integrated working -** this will be essential in managing demand drive by frailty
- **Urgent care operating model –** who will deliver proposed changes?
- **Struggling and changing primary care locally** – does ESHT have a role in solving this issue and/or entering the primary care space?
- **Portfolio of elective services**
  - A number of services have issues and could be transformed
- **Commerciality -** develop a more pro-*ESHT,* commercial side to add onto the recent focus on quality
- **Pathology and back office -** are being reviewed elsewhere but a plan needs to be settled on and delivered

At the headline level – it looks like you will need to fit future demand (assuming you will be paid for it) into your current resources and make some service changes to become sustainable

What's next

1. Finishing main analytical phase – sense check and data challenges needed
2. Develop financial model scenarios
3. Produce projections for hospital resources in those scenarios
4. Await Drivers of Deficit to start
5. Report for challenge and testing with Execs
6. Going back to senior leaders forum to discuss findings
7. Support preparation for NHSI board to board
8. Prepare papers for board seminar
9. Run seminar
10. NHSI Board to Board

We will use long term financial modelling to pull the clinical and financial options together




WHAT
MATTERS
TO YOU
MATTERS
TO US
ALL

Mortality Report – Learning from Deaths 1st April 2016 to 31st December 2017

Meeting information:			
Date of Meeting: 5th June, 2018		Agenda Item:	10
Meeting:	Trust Board	Reporting Officer:	David Walker

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

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

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

Executive Summary:

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

The requirements set out in the Care Quality Commission Learning from Deaths review have been incorporated into Trust policy. The mortality database has been updated to reflect the new review process and now includes a record of all plaudits and care concerns raised by family or carers of the deceased.

This report details the April 2016 – December 2017 deaths recorded and reviewed on the Mortality database. The importance of reviewing deaths within the 3 month timescale is critical to ensure reporting is accurate and provides a useful overview of the number of deaths that were actually or potentially avoidable. This is the only risk remaining with the learning from deaths process changes. Consultants have been reminded (again) of the importance of timely review and accuracy of grading the avoidability of deaths.

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

N/A

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

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

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

Department of Health

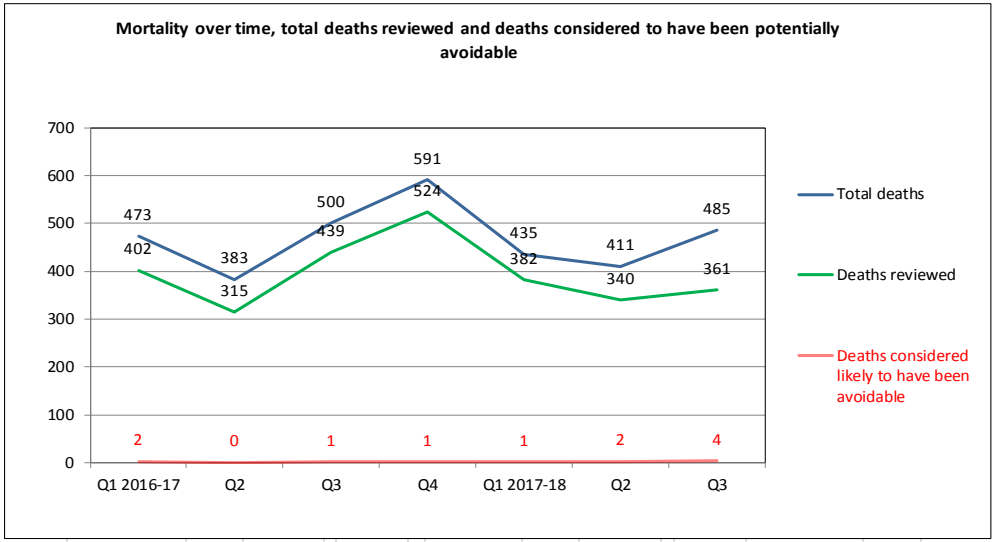
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 25/05/2018)

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

Time Series:	Start date	2016-17	Q1	End date	2017-18	Q3

Total number of deaths in scope		Total deaths reviewed		Total number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
192	145	135	114	1	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
485	411	361	340	4	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1331	1947	1083	1680	7	4



Total deaths reviewed by RCP methodology score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	1	25.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	3	75.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	9.1%	This Quarter (QTD)	3	27.3%	This Quarter (QTD)	2	18.2%	This Quarter (QTD)	1	9.1%	This Quarter (QTD)	4	36.4%
This Year (YTD)	0	0.0%	This Year (YTD)	2	11.1%	This Year (YTD)	5	27.8%	This Year (YTD)	4	22.2%	This Year (YTD)	2	11.1%	This Year (YTD)	5	27.8%

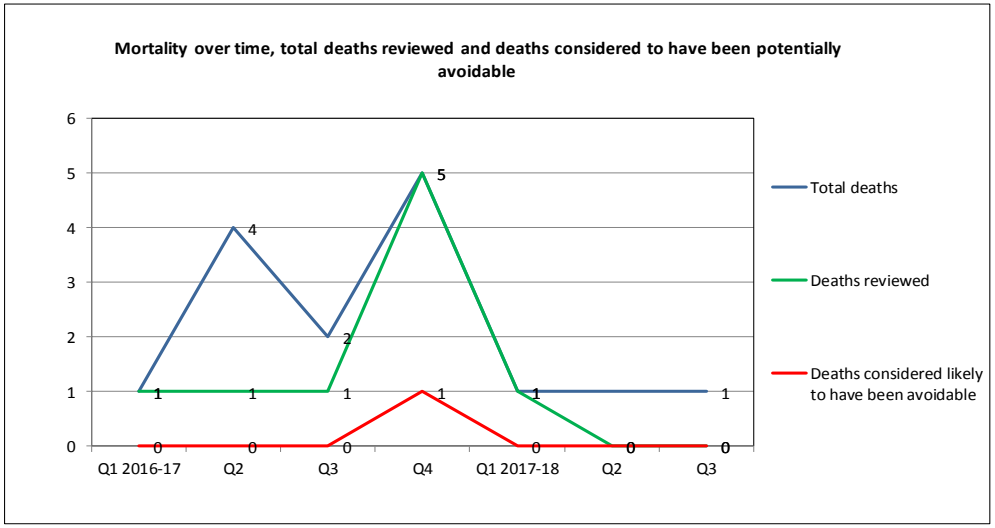
Data shown above is as at 25/05/2018 and does not include patients with identified learning disabilities.
Family/carer concerns - Concerns expressed to the Trust Bereavement team are now recorded on the mortality database. There were 9 care concerns raised relating to Q3 deaths, 2 of which are being taken forward as formal complaints.
Complaints - Of the complaints relating to 'bereavement' which were partially or fully upheld during Q3, none had reviews on the Mortality database which concluded poor or very poor care.
Serious incidents - There were two severity 5 incidents reported for Q3, one of which was a still birth. The other is being taken forward as an Amber investigation and has been fully reviewed on the Mortality database and given a care rating of 'adequate'. (Return to theatre after a high risk operation)
As at 25/05/2018 there were 248 April 2017 - December 2017 deaths still outstanding for review on the Mortality database however, any deaths suspected of being related to poor care have been reviewed.

Summary of total number of learning disability deaths and total number reviewed (Data as at 25/05/2018)

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

Time Series:	Start date	2016-17	Q1	End date	2017-18	Q3

Total number of deaths in scope		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2	12	1	8	0	1



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

Quality Improvement Priorities 2018/19

Meeting information:			
Date of Meeting:	5th June 2018	Agenda Item:	11
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

The Quality Account (QA) is a mandatory annual report to the public from NHS healthcare providers regarding the quality of services provided. It must include at least 3 improvement priorities for the forthcoming year and report progress and achievement on the current year's improvement priorities.

In the 2017/18 Quality Account, eight quality improvement priorities and seven continuous improvement priorities were identified. These formed part of the three year trust Quality and Safety Strategy.

To develop the quality Improvement priorities for 2018/19, progress of all improvement areas within the strategy were reviewed in December 2017. This identified areas where progress had been made but improvement was still required, these areas formed a list of potential priorities for improvement in 2018/19. Public and staff engagement was undertaken and the following priorities have been identified to be included into the Quality Account 2018/19.

Domain	Suggested Improvement area
Patient Safety	Continue to reduce the number of avoidable falls
	Continue our focus on reducing avoidable grade 3 and 4 Pressure Ulcers
	Improve early recognition, escalation and treatment of the physiologically deteriorating patient • Improving recognition , escalation and treatment of the deteriorating patient • Improving early recognition and treatment of sepsis • Improve the prevention, progression and treatment of Acute Kidney Injury

Clinical Effectiveness	Continued Implementation of the Excellence in Care programme
	Safe and effective patient discharge – Improving the experience of getting home.
	7 day services - Working towards providing consistent high quality acre for our patients 7 days per week • Standard 2 – 14hrs Consultant review • Standard 5 – Access to diagnostics • Standard 6 – Access to consultant delivered interventions • Standard 8 – On going consultant directed review
Patient Experience	Continue to improve the quality of our end of life care by improving our processes and documentation
	Improving young people's experience of being in Hospital (Locally identified through Patient experience Team)

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

No

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

The Trust Board is asked to note the eight improvement priorities which will be outlined in the quality account 2018/19 when it is published on the 30th June 2018

1. Introduction

The Quality Account (QA) is a mandatory annual report to the public from NHS healthcare providers regarding the quality of services provided; they are both retrospective and prospective in content. They allow us to provide assurances to our patients, the local public and our Commissioners in regards to the quality of care being delivered, and allow us to demonstrate our commitment to continuous, evidence-based quality improvement.

There is a requirement for the Quality account to -

- Identify at least 3 priorities for improvement
- Identify how progress to achieve the priority will be measured and monitored by the provider
- Identify how progress will be reported by the provider.

2. Developing the Quality Improvement priorities for 18/19

Progress of the projects and improvement initiatives which are identified in our Quality and Safety Strategy were reviewed in December 2018 leading to a list of areas which although improvement was being made a continued or renewed focus was required.

To support the development of the improvement priorities, two public engagement events were undertaken in February. The first formal event was held at Kings Centre, EDGH and the second drop in and outreach event at Station Plaza, Hastings.

The focus of the events was to gauge public opinion as to what is important to them related to the suggested patient experience improvement areas. Facilitated group work at the Kings centre, produced a number of areas which the attendees identified as most important to them. Public were then asked to prioritise these at the event at Station Plaza.

Five staff engagement roadshows also took place during late February and early March to raise awareness of the Quality Account, Quality and Safety Strategy and provide the opportunity for staff to participate in developing the improvement priorities for 2018/19 through undertaking an online survey. The survey set out the suggested areas for improvement and asked staff to provide their own ideas and suggestions for improvement.

The outputs from the engagement was reviewed and the following eight Quality Improvement Priorities (QIPs) have been identified for inclusion into the Quality Account for 2018/19

4. Quality Improvements Priorities 2018/19

No. 1 Improving the early recognition, escalation and management of the deteriorating patient

Why we have chosen this

Early detection and treatment of physiological deterioration has been shown to improve the clinical outcomes for patients.

We have made considerable improvements in the monitoring and detection of patient deterioration using an electronic observation system and now want to further improve escalation processes to ensure patients are assessed, treated and ongoing care is planned appropriately.

Amongst the main causes of deterioration is Sepsis and Acute Kidney Injury (AKI).

Sepsis is a common and potentially life threatening condition which arises when the body's response to an infection injures its own tissues and organs. This can lead to shock, multi organ failure and death therefore early detection and treatment is essential. We have made improvements on both our wards and emergency departments and want to continue our focus on this. In addition we want to provide our community teams and hospitals the clinical tools to support the early recognition and escalation of suspected sepsis in these areas.

Acute Kidney Injury means that your kidneys suddenly stop working as well as they were. This often happens as a complication of other serious illness and for a variety of reasons including severe dehydration, sepsis and side effects of medications. We want to improve the early detection by alerting clinical team and pharmacists to patients who have AKI and improve the pathway of care they receive.

What are we going to do?

We will develop a clinically led Improvement group to oversee and drive improvement in the three areas of, Improving escalation processes, sepsis recognition and prompt treatment and AKI alerting and treatment.

Escalation pathways
We will work with front line staff through Improvement workshops to understand where current systems and processes can be improved and involve them in shaping the new pathways.

Sepsis

We will continue to support our frontline teams to embed consistent screening and early treatment of sepsis. We will implement a community sepsis screening tool and continue to raise awareness of sepsis in a variety of ways, provide training, education and online resources for our staff to access.

Acute Kidney Injury

Revise and improve the Acute Kidney Injury pathway through working with front line staff. Raise awareness of the importance of early recognition and prompt treatment and develop alerting to our pharmacy teams to trigger review of medications which may be contributing to the onset of the condition.

What will success look like?

- Revised and improved escalation pathway developed and implemented
- Reduction in cardiac arrests associated with suboptimal management of physiological deterioration
- Increased percentage of patients screened for sepsis in our acute hospitals
- Increased percentage of patients with Sepsis who receive Antibiotics within 1 hour of diagnosis.
- Implementation of a sepsis screening tool in our community hospitals and teams
- Revised and improved AKI pathway implemented
- Pharmacy medication review alerting

How we will monitor progress?

We will monitor progress and track the measures of improvement through the newly formed Deteriorating Patient Improvement Group (DPIG) which reports to the Trust Clinical Outcome Improvement Group chaired by the Medical Director.

No.2 Continue to reduce the number of avoidable falls

Why we have chosen this

Injury to patients from a fall whilst in hospital can be at worst catastrophic and at best result in further pain and suffering with potential increased length of stay and delayed recovery.

Although we acknowledge patients must mobilise to enable recovery, which may create an increased risk from falling, we know from investigating serious and moderate incidents that there are occasions when we could have done more to try and prevent the fall from occurring. We need to provide assurance we did all possible to prevent a patient from falling.

The number of patient falls has reduced each year over the last three years and we will continue this improvement journey.

What are we going to do?

We will continue to roll out the new assessment and care plan to all wards and raise the profile of falls prevention through education, leadership and challenge.

Effective leadership on the wards and clinical areas to ensure robust assessments are completed with clear prevention plans that are documented and checked to ensure in place on a daily basis. This will further reduce falls and subsequent harm to patients. To achieve this we will ensure education programmes are in place and the continued roll out of the Excellence in Care programme to support the leadership on falls reductions.

What will success look like?

Our aim is to -

- Meet the challenging target of no more than 5 falls per 1000 bed days compared with 5.6 in 2017/18
- Continue to reduce the total number of falls occurring within the trust from 1624 reported in 17/18

How we will monitor progress?

Progress will be tracked and reported on a monthly basis through the Sign up to Safety report to the Patient Safety and Quality Group (PSQG)

No. 3 Continue our focus on reducing avoidable Grade 3 and 4 pressure ulcers

Why we have chosen this

All patients are at risk of developing a pressure ulcer. This increases for patients who are acutely ill, have impaired mobility or nutrition or who have conditions that affect the flow of blood through the body such as diabetes.

Pressure ulcers occur when an area of skin is placed under pressure. The increased pressure affects the blood flow causing the skin to be starved of oxygen and nutrients which leads to break down of the skin and surrounding tissues leading to ulcer formation.

We have chosen this as priority in 2018/19 as although we have made a number of improvements we recognise there is more to do. Our focus is to reduce the amount of avoidable grade 3 and 4 pressure ulcers with the ultimate aim of eliminating these entirely.

Prevention of skin damage is an integral part of the care we provide at ESHT. Therefore a collaborative multidisciplinary approach, where each member of the healthcare team takes responsibility for the early identification of skin damage through assessment and on-going management is required.

What are we going to do?

Develop our annual Improvement plan which includes the following actions,

Understanding the key themes and share the learning

- Through the monthly Pressure Ulcer Review Group (PURG) we will review all Grade 3 and 4 pressure ulcers
- Using the Department of Health definition, we will categorise whether the Pressure Ulcer was avoidable or unavoidable.
- If it is found that our trust policy has not been followed and the pressure was avoidable it may be necessary to raise an incident under the Serious Incident process for full investigation
- Analysis will be undertaken so themes and trends are clearly identified with actions are identified and learning shared.

Training, education and improving awareness

- Introduce ‘Pressure Ulcer Prompt cards’ to all our hospital and community staff to raise awareness and provide accessible information on prevention and management.
- Continue to provide formal and informal training and education for our staff.
- Support and develop our newly formed Pressure Ulcer ward and community team Champions so they able to support improvement in their areas.

Measuring for Improvement

- Review our existing measures of improvement and develop a set of measures which we will monitor regularly so we can track if improvement is being made.

- Revise our monthly ward/team audits to ensure we track our compliance with key standards such as assessment using Purpose T and the SSKIN bundle.
- Provide support to teams or wards where our compliance could be improved.

What will success look like?

- All avoidable pressure ulcers are identified, investigated and actions implemented
- Reduction in the number of avoidable Grade 3 and 4 pressure ulcers from our baseline data collated in the first 3-6 months of 18/19

How we will monitor progress?

We will monitor progress through the Pressure Ulcer Steering Group (PUSG) and if required also into the Serious Incident Review Group (SIRG)

The Pressure Ulcer Steering Group (PUSG) is a bi monthly multi-disciplinary meeting chaired by the Deputy Director of Nursing. It reviews findings and actions from the pressure ulcer review group (PURG) and tracks the progress of the pressure ulcer improvement plans and improvement measures.

No. 4 Working towards providing consistent high quality care for our patients seven days per week

Why we have chosen this

There is a national drive to improve access to emergency care 24 hours a day, 7 days a week. A large programme of work has been established by NHS England and NHS Improvement with early adopters including Oxford and Southampton.

Ten core standards were identified by the 'NHS Services, Seven Days a Week Forum' in 2013, which were based on the Royal College of Physicians' guidance on acute and emergency admissions. They apply only to emergency admissions and not planned care.

The original ten standards are still in place; however, there are four core standards that need to be delivered by the Trust by 2020/21:

- Core Standard 2- patients wait no longer than 14 hours to initial consultant review after admission.
- Core Standard 5- patients get access to diagnostic tests with a 24 hour turnaround time. For urgent requests, this drops to 12 hours and for critical patients, 1 hour.
- Core Standard 6- patients get access to specialist, consultant-directed interventions
- Core standard 8- patients with high-dependency care need twice daily specialties consultant review and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds.

What are we going to do?

We acknowledge the need to achieve the four core standards by 2020/21; as such we plan to approach this 3 year scheme in a phased approach.

In 2018-19 we will initially focus on the first phase. This will include:

Monitoring
- Completing and responding to mandatory audits and benchmarking achievements against national peers.
- Reviewing automated data capture systems with a view to reduce administrative overheads

Communications and Engagement
- Leading by example to increase awareness and improve services across the Trust; improving clinical safety and achievement of core standards
- Improve internal communications to enable sufficient access to out of hours services
- Liaising with, and learning from, early adopters sites
- Networking with other NHS Trusts to share best practice

Proof of Concept
- Putting in to practice in our local health economy changes in clinical practices as a response to the lessons learnt both internally and nationally
- Using an improvement methodology to enable initiatives to be positively adopted, tested and adjusted in anticipation for trust wide roll out.

Staffing
- Baseline existing workforce for acute and emergency admissions areas and clinical support areas
- Compare to requirements for seven day services achievement

.

Produce plans to identify solutions as to how the gap will be filled

What will success look like?

We aim to end this first phase with an

- Improvement on core standard delivery, resulting in audit results as follows by March 2019:
    a. Core Standard 2= 80%
    b. Core Standard 5=77%
    c. Core Standard 6= 90%
    d. Core Standard 8=50%
- Developed specialty or divisional level plans for further improvement
- Automated data capture solution identified, and implementation plan agreed

How we will monitor progress?

A number of workstreams will be established to focus on the key areas of work, reporting into the Project Steering Group, which subsequently is accountable to the Clinical Effectiveness Group, chaired by the Assistant Medical Director.

No.5 Continued Implementation of the Excellence in Care programme

Why we have chosen this

In the past we have collected information on ward performance through incidents, patient feedback and numerous audits and data collection. These have been collated on and reported from different systems in varied ways which has proved difficult for wards to easily access, review and analyse the information to identify areas for improvement or to celebrate the high quality care they are providing.

The Excellence in Care Programme was developed in response to our trust commitment to continuous improvement and empowering teams to lead change. It clearly identifies key measures collated from all the different systems into a user friendly dashboard and highlights areas which require improvement enabling staff to make changes to further improve the quality and delivery of the care they provide.

The dashboard enables wards to measure the desired improvement as a consequence of the positive action and changes they make to reduce harm, improve outcomes as well as improving patient and staff experience and also the overall contribution to quality improvement across the trust

What are we going to do?

We will continue to roll out the Quality and Safety Dashboard which is currently within 10 wards to all our acute inpatient ward areas. Monthly reports will be available to enable review of information to identify areas for improvement

We will develop a set of process and outcome measures to assess our performance in the domains of Access and Delivery and Leadership and Culture and aim to test these on 2 wards.

What will success look like?

- The Quality and Safety measures dashboard will be available to all inpatient wards across the Trust by 31/03/2019. Monthly reports will be available to enable review of information to identify areas for improvement
- Improvement measures for the other domains of Access and Delivery, Leadership and Culture domains will be developed agreed and be piloted on 2 wards.

How we will monitor progress?

The Excellence in Care Project Board is responsible for monitoring and guiding the delivery of Excellence in Care programme. Overall progress is monitored by the trust Patient Safety and Quality Group (PS&QG)

No.6 Safe and effective discharge and improving our patients experience of getting home

Why we have chosen this

The national inpatient survey 2017 highlighted a number of areas regarding communication and information provided to patients on discharge where we were underperforming compared to our peers. In addition some serious incident investigations have identified problems regarding information sharing prior to patient discharge and the quality of the discharge notification letter sent to GPs. Our own internal complaints and inpatient questionnaire data identified poor results from patients receiving written information on discharge and being involved in decisions.

What are we going to do?

Design and implement a system for the communication and provision of information for patients and their families or carers prior to and during their discharge from hospital by the end of September 2018. This will be achieved through engagement with patients and staff on one ward in each Division to review the current systems in place and identify the gaps to re-design an effective communication system for verbal and written information. Once improvement can be demonstrated and the system is effective it will be rolled out to other wards. We will work with ESBT and system partners to ensure a comprehensive and collaborative approach.

What will success look like?

Improved feedback from the people who use our services about the discharge process, one about communication and one about information regarding the discharge process. We also hope to see more positive feedback from our staff.

How we will monitor progress?

Improvement will be monitored through the inpatient questionnaire via two questions about the discharge process, one about communication and one about information regarding the discharge process. The National Inpatient Survey will be used but is unlikely to show improvement in the 2018 survey due to the focus work with individual wards. We will also look to survey a number of staff involved in the process.

No. 7 Continue to Improve the quality of End of Life Care by improving processes and documentation

Why we have chosen this

We have made a number of improvements in the care we provide to patients at the end of their life during 2017/18 which we have outlined in the latter section of the Quality Account. Although we have achieved this we also recognise that there a number of improvements required in some of our processes and documentation. Therefore this year we will focus on specific areas where improvement in systems and process is a key enabler to enhancing the overall experience of care we provide.

What are we going to do?

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Implementation

ReSPECT is a process that creates personalised recommendations for a person's clinical treatment in a future emergency in which they are unable to make or express choices. It provides healthcare professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment.

The plan is created through conversations between a person and healthcare professionals and recorded on a form which includes their personal priorities for care and agreed clinical recommendations about care and treatment that could help to achieve the outcome that they would want, that would not help, or that they would not want.

We plan to start implementation of ReSPECT in August 2018 initially within our acute hospitals. We will provide training to undertake the ReSPECT process to key members of staff within our acute and community teams raise awareness through a number of mechanisms and provide information and training resources for staff to access.

EOLC for Neonates and Children and Young People

In recognising the different requirement for our patients and staff, we will develop with patients and parents a specific End of Life Care Strategy for Neonates, Children and Young People.

We will, as part of our year one improvement plan, introduce a process whereby neonates, children and young people who have life limiting conditions have an initial advance care planning discussion with a Paediatrician.

Measuring for Improvement

In 2017/18 we developed a range of indicators to measure for the improvement we are expecting as a consequence of the planned improvement actions we have implemented. This includes how well we are documenting the care we provide in the last hours and days of life care plan.

We will continue to monitor this on a monthly basis In 2018/19 and also review the information we gain through the Voices Survey which bereaved relatives and friends complete to give us feedback on the care experience or their loved one and of their own experience of the services we have provided.

What will success look like?

- ReSPECT advocates from our acute and community teams will be identified, trained and will be able to provide the ReSPECT process training to colleagues in there clinical areas.
- The ReSPECT process and document will be implemented within our acute hospitals
- We will see improvement in the documentation of last days/hrs of care

How we will monitor progress?

The End of Life Care Steering group provides oversight of the EOLC full programme of work and the measures of improvements. The group reports into the Clinical Outcome Group (COG) which is chaired by our Medical Director.

No. 8 Improving the experience of young people in hospital

Why we have chosen this

Results of the National Children and Young people survey highlighted areas where young people were not happy with during their stay as an inpatients. We scored in the bottom 20% of trusts for the following questions;

- Were there enough things for you to do in hospital?
- Did hospital staff play with you or do any activities with you while you were in hospital?
- When the hospital staff spoke with you, did you understand what they said?
- Were you involved in decisions about your care and treatment?
- Did the hospital staff answer your questions?
- Was it quiet for you to sleep when needed in the hospital?
- If you had any worries, did a member of staff talk with you about them?
- Before the operations or procedures, did hospital staff explain to you want would be done?
- Afterwards, did staff explain to you how the operation or procedures had gone?
- If you wanted were you able to talk to a doctor or nurse without your parents or carer being there?

Our improvement priority is to work with the Patient Experience Lead and team, the Associate Director of Communications and Engagement to undertake engagement events or communications to consult with young people and their families around what can be done to improve the experience they have.

What are we going to do?

We will develop a questionnaire that will be available as an online survey or as a paper survey which we will ask young people and their families to complete regarding their recent hospital experience.

We will undertake the survey over a three month period and use the information gained to develop a plan of improvements on our children's wards. We will implement the changes in the later part of the year.

We will work with the patient experience team to break down the Friends and Family Test (FFT) responses by age groups so we are able to monitor and track the experience of care and the ward environment for all age groups. We may also add a specific question to the FFT questions to test out that our actions are having the desired effect for the focus age group. The result of the FFT is reviewed monthly by the ward Matrons and Heads of Nursing and improvements made accordingly.

What will success look like?

Success will be measured by

- An improved Children and Young People National Survey
- No longer being in the bottom 20% of trusts
- Improved FFT response from young people

How we will monitor progress?

Progress will be monitored monthly by the matrons and Heads of Nursing by regularly reviewing our patients experience data available including FFT, plaudits and complaints.

The trust patient experience steering group will monitor overall progress of the improvement priority.

ESBT Alliance Test Bed Year 2017/18 Draft Impact and Learning Report

Meeting information:			
Date of Meeting:	5th June 2018	Agenda Item:	12
Meeting:	Trust Board	Reporting Officer:	Catherine Ashton

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

Has this paper considered: (Please tick)

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

Other stakeholders please state: .....

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

Executive Summary:

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

This is the draft Impact and Learning Report on the ESBT Alliance Test Bed Year 2017/18. Prior to the test bed year starting we also initiated an independent Accountable Care System Health Check supported by Optimity Advisors. This involved eliciting partners' views across ten domains that contribute to the success of accountable care, to provide a baseline of our levels of maturity as a system at that time. Phase 1 of the health check reported in May 2017 and made some recommendations for improvement, which resulted in the second phase of the health check focussing on localities. Our intention is to conduct the third and final phase of the health check in June-July 2018, to determine how far we have matured as an accountable care system since the findings that were reported in May 2017.

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

ESBT Partner Boards

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

To note the report, to note progress and to advise if specific actions or information is required

PLEASE NOTE

This paper is **draft:** it sets out our assessment of the impact and learning from our 2017/18 test-bed year as an integrated (accountable) care system. The analysis is not definitive, and is intended to help inform wider discussions as we develop our thinking for strengthening our ESBT Alliance governance arrangements 2018/19.

ESBT Alliance Test Bed Year 2017/18

Draft Impact and Learning Report

1. Introduction

1.1 In April 2017 the members of the ESBT Programme Board moved formally into an ESBT Alliance arrangement for a test bed year, in order to enable us to rapidly develop our capacity to manage the health and social care system collectively as an Alliance partnership.

1.2 This arrangement was underpinned by an Alliance Agreement which provided the framework to operate 'as if' were an accountable care system, in order to test ways of working, configure resources more flexibly, and improve services for the population in 2017/18 and in the longer-term.

1.3 To support our ambition to work as one system in 2017/18 we put in place a system wide governance structure, to support our ESBT Alliance to cover the following areas during the test bed year:

- The commissioning and delivery of health and care services to the local population and with an annual budget of approximately £860m (2017/18), focussing on what matters to local people. This has included continuing our programme of transformation and service change and raising the profile and investment in prevention and proactive care while reducing reliance on secondary care (hospital) services;
- Collaboration to deliver our integrated Strategic Investment Plan and further development of integration plans and practice; and
- The alignment of our budgets so we can design a payment mechanism that incentivises population health outcomes more than activity and invest appropriately across our health and care system to best benefit local people.

1.4 Part of the purpose of the test bed year was to create the space and time to undertake the necessary learning and development, with support from NHS Improvement (NHSI) and NHS England (NHSE) as the system regulators, to design our ESBT Alliance integrated care model.

1.5 These transformation activities were set out in schedule 2 of the ESBT Alliance Agreement, and a draft summary of the progress made with the activities in the test bed year is set out in Appendix A. This summary is not definitive, and is intended to support wider discussions to aid planning for 2018/19.

1.6 Prior to the test bed year starting we also initiated an independent Accountable Care System Health Check supported by Optimity Advisors. This involved eliciting partners' views across ten domains that contribute to the success of accountable care, to provide a baseline of our levels of maturity as a system at that time. Phase 1 of the health check reported in May 2017 and the findings commended the maturity of our partnerships, our evident shared ambition and vision, and our approach to deep and wide stakeholder engagement, recognising the specific continued engagement that will be needed across primary care in particular. Some recommendations were also made for improvement, which resulted in the second phase of the health check focussing on localities. Our intention is to conduct the third and final phase of the health check at a future point in 2018/19, to determine how far we have matured as an integrated accountable care system since the findings that were reported in May 2017.

2. Strengths and impact in the test bed year

2.1 Our formal ESBT Alliance arrangement in 2017/18 has enabled a system-wide approach and focus to operational delivery. The indications are that this has enabled us to continue to build on our successful ESBT partnership working over the previous three years to begin to bend the curve in demand, including in the following ways:

- For those aged over-65 there has been a sustained reduction in A&E attendance, unplanned admissions, acute referrals, and admissions from care homes that demonstrates how we have produced a bend in the demand curve to be much better than regional and national average.
- Consequently, system performance has significantly improved for key national standards, including Referral to Treatment Time (RTT), Accident and Emergency (A&E) and Delayed Transfers of Care (DTOC).
- A&E is now in the upper quartile of performance nationally and DTOCs have reduced from approximately 8% to as low as 2%. RTT regularly performs at over 90%; during December 2017 and over Christmas we were between 7th and 9th best nationally.
- Over and above this, by working together we have reduced serious incidents, and improved stroke measures and outcomes.

2.2 This positive picture of collaboration was recognised at the 2017 Health Service Journal (HSJ) Awards, where the ESBT Alliance won the 'Improved Partnerships between Health and Local Government' award in recognition of the hard work and commitment to integrating health and care services in East Sussex.

2.3 The Care Quality Commission (CQC) Local System Review of East Sussex, undertaken in November 2017 has been equally instructive. This reported that ESBT system leaders in East Sussex had a clear and aligned purpose and vision for providing health and social care services, with strong commitment and a high level of trust between the system leaders[1].

[1] East Sussex Local System Review November 2017 Report (Care Quality Commission, January 2018)

2.4 The Local System Review was also extremely positive about preventative approaches to health and social care delivery saying this was "well thought through and embedded….a wide range of effective initiatives that were supporting people to remain in their own home and maintain their wellbeing". This had resulted in East Sussex having lower rates of attendance of older people in A&E than comparator areas and nationally[2].

2.5 In 2017/18 we have continued to build our locality model to shift to a proactive, community based model of care. This includes continued implementation of integrated locality teams, frailty practitioners, crisis response and proactive care teams. In addition Health and Social Care Connect has become fully embedded and operational as our streamlined single point of access for all adult health and social care enquiries and assessments. Progress has been made with building the locality planning and delivery model in 2017/18 in order to facilitate stronger partnerships across the health and care system to support delivery in our six ESBT localities.

2.6 Although it is too soon to measure comparative performance against previous years' performance, the indications are that our new ESBT Alliance Outcomes Framework for 2017/18 will show some measurable improvements in the areas that local people have told us are important.

2.7 We have also been able to undertake an options appraisal of future ESBT delivery models in the test bed year, and have agreed recommendations about our preferred option through our sovereign organisations. This has put us in a strong position to move forward with developing the business case for our Integrated Care System[3] delivery model.

3. Challenges

3.1 We have made significant in-roads into addressing inequalities and improving access, quality and safety for local people. However, this has not translated quickly enough into reducing either the level of activity or the unit cost, and so we must now redouble our efforts to demonstrate that we are making these improvements for the people of East Sussex in a way that makes the very best use of available resources.

3.2 System financial recovery is now a critical focus for 2018/19 and any changes to ESBT Alliance governance and leadership must support a better grip on the delivery of system plans, and enable a more speedy and flexible response to support financial improvements. In particular our ESBT governance in 2018/19 must reflect the role and contribution of partnerships in our localities, in

[2] East Sussex Local System Review November 2017 Report (Care Quality Commission, January 2018)

[3] In keeping with national direction, we're beginning to reflect the latest NHS Planning Guidance for 2018/19 "*We are now using the term 'Integrated Care System' as a collective term for both devolved health and care systems and for those areas previously designated as 'shadow accountable care systems'. An Integrated Care System is where health and care organisations voluntarily come together to provide integrated services for a defined population"* www.england.nhs.uk/publication/refreshing-nhs-plans-for-2018-19/ (February 2018)

leveraging the added value required to achieve our ESBT objectives of improvements to quality and finance.

3.3 Strong progress has been made with creating our single ESBT system-wide budget, and aligned incentive contracting has been explored. However, there has also been a tension in the way we have had to operate separate organisation financial planning arrangements and control totals at the same time. More can be done to remove organisational barriers for financial planning and the proposals we have shaped for a Financial Framework Agreement and ESBT Integrated Commissioning Fund will support this, in addition to a refreshed system recovery plan.

3.4 Although the CQC Local System Review recognised there was a clear and aligned purpose and vision for providing health and care services, some areas for improvement were identified including areas relating to whole system governance and accountability:

- Work is required to develop a wider system vision for the STP footprint and develop a common framework for prioritizing actions and for specifying accountabilities and shared governance arrangements across ESBT and C4Y
- The Health and Wellbeing Board (HWB) would benefit from increased vigour in calling system leaders to account to ensure that agreed plans and services are delivered, and to secure whole system integration.

3.5 Actions to deliver this improvement have been agreed and involve the following:

- Review system representation and associated accountabilities on the STP Board and workstreams;
- Review of the Health and Wellbeing Board to provide a robust whole system approach to transformation, improved health and wellbeing outcomes for local people, and review its role and purpose to:
    - streamline and rationalise whole system governance arrangements
    - establish the system leadership role of the Board;
    - confirm and strengthen the relationship with the STP;
    - provide a robust whole system view of planning, performance and commissioning;
    - Review membership of the HWB and clarify roles of Board members;

3.6 These actions will have ESBT governance at their heart and will have a bearing on how we shape our proposals for our integrated governance over the medium to long term. Our refreshed arrangements for ESBT governance for the first six months of 2018/19 will allow us the opportunity to test our ideas about strengthening ESBT Alliance governance, and the learning from the ESBT Alliance test bed year, as well as feed this into the wider STP and HWB review processes.

4. Key learning points to inform plans for 2018/19

4.1 Building on our thinking so far about how we can strengthen the ESBT Alliance, the key learning points from our test bed year and the CQC Local System Review can be summarised as follows:

- Building on the trust and successful system working we have developed as an ESBT Alliance to enable more delegation to our system governance of statutory accountabilities, making our governance more rationalised and our decision-making to move more responsively at the pace the system requires.

- Consolidating our approach to ESBT governance, leadership and commissioning in the context of our 'place' to ensure a shared understanding of the health, social care and wellbeing needs of our ESBT population, and a clear place-based strategy to meet those needs.

- Consolidating the financial arrangements that underpin the place-based governance and leadership, through our proposals for an ESBT Integrated Commissioning Fund (ICF) and a Financial Framework Agreement to support the operation of the ICF.

- Strengthening our approach to building the 2018/19 ESBT system financial recovery plan. The system-wide plan will describe the key service redesign priorities, financial and activity targets for the ESBT system in 2018/19, to serve as the 'bridge' between the ESBT Alliance Outcomes Framework and the delivery plans for each of the six ESBT Localities. This will help the Locality Planning and Delivery Groups be clear about their contribution to the overall ESBT Alliance objectives to achieve the financial sustainability, care quality and population health improvements for 2018/19.

- Ensuring the voice of localities is at the heart of ESBT, providing the oversight needed to drive improvements in the day-to-day operational performance of our system quality and finances. This would be supported by a reinforced focus for the ESBT Alliance Executive on managing the in-year operational performance of our system, with the newly formed Locality Planning and Delivery Partnerships facilitating the contribution of the local partnership environment to delivery.

- Reinforcing the role of the ESBT Integrated (Accountable) Care System Development Group to enable a continued focus on the transformation required to put the system on a stronger footing by 2020/21.

- Ensuring we work well within our STP to ensure our ESBT plans help manage demand, as well as influence and contribute to a shared commissioning approach to networks of services that work better on an STP-wide footprint.

Appendix A (21/02/18)

Progress against ESBT Alliance Transformation Activities in 2017/18

In addition to facilitating closer operational working across our system, schedule 2 of the ESBT Alliance Agreement set out a number of transformation activities for development and agreement during the test-bed period. Progress against each of these activities has been summarised below and given an initial overall RAG rating. This is a self-assessment exercise; the analysis is not definitive but more intended to support wider discussions. It has been produced to help review the achievements of the test bed year and inform discussions about strengthening the Alliance in 2018/19.

	ESBT Alliance transformation activity	RAG rating
1	**Activity:** Develop and implement a collective integrated operational, financial and performance management platform to enable the Alliance to transform services and improve system delivery to the standards required following the Test-Bed Period	
	Progress: Strong progress has been made with integrating operational and financial arrangements which has led to improvements in the quality and safety of services in 2017/18, significantly helping us to bend the curve in demand. However, we have been unable to move at the pace the system requires to impact on finances in 2017/18. A priority for 2018/19 will be to reinforce effective governance and leadership of performance at a strategic system level and in our ESBT localities as we implement our financial recovery plan. We have started to test a system-wide portfolio management office to support the ESBT Integrated Strategic Planning Group, and work is also in progress to integrate our business processes for performance management of the Alliance.	
2	**Activity:** Design and agree a whole system pilot outcomes framework and performance incentivisation scheme, based on the outcomes that matter to local people, that aligns outcomes across the system and gives an indication of the performance of the system as a whole.	
	Progress: The ESBT Alliance Outcomes Framework was developed following local engagement in the Autumn of 2016 and a data review carried out to provide a picture of what is important to local people about their health and care services. The data review brought together the wide range of qualitative information and feedback already available across all our organisations and through our engagement events, and which represents the views of thousands of people who are using local health and social care services, both children and adults. This included feedback gathered by Healthwatch and through the ESBT Public Reference Forum.	

	From this we developed and agreed an integrated ESBT Alliance Outcomes Framework to enable oversight of the performance of the system, which was agreed, adopted and owned by Alliance partners June 2017. Work is also in progress to explore integrating our business processes for collecting data and analysis to describe the performance of our system and delivery of the outcomes.	
3	**Activity:** Operate and test a locality based operational model that is based on 'one budget, one system' and is rooted in communities, and develop integrated care pathways to reduce variation and increase standardisation in line with evidence-based best practice to deliver the Alliance Aims and Objectives, and ensure optimum cost effectiveness through delivery of integrated locality based services at the lowest level of effective care	
	Progress: Although we haven't been able to move at the pace our system requires to impact on finances, we have continued to build on our locality model to shift to a proactive, community based model of care and bend the curve in demand. This includes continued implementation of integrated locality teams, frailty practitioners, crisis response and proactive care teams. In addition Health and Social Care Connect has become fully embedded and operational as our streamlined single point of access for all adult health and social care enquiries and assessments. Progress has been made with building the locality planning and delivery model in 2017/18 in order to facilitate stronger partnerships across the health and care system to support delivery in our six ESBT localities, and add value through reducing variation and integrating care pathways. A priority in 2018/19 will be to further develop the locality focus of our governance, leadership and system plans.	
4	**Activity:** in keeping with the key principles and characteristics of our local ESBT accountable care model, build on the SIP, and pooled and aligned funding model to test and design a whole population capitated budget, constructed around localities and a whole life cycle approach.	
	Progress: An aligned incentive contract was explored in 2017/18 as a stepping stone to designing a whole population budget, and there was local agreement to implement an AIC. However, we did not get permissions from our regulators to suspend Payment by Results and implement this either in-year or in 2018/19. Our key focus means we must build on a PBR contract and ensure the activity and resources are aligned across commissioners and providers to offer best use of available resources.	
5	**Activity:** develop and agree an appropriate risk and reward sharing model, and test it in shadow form during the Test-Bed Period between the Full Alliance Members to inform future contracting	

	arrangements.	
	Progress: This was explored as part of the Aligned Incentive Contract discussions, noted under 4.	
6	**Activity:** further develop our IT digital and back office systems and approach to estates to support the delivery of integrated care, and the active participation of patients, clients and local citizens in decisions about their care and support, self-care and self-management	
	Progress: The updated ESBT Digital Strategy 2017-2021 was endorsed by the ESBT Alliance Governing Board in November 2017. The ESBT back office infrastructure project initiated integrated action in the areas of workforce, finance and estates. Work continued on integrated wholes system solutions to our workforce recruitment and retention challenges under the ESBT workforce strategy. The ESBT Communications and Engagement Strategy was refreshed to support core C&E activity across the system. A start has been made with implementing the Patient Activation Measure (PAM) tool and this will be rolled out further in 2018/19.	
7	**Activity:** continue to work with the emerging local GP federations and the Local Medical Committee to develop a menu of options for the structural relationship of General Practice with the Alliance during the Test-Bed Period and with the future ACM	
	Progress: the GP Federations and the LMC were part of the options appraisal exercise for the future model in June 2017. A task and finish group is being set up to explore the options for GPs as independent contractors to engage with the future integrated care model, as well as with the ESBT Alliance in the interim.	
8	**Activity:** agree the design criteria for our future ACM after the Test-Bed Period, and use this criteria to identify and appraise the options for structural form (including the organisational form and contracting arrangements for the model)	
	Progress: the design criteria for the future model was developed and agreed with our stakeholders. This was used in the options appraisal exercise in June 2017 to support discussions and arrive at a preferred option for the future ESBT integrated care system delivery model.	
9	**Activity:** agree the roadmap and implementation plan for the recommended option by July 2017, and enact implementation plans and due diligence processes as appropriate after July 2017	

	Progress: a milestone plan by was agreed in July 2017. It described the critical path for the recommended option, including strengthening the ESBT Alliance in 2018/19 and building the business case for our integrated care system by 2020/21. Implementation plans and due diligence will be developed enacted once the business case has reported.	
10	**Activity:** develop an approach to engagement with key stakeholders on the above, including consultation as appropriate and working with system regulators such as NHSE, NHSI, DoH and the CQC, to seek appropriate permissions and using the NHS Integrated Support and Assurance Process ("**ISAP**")	
	Progress: local discussions with our key stakeholders shaped the criteria for the options appraisal, and Healthwatch, the LMC, GP Federations and NHSE participated directly in the options appraisal exercise. Discussion with the NHS ISAP team also too place to determine appropriateness and timing for using the process if necessary. An action plan outlining the specific approach to engaging key stakeholders in developing the business case for the future ESBT integrated care model has been drafted for testing with our stakeholders.	
11	**Activity:** develop a proposal for the residual strategic commissioning functions (population needs assessment, outcomes setting and oversight of performance) for the Alliance Commissioners	
	Progress: this is part of the work to shape proposals for integrated place-based commissioning in 2018/19, focusing on the senior management elements for April 2018, with a phased approach to implementation with the wider commissioning work programmes and functions during 2018/19. Proposals for retained integrated strategic commissioning functions will be developed in conjunction with the business case for our integrated care system to ensure we have the right capacity across all of our system for planning, commissioning and contracting.	
12	**Activity:** develop a 'whole system' organisational development approach in order to underpin transformation and support staff through the transformation to 'one budget, one system', and empower them to become leaders of change and innovation that puts local people at the heart of services	
	Progress: a high level OD plan has been produced, underpinned by the integrated ESBT Communications and Engagement Strategy and this will be operationalised as part of ongoing ESBT workforce development strategies	

13	**Activity:** design an integrated governance model for the Test-Bed Period and future ACM that integrates citizens into the leadership of the new care model of care and engages them appropriately at all levels of the governance structure	
	Progress: a new Health and Wellbeing Stakeholder Group has been co-designed with stakeholders and a representative has been nominated to sit on the ESBT Strategic Commissioning Board. The meetings of the group are focussed around key areas of service development, and other areas of interest for our stakeholders. Healthwatch also has a seat on key elements of the ESBT Alliance governance structure to ensure that the views of local people are taken into account. Representatives from the voluntary sector also participate in the planning and design groups for personal and community resilience and community services, and the ESBT locality planning and delivery groups and locality networks which are focussed on engagement with local groups and organisations working in their areas. As part of the preferred option for the future integrated care model agreed in July 2017, it has been agreed to co-design models of citizen governance so that our future integrated care delivery model is owned and championed by local people.	

Emergency Preparedness, Resilience & Response (EPRR)

Meeting information:			
Date of Meeting:	5th June 2018	Agenda Item:	13
Meeting:	Trust Board	Reporting Officer:	Joe Chadwick-Bell

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

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

Other stakeholders please state: Sussex Resilience Forum (&) Sussex Local Health Resilience Partnership.

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

Executive Summary:

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

The Trust as a Category 1 Responder under the Civil Contingencies Act 2004 (CCA 2004) and as such has statutory duties to:

- Assess the risk of emergencies occurring and use this to inform contingency planning;
- Put in place emergency plans;
- Put in place Business Continuity Management arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance co-ordination; and
- Co-operate with other local responders to enhance co-ordination and efficiency;

NHS England (NHS E) maintains an EPRR Framework, which places similar duties to the above on all NHS-funded organisations, whether or not they are a Category 1 responder under the CCA, or not. The performance of each Trust is audited against the EPRR framework annually in September / October, via the NHS E Core Standards for EPRR. This process is managed in Sussex by NHS E South (South-East), with assistance from (in our case) the east Sussex CCGs. The CCGs co-ordinate the local health response on our behalf and as such we work closely with both the CCG and NHS E through the year to ensure ESHT is able to prepare and respond effectively. The assurance process involves assessment against approximately 90 separate core standards.

The level of compliance against the core standards is assessed as follows:

	Compliance Level Evaluation and Testing Conclusion	CS No's not complied with
Full	Green	0
Substantial	Green	1-5
Partial	Amber	6-10
Non-compliant	Red	11+

As reported to the Board in November 2017, ESHT demonstrated a **Partial Compliance** against the Core Standards, the same level as the previous year. NHSE require assurance that the Board considers and engages in promoting full compliance with the EPRR Core Standards and is aware of the current level of compliance together with the Action Plan to achieve full compliance.

The key areas of non-compliance in November (together with summarised progress against each area and showing outstanding actions) are shown in Appendix A, ESHT EPRR Core Standards Action plan for Compliance (V4, May 2018). (This Core Standards Action Plan is reviewed monthly and has been reported through the EPRR steering group, demonstrating progress to date).

In addition, progress has also been made in the following areas:

- Appointment of a new head of EPRR and Business Continuity
- Review of ESHT EPRR steering group, (meeting held in April and further dates set for the year).
- EPRR has been linked to the Trust's Risk Management System
- Development of an EPRR annual work-plan
- Trust Incident Response Plan drafted (in accordance with NHS E guidance) submitted for comment with imminent sign-off and ED major incident plans are under review.
- Shared practice and network visit completed with MTW NHS Trust
- Review of ESHT EPRR policy completed
- Actions from Birling Gap and Gardner ward (flood) BC Incident identified to be addressed.
- Trust NHS Digital and EPRR Staff working together on Cyber Security / Incident response post attendance at a workshop to develop plans and working practices.

Planned next steps in the forthcoming period include:

- Sign-off and implementation of the above-mentioned plans and policies
- Delivery of the revamped EPRR training program
- Review of the Corporate Business Continuity Plan
- Ensuring appropriate range of risks identified on risk registers
- Mass Casualties plans refined with Major Trauma Network, and linked to Trust ED major Incident plans.
- Ratification of the amended Major incident plan.

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

EPRR steering group

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

The Board are asked to receive assurance and note the improvements made to raise the level of compliance against the NHS England 'Core Standards for EPRR', with a view to the Trust achieving substantial compliance by autumn 2018, when the 2018 assurance submission is due. Although it should be noted the 2018/19 assurance standards have not yet been issued.

Joe Chadwick-Bell

Chief Operating Officer (and Accountable Emergency Officer),
East Sussex Healthcare NHS Trust.

No.	Core Standards Description	Actions	When by?	Who by?	Completed
		Governance			
DD1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a pubic Board/Governing Body meeting for sign off within the last 12 months.	Board will receive annual report on EPRR assurance	November 2017	Accountable Officer	Completed Nov 17
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	The 2017/18 assessment will be published in the Trust's Annual Report	September 17	Accountable Officer	Completed Sep 17 AGM & annual report
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	ESHT to confirm Non-Executive Director with an EPRR portfolio is identified	April 2018	Head of EPRR	NED Mike Stevens
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Annual plan to be updated. CCG to confirm timeline of recruitment of additional EPRR resource at ESHT	November 2017	Head of EPRR is now in place	Annual EPRR work-plan Completed in March 18 and now live.
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and those adequate resources are made available to enable the organisation to meet the requirements of these core standards.	Report scheduled for presentation to the board Head of Emergency Planning and Business Continuity to start in post	November 2017 December 2017	Accountable Officer	June report drafted: Board reports for June & Oct Board Meetings
		Duty to assess risk			
5	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	Develop a structure to identify, review and manage risks presented to LHRP	November 2017	Emergency planning officer in conjunction with the EPRR Lead	**Meeting with RM Team held, RA's to be drafted**
8	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan)) Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your	CCG to review ESHT's Major Incident Plans, specifically with regards having a separate major incident plan for each site, the absence of reference to Community Services in these plans and their narrowly focussed sub-titles	August 2018	Head of EPRR	**Drafted for EPRR Steering Group April Meeting, now out for**

	resources and capacity.				**comment & sign-off**
9	Business Continuity Plan (As above)	ESHT to confirm that it has a Business Continuity plan that includes community services	Sept 2018	Head of EPRR	**To be reviewed June 2018**
18	Evacuation Plans (As above)	Review hospital evacuation Plans for EDGH, Conquest, Rye and Irvine Unit.	October 2018	Emergency Planning Team in conjunction with Estates & Facilities, Fire Officer and multi-agency partners	**Planned work in conjunction with Estates is underway to address and progress**
15	Fuel Plans	Fuel plan that aligns with the NEP- to be ratified at June EPRR group	June 2018	Emergency Planning Officer in conjunction with Facilities	**Being Drafted for EPRR Steering Group**
		Command and Control			
34	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPS) and/or commonly recognised information picture (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.	Draft section in command and control plan (MI) MI plan to be reviewed post formal debrief following Sep 17 MI. Plans to be agreed and signed off at EPRR group June 18	June 18	Emergency Planning Team	**Incident Response plan Incl command / control drafted for EPRR Group now out for comment.**
31	That on-call must meet identified competencies and key knowledge and skills for staff.	A training matrix to be completed in support of the training needs analysis and programme. Specific Role base training to be completed - Gold and Silver - Other roles	June 2018	Emergency Planning Team	**Papers drafted for June EPRR Group meeting**
36	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Confirm arrangements in place Ensure BC and MI plan reflects arrangements	August 2018	Emergency planning officer	**Meeting organised May 18 to discuss and take forward**

Training and Exercising					
49	Arrangements include a current training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	A training matrix and plan to be completed in support of the training needs analysis to be included as part of the BC programme	March 2018	Emergency planning officer	**Completed Mar 18 for April EPRR Group meeting**
50	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	A programme is partially developed	June2018	Emergency planning officer	**Completed Mar 18 for April EPRR Group meeting**
52	Preparedness ensures all incident commanders (on call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.	To be completed as part of a rolling programme. Attendance certificates to be issued	July 2018	Emergency planning officer	**Discussed in conjunction with MTW. To be progressed as part of training review.**
Business Continuity Management					
BCM	Contractors to have suitable BC Plans	As part of annual plan undertake review of new contractors to ensure compliance	Aug 18	Emergency Planning Officer and Trust Policy Group	**Corporate review underway and service level register to be collated as part of the EPRR group**

CNST Maternity Incentive Scheme 2018

Meeting information:			
Date of Meeting:	5th June 2018	Agenda Item:	14
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth/Sarah Blanchard Stow

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

In January 2018, NHS resolution wrote to Trusts to advise them of an incentive scheme that was available if compliance in ten key areas was achieved and evidence was available if required. Since that time the WCSH Division have collected data and evidence to support the work with a detailed account in the table below:

Project Tracker - CNST Incentive Scheme for Maternity

#	Safety Action	Task & Finish Lead	Status
1	Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	Sarah Blanchard-Stow	COMPLETE
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Sarah Blanchard-Stow and Dexter Pascall (or local contacts Graham Whittal / Belinda Homewood)	COMPLETE
3	Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	Wendy Thompsett / Debbie Laing / Gayle Clarke / Dexter Pascall	COMPLETE
4	Can you demonstrate an effective system of medical workforce planning?	Brenda Lynes-O'Meara	COMPLETE
5	Can you demonstrate an effective system of midwifery workforce planning?	Sarah Blanchard-Stow / Jo Shayler	COMPLETE
6	Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	Sarah Blanchard-Stow	COMPLETE
7	Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	Eileen Weeks / Debbie Laing / Nikki Mason	COMPLETE
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Waleed Yusuf / Gayle Clarke	COMPLETE
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Vikki Carruth / David Walker	COMPLETE
10	Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	Wendy Thompsett / Rachel Lister (Governance)	COMPLETE

Evidence is available to support the compliance of the above data and stored on a local drive for ease of access.

Whilst all standards are completed, it has to be noted that Standard 6 is completed to the best of our ability with a robust action plan to ensure continued focus in this area. The implementation of the new 'fetal wellbeing midwife' post will provide increased robust delivery in this area. This post is currently out to recruitment with an aim that the post holder will lead and advance all elements of the SBL care bundle to a standard of high achievement. An area of this standard where compliance is progressing but not fully achieved is the GAP/GROW model. This is due to restrictions within our radiography department and recruitment of sonographers (this is a national issue). The Trust/Division is currently supporting five members of staff to complete the third trimester scanning course to help relieve pressure on the team and provide opportunity for progression of this standard. We are due to adopt the customised fetal growth charts as a strand towards compliance and to enable an increased awareness of growth restriction. An action plan is in place with mitigation until compliance is achieved.

Standard 8 is achieved but additional scrutiny with medical training needs to be pursued with an action plan to be in support of this.

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

Women & Children's IPR 18/5/18
Women & children's Governance Meeting

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

The Board are asked to receive assurance about the CNST process and to sign off the Board Report confirming that:

- The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.

CNST Compliance

1. Introduction

The Women, Children and Sexual Health Division has reviewed its compliance against the CNST and confirms compliance against all areas. The full level evidence is available to complement the synopsis described below.

Standard 1
Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?

ESHT have embedded the NPMRT tool into their Governance arrangements from January 2018. At the time of writing this report the Trust has had 7 deaths (22+0 weeks and above or died up to 28 days of life). ESHT have commenced review of all deaths using this tool. Currently the Trust is developing the framework to support the required process (including external engagement).

Standard 2
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

ESHT can confirm and demonstrate that we submit the following 10 criteria to the required standard through the Euroking 3 system

- *Submitted MSDS in all of the last three months (i.e. data relating to January - March 2018)*
- *Latest submission contained* ***booking appointments in the month***
- *Latest submission contained* ***method of delivery for at least 80% of births***
- *Latest submission contained* ***at least 80% of HES births expectation (unless reason understood)***
- *Latest submission contained* ***all of the tables 501, 502, 404, 409***
- *Latest submission contained* ***all the tables 401,406,408,508,602 (unless justifiably blank)***
- *Latest submission contained* ***valid* smoking at booking for at least 80% of bookings***
- *Latest submission contained* ***valid baby's first feed for at least 80% of births***
- *Latest submission contained* ***valid in days gestational age for at least 80% of births***
- *Latest submission contained* ***valid* presentation at onset for at least 80% of deliveries where onset of labour recorded***

Standard 3

Can you demonstrate that you have transitional care facilities in place and operational to support the implementation of the ATAIN Programme?

ESHT continue to asses our transitional care provision, a brief overview below identifies activity at the end April 2018;

- Work with the South East Coast Neonatal Operational Delivery Network who provide graphs, data and statistics for our Trust. These are discussed at the ATAIN (Avoiding Term Admissions into Neonatal Units) meetings (see below).
- All term admissions to the Neonatal unit are put onto "Datix" (incident reporting system) and investigated jointly by maternity and neonatal staff to establish if the admission was unavoidable. This is discussed at the daily Risk meeting held by Maternity with Neonatal attendance.
- ATAIN leads have been identified- Consultant Obstetrician, Paediatrician and Midwife and Neonatal Nurse.
- Regular ATAIN meetings are held. TOR's available
- Regular presentations and display of information updating staff with ESHT's results
- ATAIN e-learning package available to all neonatal and midwifery staff
- Introduced a new hypoglycaemia guideline and related teaching. In April 2017 BAPM published their new Framework for Practice suggesting a lower threshold Policy is under review
- Introduced a flowchart for midwives for the prevention of hypothermia.
- Enhanced training to midwives regarding babies with jaundice in order to care for these babies on the post-natal ward.
- Review of the induction pathway with identified improvements now in place improvements.
- Creation of a new midwifery post- there is now a designated midwife for caesarean sections to ensure these are always undertaken appropriately.
- Introduced the "Bobble Hat Care Package" which aims to identify babies at risk.

Standard 4
Can you demonstrate an effective system of medical workforce planning?

This standard is to demonstrate that no more than 20% of middle grade sessions on labour ward are filled by consultants acting down from other sessions.

ESHT self-assessed against a 4 week period in March using the Royal College of Obstetricians and Gynaecologists (RCOG) workforce monitoring tool this identified that 0% of middle grade sessions on labour ward were filled by consultants acting down from other sessions.

Standard 5

Can you demonstrate an effective system of midwifery workforce planning?

*1. Evidence of a **systematic, evidence-based process** to calculate **midwifery staffing establishment;***

*2. Trust policy demonstrating that, as standard, midwifery labour ward shifts are rostered in a way that allows the **labour ward coordinator to have supernumerary status** (defined as having no case load of their own during that shift); and*

*3. Good practice includes **neonatal workforce within work force plans.***

- A Birth-rate plus review was completed within ESHT in May 2018
- The role of labour ward co-ordinator is supernumerary and takes no caseload during her shift. This is evidenced on health roster, in line with RCM/RCOG and MBBRACE recommendations
- The maternity unit works closely with the neonatal unit and utilises enhanced staffing opportunities when acuity allows. The division run joint projects such as ATAIN, to reduce risk of term admissions to SCBU. Nursery nurses work on the postnatal ward to support enhanced care with neonates

- SCBU use the RCN accredited tool to plan their workforce and manage acuity (through BadgerNet)

Standard 6
Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?

Evidence below demonstrates Board level consideration of the SBL care bundle in a way that supports the delivery of safer maternity services. Board minutes demonstrate that each element of the SBL care bundle has been or is in the process of being implemented or that an alternative intervention put in place to deliver against element(s). ESHT includes this area as a priority within the maternity Board. Evidence provided is at end April 2018 for all four elements

i. Reducing smoking in pregnancy

ESHT carries out Carbon monoxide (CO) testing of all pregnant women at their booking appointment and refers where required through an opt out scheme, to a stop smoking service. Evidence is recorded on the maternity E3 system.

. The following service is offer includes:

- An appointment which suits their individual needs
- A quit date is set
- NRT provision
- Weekly appointments
- If the service is declined they are informed they can contact the service at any stage of their pregnancy / or ask their midwife to contact the specialist midwife if they would like the service at a later date

A woman can be re-referred back into the stop smoking service at any point in their pregnancy and postnatal period.
Smoking cessation training is covered in the 'Making Every Content Count' mandatory training for maternity 2018/2019.
A Nicotine Replacement Therapy (NRT) pathway is being developed for maternity so NRT can be offered to women who want to give up smoking while an inpatient on the maternity.

ii. Risk assessment and surveillance for fetal growth restriction

This area is completed to the best of our ability and the implementation of the new 'fetal wellbeing midwife' post (currently being recruited to) will strengthen further. This post holder will lead and advance all elements of the SBL care bundle. The above area of this standard where compliance is currently under review with a robust action plan.
Due to restrictions within our radiography department and recruitment of sonographers the GAP/GROW model remains outstanding. However our current plan includes supporting five members of staff to complete the third trimester scanning course to provide enhanced support to the sonography team and progression of this standard. We are in the process of implementing customised fetal growth charts as a strand towards compliance and enable increased awareness of growth restriction. An action plan is in place with mitigation until compliance is achieved.

To also understand the scale of neonates who are being missed with IUGR (if they are or not), an audit is currently being performed with medical support.

iii. Raising awareness of reduced foetal movement

ESHT ran an awareness week for reduced fetal movements for all staff during December 2017. Women experiencing RFM are identified through a branded sticker attached to their notes.

iv. Effective fetal monitoring during labour

1. ESHT provide all women with an information and advice leaflet on reduced fetal movement (RFM), based on current evidence, best practice and clinical guidelines, to be provided to all pregnant women by the 24th week of pregnancy with RFM discussed at every subsequent contact.
2. Use a standardised protocol and checklist to manage care of pregnant women who report reduced fetal movement, in line with RCOG Green-top Guideline 57

All midwives regardless of their work setting attend yearly training within the PROMPT skills study day.

End of March rolling year Midwifery attendance 97%.

All Midwives and doctors must complete the K2 Fetal monitoring package on a yearly basis. The diversity that K2 gives us is the ability to add local questions using local/National recommendation or any identified trending risk to provide local assurance.

Acute site midwives are provided with a 3.5h session approximately 1 month prior to rotating back to labour ward to enhance knowledge base and learning.

Standard 7
Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership (MVP) Forum, and that you regularly act on feedback?

This action is self-explanatory.
Evidence would include minutes of regular MVP meetings demonstrating their business.
Trusts should be evidencing the position as at end April 2018.

ESHT has strong feedback mechanisms ranging from online platforms to user forums to allow for the continuous improvement of maternity services and to enhance the experience of its patients.
One mechanism used is the MVP which is made up of staff and service users. The forum is active at both the EDGH and the Conquest Hospital.
Meetings are held quarterly and chaired by two lay co-chairs. There is a formal agenda, a programme and minutes are circulated after each meeting. The discussions in these meetings involve initiatives and improvements currently being undertaken at ESHT. User representative group members provide periodic

feedback from women and their families direct from their postnatal groups. This is shared and actioned at the Midwifery Senior Group (MSG) which is made up of a senior management, clinical and specialist midwives. Members from the MSG attend the MVP to provide a feedback loop about any improvements that are being made.

The MVP is also part of a project group working to develop the Eastbourne Midwife Unit (EMU). Similarly, the maternity services at ESHT carried out an extensive public and staff engagement initiative. A report of the initiative 'Reporting on East Sussex Healthcare NHS Trust (ESHT) Midwifery Service Review' (published in February 2016) included over 400 responses from staff and service users which fed into the implementation of the programme of improvement. The engagement led to 32 recommendations being made and of those recommendations one raised by (service users) was to do with the care of women in early labour on the ante-natal ward. The recommendation made was to design a specific room (The early labour room), this resulted in (a new guideline and a staged refurbishment while will culminate in a sensory room to promote relaxation.
To enable greater reach of feedback there are also informal feedback mechanisms that are administered by the maternity team on online platforms such as Facebook. Although the feedback is only one-way (users do not receive a response), this allows for candid feedback and a greater portfolio of feedback to ensure the service meets the need of all of its users. This has helped staff morale as the feedback through these platforms is easier to give and the service often receive very complimentary feedback.

The Friends and Family Test is another mechanism that has been embedded into the service to drive improvement. The results are shared amongst all staff through team meetings by the Matrons as a regular agenda item. Any issues are discussed and an atmosphere of learning has been developed to allow for fast action and mitigation of risk.

Service users also have the ability to feed back through the Trust's website.

This is a direct link for anyone to ask questions to a midwife directly and all queries are managed by a senior team of midwives. Although the queries are often logistical the portal allows for an efficient and timely response to put service users at ease before they come in to deliver their baby.
Maternity strategy – The Trust's maternity services strategy is in the process of being finalised after having been developed with the multidisciplinary team and MVP feedback. The strategy is also in the process of being sanctioned by the Quality & Safety team at the Trust.

Standard 8
Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Training should include fetal monitoring in labour and integrated team-working with relevant simulated emergencies and/or hands on workshops. The training syllabus should be based on current evidence, national guidelines/ recommendations, any relevant local audit findings, risk issues and case review feedback, and include the use of local charts, emergency boxes, algorithms and pro-formas. There should also be feedback on local maternal and neonatal outcomes.

- The PROMPT course is a multi-professional training package that enables midwives, obstetricians and anaesthetists, working as an integrated team to implement a fully evaluated obstetric emergencies course within their own maternity
- This training programme is based on National Guidelines, local audits and related recommendations for example; the *CEMACE* report identifies that 70% of direct maternal deaths could have been prevented with better care, a lack of multi professional team working and communication failures were identified as a contributory factor. Scenarios set provide assessment of areas including:

i. Clinical roles and delivery
ii. Communication
iii. Situational Awareness
iv. The role of the Team

All programmes include as standard, Fetal monitoring in labour and integrated team working and feedback on our local neonatal and maternal outcomes. Training programmes, attendance and compliance are available as evidence for review (Evidence provided as at End April 2018).

Standard 9
Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?

Evidence of bi-monthly meetings through meeting agendas, minutes etc. demonstrating reviews of published national reports (such as Each Baby Counts and MBRRACE-UK), reviews of locally collected clinical measures, inspection reports and feedback from women and families.
Trusts should be evidencing the position as at end April 2018.

- ESHT have set up Bi-Monthly meetings in line with Standard 9 compliance between the ADN/HOM and Board Safety Champion.
- Board Safety Champion – Vikki Carruth (Director of Nursing)
- Trust Safety Champion – Dexter Pascal (Clinical Lead for Maternity)

Documented Evidence includes:
1. Women, Children & Sexual Health Division Integrated Performance Review (minutes)
2. Weekly Patient Safety Summit (log)

Standard 10
Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification

scheme?
Reporting of all qualifying incidents that occurred in the 2017/18 financial year to NHS Resolution under the Early Notification scheme reporting criteria. *Trusts should be evidencing the position as at end March 2018.*
ESHT can confirm that we have a Governance process in place which includes reporting all qualifying incidents to NHS Resolution under the early Notification scheme reporting criteria through Legal Services.

SECTION C: Sign-off

……..

For and on behalf of the Board of East Sussex Healthcare NHS Trust confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Position: **…….**

Date: **…….**

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Health & Safety at Work Policy

Meeting information:			
Date of Meeting:	5th June 2018	Agenda Item:	16
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth

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

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

Executive Summary:

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

Health and Safety at Work Policy - this policy lays down the organisation aims and objectives in the important area of health and safety. It sets out, in broad terms, how to implement these aims and objectives.

All employees must co-operate in this endeavour.

The policy statement will be issued and/or on display to all employees. It incorporates our general approach towards compliance with prevailing health and safety legislation.

Where the Trust shares a workplace with another employer or organisation, or where another employer or organisation controls a workplace occupied by, or otherwise affecting, Trust staff, the Trust will co-operate with the other employer or organisation, so far as is necessary to protect the health, safety and welfare of Trust staff or others affected by the activities or processes involved.

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

Reviewed by Health and Safety Steering Group March 2018 and approved. Ratified by the Policy and Documentation Group May 2018

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

The Board note the Health and Safety at Work Policy for their assurance.

East Sussex Healthcare NHS Trust

Health and Safety at Work Policy

Version:	V3.0
Ratified by:	Patient Documentation and Policy Ratification Group
Date ratified:	May 2018
Name of author and title:	Nicky Creasey, Trust Lead Health & Safety
Date Written:	March 2018
Name of responsible committee/individual:	Health & Safety Steering Group
Date issued:	May 2018
Issue number:	2018292
Review date:	March 2021
Target audience:	All Staff
CQC Fundamental Standard:	Safe Care and Treatment Premises and Equipment Good Governance
Compliance with any other external requirements (e.g. Information Governance):	Health & Safety Executive (HSE); Care Quality Commission (CQC)
Associated Documents:	See page 21 for the list

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Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V4 2009186	September 2009	David James	Update	none
V1 2011252	September 2011	Tony Humphries	Update for merged organisation	Two organisation policies merged
V1.0 2012157	June 2012	Nicky Creasey	Update	reviewed
V2.0 2015021	February 2015	Nicky Creasey	Update & change in Trust Structures	Reviewed changes to HSE guidance POPIMAR replaced with new HSE management model Plan, Do, Check, Act
V3.0	March 2018	Nicky Creasey	3 yearly update and review	Full review

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
2011252 - various	Sept 2011 V1; ratified 28/09/2011	ESHT Board
Health & Safety Steering Group		November 2014
Health & Safety Steering Group		March 2018

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Health and Safety Policy Statement

It is the policy of East Sussex Healthcare NHS Trust to comply with both the letter and spirit of the Health and Safety at Work, etc Act 1974 and all other relevant legislation, and to regard the provisions of this legislation as minimum requirements.

As with all other aspects of the Trust's undertakings, health and safety must be properly managed and cost effective being aware that some aspects will have to be changed regardless of the financial cost and other elements will be assessed and clear reasons and rationales provided where further changes and or expenditure is covered so far as reasonable and practicable.

Employees of the Trust have a right to work in safe and healthy conditions. These conditions will be created and maintained by the preparation of, and adherence to, this Health and Safety policy. The Directors/managers fully appreciate that responsibility for health and safety is an integral function of management, on a par with responsibilities for all other business operations and we recognise the benefits of a fit and healthy workforce.
Patients, the public and visitors safety is also integral to our philosophy.

The Trust will undertake to provide relevant health and safety training and to provide relevant information to all employees to enable them to improve their knowledge base and awareness of health and safety so that as employees they can discharge their own health and safety responsibilities.

I believe that it is important for all personnel, whatever their position, to accept their personal responsibilities as detailed in this policy and I seek active co-operation between management and employees to promote a safe and healthy environment for ourselves and for those who avail themselves of our service.

Finally, we undertake to review and revise this policy as often as is required by changing legislation. All changes will be brought to the attention of all employees.

Chief Executive Officer: Dr Adrian Bull MD

Signed:

Date: 5th April 2018

2. Introduction

This policy lays down the organisation aims and objectives in the important area of health and safety. It sets out, in broad terms, how to implement these aims and objectives.

All employees must co-operate in this endeavour.

The policy statement will be issued and/or on display to all employees. It incorporates our general approach towards compliance with prevailing health and safety legislation.

Where the Trust shares a workplace with another employer or organisation, or where another employer or organisation controls a workplace occupied by, or otherwise affecting, Trust staff, the Trust will co-operate with the other employer or organisation, so far as is necessary to protect the health, safety and welfare of Trust staff or others affected by the activities or processes involved.

2.1. Aims of the policy

To conduct all of our undertakings so as to avoid, or control to an acceptable level, risks to the health and / or safety of all of our employees, all users of our services, all members of the general public who are exposed to our activities and all other people who work on, or visit, our premises.

To create and maintain a positive health and safety culture within all areas of our organisation, so that there is a continuous, improvement in our health and safety performance.

These aims will be pursued regardless of whether the particular services which form part of the organisations' undertakings are performed by our employees, or by outside contractors acting on our behalf.

These aims will be borne in mind in all policy and operational decisions made by the organisation, especially in relation to the adequate provision of resources. It is recognised that managers could render themselves liable under criminal health and safety law should they place requirements upon staff that are contrary to this policy.

2.2. Objectives of the Policy

The organisation is committed to working towards the achievement of the following objectives in the field of health and safety:

- To comply consistently with the Health and Safety at Work etc. Act 1974 and the Management of Health and Safety at Work Regulations 1999 (as amended) and all other relevant statutory provisions, including health and safety approved codes of practice and guidance and relevant fire safety legislation.
- To effectively identify all significant hazards arising from our activities, to assess all the resultant risks to the health and safety of our employees, patients and visitors and other people who may be affected and to develop the appropriate preventive and protective measures necessary to control these risks.
- To align and apply the Plan – Do – Check – Act management model; HSE in August 2013 revised and replaced health and safety guidance HSG 65 'Managing for health and safety.

- To establish, and where necessary implement, appropriate emergency procedures to be followed in situations of serious and imminent danger and to; co-operate and co-ordinate with the emergency services and other employers as appropriate.
- To provide and maintain suitable and safe vehicles, plant, equipment and systems of work.
- To provide employees with relevant health and safety training and supervision and to take account of employees' capabilities as regards health and safety matters when assigning tasks to them.
- To provide employees with comprehensible information on health and safety risks identified by assessments and on the preventive and protective measures necessary to control these risks.
- To avoid safety, health and fire risks in connection with the use, handling and storage of articles and substances.
- To provide a safe place of work and a healthy working environment.
- Where appropriate on health and safety grounds, to ensure that employees are provided with, and use, suitable personal protective clothing or equipment. Also to make adequate arrangements for the storage and maintenance of such personal protective clothing and equipment.
- Where beneficial to the prevention of work related illnesses or ill health conditions, to provide employees with appropriate health surveillance.

3. Definitions

- **(SHE) Assure** – health and safety risk assessment database. It is used by all services within ESHT for the creation, editing, submitting and viewing of health and safety risk assessments and internal audits conducted by the Trust Health and Safety team.
- **HSE** – Health and Safety Executive
- **HSSG** – ESHT Health and Safety Steering Group
- **OHSMS** – Occupational Health Safety Management Systems
- **PDCA management model** – Plan, Do, Check, Act
- **PPE** – Personal Protective Equipment
- **Health Surveillance** – Health surveillance is a system of health checks undertaken by the Occupational Health and Wellbeing Department which may be required for employees who are exposed to hazards which could adversely affect health

4. Accountabilities and Responsibilities

4.1. Health and Safety Management Structure

4.2. Health and Safety Steering Group Structure

A Health and Safety Steering Group has been established to provide the formal consultation group for the Trust, in accordance with the provisions of the Health and

Safety at Work etc Act 1974 and the Safety Representatives and Safety Committees Regulations 1977 as amended by the Management of Health and Safety at Work Regulations 1999.

5. Responsibilities

5.1. Chief Executive

The Chief Executive has overall and final responsibility for the management of health and safety in East Sussex Healthcare Trust and for the health, safety and welfare of employees and others who may be affected, and:

- Will ensure that there is an effective policy for health and safety which is kept up to date within the organisations.
- Will ensure that relevant risks are assessed and will make available sufficient resources and funds to allow for the appropriate control of these risks.
- Will ensure implementation of the policy and fully support all persons who carry out the policy.
- Will have the responsibility of discharging the organisations' duty, under Section 2(3) of the Health and Safety at Work etc. Act 1974, of bringing the general statement of health and safety policy and the organisation and arrangements for the carrying out of that policy, to the notice of employees.
- Will ensure that the health and safety policy for the organisation is understood at all levels.
- Will fully support the training of staff / union health and safety representatives and arrange for consultation on health and safety matters as appropriate.
- Will ensure that an annual report on health and safety performance is produced.

5.2. Trust Board and Executive Lead

- The Trust Board and Executive lead will accept their collective role in providing health and safety leadership in the organisation.
- Each member of the Trust Board and Executive Team accepts their individual role in providing health and safety leadership.
- All Executive Team members and the Trust Board decisions will reflect the Trust commitment to achieving the objectives set out in this Health and Safety Policy Statement.
- The Trust Board and Executive Lead will seek to engage the active participation of employees in improving health and safety.
- The Director of Nursing and Governance has Executive responsibility for health and safety within the Trust.

5.3. Trust Lead Health and Safety

The Trust Lead is responsible for Health and Safety and provides the management lead for the health and safety specialist function and acts as the 'competent person' as required by Regulation 6 of the Management of Health and Safety at Work Regulations 1999. The Trust Lead Health and Safety reports to the Director of Nursing and Governance on Health and Safety matters and is a member of the Health and Safety Steering Group. Duties include:

- Supporting Senior Managers of the organisation in setting a positive Health and Safety culture.
- Formulating Health and Safety action plans, key performance indicators, policies and operating procedures;
- Producing reports to the board including the annual Health and Safety report;
- Being responsible for formulation and review of policies
- Promoting a positive health and safety culture;

- Assist the Executive Lead in reviewing health and safety performance;;
- Being the point of contact for external agencies such as the HSE;
- Advising on legislative requirements and best practice;
- Investigating accidents as appropriate;
- Advising on the undertaking of general or specific risk assessments in support of managers and others;
- Assisting managers, as appropriate, with workplace inspections;
- Liaising with union safety representatives on matters of health and safety;
- Undertaking health and safety audits Occupational Health Safety Management Systems (OHSMS);
- Ensuring health and safety training is provided as appropriate for managers and staff.
- Investigate incidents/accidents as appropriate and complete reports

5.4. Deputy Trust Lead Health and Safety

The Deputy Trust Lead is responsible for Health and Safety reports to the Trust Lead Health and Safety and is responsible for providing assistance in the functions described in 4.3.3 above and will deputise in the absence of the Health and Safety Manager. They are:

- Responsible to line manage the Assistant Health and Safety Advisors/Trainers;
- Responsible for facilitating the Health and Safety Steering Group;
- Undertake regular liaison with nominated Directorate/Division/Clinical Unit Managers/ named representatives responsible for health and safety within a service/s;
- Work with the Trust Learning and Development team and health and safety team administrator on ensuring appropriate health and safety training is being recorded on Electronic Staff Record (ESR) database and face to face training /e-learning packages for all levels of staff are available.
- Are responsible for the development and implementation of the H&S Link staff process within the various services across the organization;
- Provide advice on health and safety matters;
- Receive and triage health and safety datix incidents/accidents reports;
- Investigate incidents/accidents as appropriate and complete reports
- Ensure health and safety quarterly reports are completed;
- Design and ensure appropriate support is in place for the embedding of the Assure health and safety database.

5.5. Health and Safety Steering Group (HSSG)

The Health and Safety Steering Group is a focal point for effective staff consultation and participation in all aspects of Trust health and safety. Accredited union safety representatives nominated by nationally recognised negotiating organisations will represent all employees of the Trust.

Its main function is to promote co-operation between staff at all levels to ensure the health, safety and welfare of all staff and those who come into contact with the services of the Trust. A full list of functions can be found in the Steering Group's terms of reference.

5.6. Divisions/Clinical Unit/Directorates

Divisions, Clinical Unit/Directorate have a variation of how health and safety incidents, accidents, near misses, concerns and issues are reviewed. A number have specific health and safety groups for others the health and agenda is discussed in risk meeting/governance

meetings to provide a focal point for effective consultation and participation in all aspects of health and safety at that level and to provide service reports to the Health and Safety Steering Group.

5.7. Divisions/Clinical Unit/Directorates Health and Safety Link Facilitators

Divisions/Clinical Units/Directorate Health and Safety link facilitators where the management can appoint / nominate a member of staff to assist managers / Matrons with day to day health and safety issues such as:

- Undertaking regular workplace 13 week inspections in conjunction with Trade Union Health and Safety Representatives (as requested);
- Undertaking risk assessments; receiving completed risk assessment documentation and action plans; record risk assessments and to make available to colleagues via the Assure health and safety database;
- Monitoring the corresponding action plans through to completion
- All documentation to be readily available for the Health & Safety team to audit the quality and the completion of the action plans for organisational assurance;
- Liaising with the Estates and Facilities Department, Trust Health and Safety Team members, Fire Safety Advisor, Security Advisor, Moving and Handling Advisor / Trainer and others as appropriate in relation to the undertaking of risk assessments, inspections, fire drills, maintenance issues and building repairs;
- Liaising with first aiders, and fire wardens in support of their duties;
- Covering any other health and safety related issues deemed appropriate to the role and the individual in discussion with local manager and is proportionate to the department's needs;
- Being at all times aware of their level of competence and expertise and to liaise with the Trust health and safety team.

5.8. Fire Safety Advisor

The Trust will have a specialist Fire Safety Advisor who will report to the Health and Safety Steering Group quarterly and will:

- Advise on legislative requirements and best practice;
- Contribute to the formulation and review of policies and procedures;
- Investigate fire Incidents as appropriate;
- Undertake fire risk assessments in support of managers and others;
- Undertake fire safety audits;
- Provide fire safety awareness training as appropriate for managers and employees.

5.9. Occupational Health and Wellbeing Department

The Trust will have in place the provision of an Occupational Health Service and Wellbeing to provide for:

- Pre-employment health screening;
- Vaccinations and TB skin testing;
- Routine health surveillance of employees where appropriate as identified by risk assessment;
- Site visits when requested;
- Advice on current health and safety legislation relevant to occupational health and wellbeing;

- Advice to managers and staff on sickness related absence and measures available to rehabilitate employees who have experienced ill health problems;
- Counselling for employees, including return to work and redeployment
- Confidential record keeping;
- Undertaking specific risk assessments as required.

The Occupational Health Specialist Nurse is a reporting member of the Health and Safety Steering Group.

5.10. Infection Control Department

Infection Control Nurses / Advisors have been appointed by the Trust. Their duties include:

- Advising on legislation and best practice relevant to infection control, including PPE, Control of Substances Hazardous to Health (COSHH), Clinical Waste Management Acts and NHS Decontamination Guidelines, contributing to the formulation and review of policies and procedures.
- Working in partnership with multi-professionals including internal and external agencies, acute hospital / community hospital teams, Infection Control Nurses Society, Occupational Health, Department of Health, Environmental Health Departments, and Public Health Department.
- Actively undertaking on-going surveillance by observing changes in the environment, and identification of individuals that may lead to an increase in disease / infection.
- Auditing of departments to monitor the safety and effectiveness of preventative and control measures.
- Providing information to clinicians, risk assessments and advice on control measures and evaluating actions taken for effectiveness.
- Only annual report specifically related to new products and continued implementation and monitoring of the Sharps regulations will be required by the Health and Safety Steering Group; and any ad hoc reports on dangerous diseases that will impact on staff health.

5.11. Moving and Handling Specialist Advisors

The Specialist Moving and Handling Trainer/Advisors will undertake all training in manual handling, assist managers to carry out manual handling risk assessments and provide manual handling advice to managers and staff as appropriate. Their duties include:

- To work with Managers and staff to ensure that risk assessments are written and that where appropriate, guidelines of safe practice are produced. This will include the use of manufacturer letters of recommendations and product advice notes.
- To co-ordinate moving and handling training within the Trust. To run courses for all staff grades to equip them with the skills and knowledge to assist in reducing moving and handling accidents/incidents in their areas. To ensure the content of training programmes is appropriate and relevant to the staff group. To keep comprehensive records of training they facilitate. To ensure that central records are updated in a timely way through provision of completed registers. To keep up to date with current research, equipment and techniques, and also to liaise with team and outside trainers to ensure parity and content of training.
- To provide training, support and advice for Managers on how to undertake risk assessments and how to implement controls. Carry out audits of the effectiveness of the Moving and Handling Policy.

- To provide advice and support on the sourcing and selection of moving and handling equipment to minimise risks in the workplace. To arrange trials of new equipment, in conjunction with other multi-disciplinary team, i.e. those that will be using the equipment and specialists. To advise on the purchase of other equipment, which impacts on moving and handling, e.g. trolleys, chairs, etc. To give ergonomic advice on workstation assessments, the design of new areas and upgrading of existing areas, where requested. To assist in carrying out departmental audit as required.
- To receive moving and handling accidents/incidents reports from the Risk Management datix database and to follow up where appropriate. Moving and handling reports will be included in the Health and Safety quarterly report to Trust Health and Safety Steering Group.
- Design and maintain lesson plans including the session objectives.

5.12. Managers and Supervisory Staff

Managers have responsibility for the effective management of health and safety within their area of control / Department(s) and for actively promoting the implementation of this Policy and associated Policy Arrangements and will:

- Familiarise themselves with the safety organisational structure by reviewing the Trust Governance structures, reporting incidents, accidents and near misses on the Trust Datix risk management database. and ensure that all staff in their charge comply with the health and safety policies as far as reasonable and practicable.
- Undertake risk assessments in the Assure database and draw up safe systems of work for their areas of responsibility.
- Ensure that site inspections are undertaken at least every 13 weeks, and the results from inspections are recorded on the Trust Health and Safety 13 week Inspection Checklist in the Assure database, indicating actions, time scales and relevant persons responsible
- Ensure that employees in their charge undertake mandatory training and other health and safety training deemed appropriate to their posts.
- Ensure that the job descriptions of employees in their charge reflect their health and safety responsibilities and these responsibilities are reviewed on an annual basis or sooner as appropriate.
- Ensure adequate supervision of employees and students are provided and commensurate with their skills and competency;
- Monitor work practices as appropriate to ensure procedures are being implemented;
- Ensure that all accidents and incidents are recorded, that they are investigated and accident reports are completed promptly and any lessons learnt are shared within and across divisions, directorates and clinical unit as appropriate;
- Ensure that all people in their charge are aware of the procedures on the Trust extranet system, to be adopted in the event of fire or other foreseeable emergency.
- Ensure that all people in their charge know the emergency arrangements including first aid arrangements, dealing with spillages in the area;
- Ensure, where reasonably practicable, that adequate supervision is available at all times for employees in their charge;
- Devise safe working practices for tasks under their control and ensure that only safe working practices are used, in order to provide maximum safety for all people in their charge;
- Ensure sufficient persons in their department available and supported to discharge health and safety responsibilities;
- Brief employees on health and safety procedures and policies through induction relevant to their role including competencies where required;

- Maintain good housekeeping standards in their departments / sites at all times;
- Ensure that any health and safety problem, which cannot be resolved by them, is escalated with their line manager.

5.13. Employees

All employees have a legal duty to take reasonable care for their own health and safety and of others who may be affected by their acts or omissions, and will:

- Make themselves familiar with the organisations' Health and Safety Policy.
- At all times make full and proper use of the appropriate safe systems of work, safety equipment and protective clothing and make full use of appropriate safety devices.
- Report to their line manager any unsafe systems of work which develop contrary to instructions, unsafe working conditions, damage to plant, machinery or equipment and report accidents and incidents immediately.
- Take reasonable care for the health and safety of themselves and of other people who may be affected by their acts or omissions.
- Co-operate with the organisations so as to enable them to carry out their own duties and responsibilities.
- Not intentionally or recklessly interfere with or misuse anything provided in the interests of health, safety or welfare by the organisations.
- Report any accident / incident which results, or could have resulted, in injury in accordance with the Trust Incident and Serious Incident Reporting Policy.
- Attend mandatory safety training as directed.

5.14. New Employees

In addition to the provisions of section 4.3.14 above, new employees shall:-

- Will be inducted in all Trust and departmental relevant health and safety requirements before working unsupervised.
- Ensure that they have read and understand instructions in the event of fire or other serious or imminent danger.
- Familiarise themselves with the Trust Incident Reporting and Management Policy.

5.15. Trade Union – Appointed Representative

The role of the health and safety representative is independent of management. Representatives represent the interests and concerns of their co-workers and respond on their behalf. They may provide co-workers valuable insight, skills and resources that help employers and attend health and safety training provided by their Union body.

Functions of union-appointed health and safety representatives:

- To represent employees generally, and
- Are consulted with about specific matters that will affect the health, safety and welfare of employees they represent
- To represent employees when Health and Safety inspectors from Health and Safety Executive (HSE) or local authority
- The representatives can investigate accidents, near misses, and other potential hazards and dangerous occurrences in the workplace

- To investigate complaints that has been made by an employee they represent about their health, safety or welfare in the workplace and share the findings of the investigation with the organisation
- To inspect the workplace with at least one other appointed representative, request in writing to the organisation Health and Safety Executive Lead
- Attend the organisation Health and Safety Steering Group

5.16. Contractors

All contracts for services in the Trust work places, or otherwise affecting Trust staff, shall comply with the terms of this policy and the Health and Safety Management Managing Contractors Policy Arrangements, so far as is appropriate to protect the health, safety and welfare of staff, patients, visitors and others who may be affected by the undertaking of the work.

6. Arrangements

6.1. Management Arrangements

The objective of the Trust is to ensure continual improvement by utilising a planned, systematic approach to managing health and safety as identified in Health and Safety Guidance (HSG) 65 published by the Health and Safety Executive.

6.1.1. 'Plan'

'Planning' has a specific legal requirement under the Management of Health and The Trust Health and Safety at Work Regulations 1999, regulation 5 which requires the employer to make and give effect to such arrangements as are appropriate; the plan should be in writing. Therefore the policy details the commitment of the organisation, the key responsibilities for health and safety and outlines the safety arrangements.

The Health and Safety Policy and Policy statement signed by the Trust Chief Executive are available for all staff on appointment and when amendments are made. This is communicated via the Health and Safety newsletter, emails sent to named link facilitators, on the Trust health and safety pages on the extranet

The Health and Safety Policy contains a commitment to continual improvement and the Trust health and safety policy arrangements.

6.1.2. 'Do' – Implementation

To implement the 'Do' step of the PDCA, the right systems and procedures to manage the hazards that arise in the organisation. Risk assessments will identify the hazards and actions taken, or to be taken, to minimise the risk. This section implies that the organisation be less reactive and more active and dynamic in approach.

- The Chief Executive is ultimately responsible for health and safety within the organisation including the achievement of the health and safety objectives, provision of appropriate resources, competent appointments, training, systems of work, monitoring and review of safety performance.
- The Nominated Director (see 4.3.2) provides specific co-ordination of health and safety requirements.
- Managers are responsible for the safe operation of the services under their control.

- The Health and Safety Steering Group is responsible for the monitoring of the health and safety within the Trust.
- Employees are kept up to date on changes which may affect their health and safety and active communication takes place through the Health and Safety Steering Group and Divisional, Directorate, Clinical Unit Health and Safety Groups/ Risk/Governance Groups.
- Key performance/work plan for the Trust health and safety team and Health and safety Steering Group specifies the actions to be taken to ensure that the organisation have assurance at all levels within the organization.
- Training of employees is fundamental to the organisation's approach to health and safety. The planned approach ensures:-

  a) Identification of training needs
  b) Training programme to ensure competence
  c) Effective training records
  d) Review and appraisal of employee performance

- The organisations are committed to ensuring employees are competent to do the job that they are required to do.
- The documentation that forms the Health and Safety Manual is kept up to date by Health and Safety Team and is available to all staff the Health and Safety extranet website.
- The organisation's extranet site provides information on the health and safety policy and supporting policy arrangements, together with safety information.

6.1.3. 'Check' and 'Act' – Monitoring and Measuring

'**Check** and Act' are the action-based elements of the cycle. 'Check' requires that the plan (policy) includes monitoring. Audits and inspections are vital tools in the 'Check' part of the PDCA. They are both preventative, active monitoring techniques. The other principal activity is 'reactive monitoring' reviewing accidents and incidents that have occurred and recorded in the risk management system – Datix web based database
'**Act'** means that having set our plan (policy) in place the health and safety team will monitor the effectiveness and additional actions that maybe required.

- The Health and safety Team will ensure that a system of internal audit is undertaken in order to ensure that the management of health and safety at work systems are effectively monitored and reported on.
- Benchmark audits of the various clinical and non-clinical services will be completed by the health and safety team and the outcomes of these audits will be reported to the service with corresponding actions (if applicable) and reported to the Trust Health and Safety Steering group highlighting the trends and actions that have been instigated or to make recommendations for changes.
- The benchmark audit programme once completed for all areas will clarify actions (if applicable) that each need to complete and provide a re audit date by the health and safety team and information captured on the Assure database.
- Clinical unit/Divisions/Directorates will complete three service audits a year for the Health & Safety Steering Group utilising the service reporting template with key headings.
- Staff/Union Safety Representatives have a statutory right to undertake workplace inspections every 13 weeks and will be completed and monitored on the Assure database.

- All accidents, incidents and non-conformances against requirements are appropriately documented, reviewed and investigated with all information on the datix risk management database.
- Risk Assessments are completed and risk treatment plans are produced to reduce the risk and prevent harm completed by the service on the Assure database and approved by the manager.
- The Health and Safety Steering Group meets every other month and carries out its functions in accordance with this Health and Safety Policy and the group Terms of Reference.

6.1.4. Changes in Legislation

- It will be the responsibility of the Trust Lead Health and Safety to ensure that the Directors, Managers, Trust Safety Representative, Joint Staff Side for the attention of the health and safety representatives and staff of the Trust are aware of changes in legislation and/or associated good practice.
- Changes will be notified to the Health and Safety Steering group and will also be distributed throughout the Trust using normal information channels.
- The Health and Safety Policy and associated Policy Arrangements will be updated as appropriate.

7. Operational Arrangements

7.1. Risk Assessments

The undertaking of risk assessments is a requirement of a range of health and safety regulations, for example:

- Management of Health and Safety at Work Regulations 1999;
- Control of Substances Hazardous to Health Regulations 2002 (as amended);
- Provision and Use of Display Screen Equipment Regulations 1992 (as amended);
- Manual Handling Operations Regulations 1992 (as amended);
- Provision and Use of Work Equipment Regulations (PUWER) 1998

Managers are required to ensure that proactive risk assessments are undertaken in accordance with legislation (see above section 5.12 of this policy).

Where health and safety regulations require the undertaking of risk assessments, it will be the responsibility of Division/Directorate/Clinical Unit and Senior Managers to ensure that they are undertaken, completed and approved on the Assure database within their entire area of responsibility, for example, where action is required it is reasonable and practicable to prevent ill health, injury and supported within the NHS Employers Framework.

Risk assessments are to be undertaken with staff involvement with the service link facilitators and or managers but link facilitator however will not be held ultimately accountable for risks not under their direct control. Managers can delegate any health and safety tasks, but they cannot delegate accountability.

Assure health and safety database is the tool that all services will complete various risk assessments, for example, Workplace and Activity risk assessment, Security, risk assessment, Team Stress assessment, COSHH risk assessments, 13 week inspections etc.

Risk assessments developed will be approved by service managers and will be available on the database for all staff. The procedures and guidance notes for staff supporting this system are available on the Trust health and safety extranet pages, through training and Health and Safety Team.

All extreme and high rated assessments (plus any assessments where “multiple fatalities” or “fatality” are identified) will be reported to the Health and Safety Team.

7.2. Safe Systems of Work and Permits to Work

A Safe System of Work (SSW) is defined as a formal procedure which allows a specific task to be carried out safely after systematic examination of that task has identified all of the associated hazards and risks. Safe systems of work are required to be put in place when the hazards identified cannot be eliminated and a level of risk remains. Managers are responsible for ensuring that a risk assessment is undertaken in respect of all tasks where there is a risk to safety or health (as required by the Management of Health and Safety at Work Regulations 1999) and for reducing those risks to an acceptable level with the introduction of appropriate control measures.

Where a task is considered to be potentially hazardous or dangerous, a permit to work (PTW) system must be introduced. This consists of the establishment of a formally written procedure involving a permit or formal written approval to undertake part of a safe system of work. This is mainly utilised, monitored and reviewed by the Trust Estates and Facilities directorate. PTW’s must be completed for the following high risk work:

- Hot Work (Fire precautions)
- Working in Confined Spaces
- Low voltage electrical working
- High voltage electrical working
- Medical gas pipelines (low and high hazard)
- Working on roofs
- Working on ventilation
- Fire alarm isolation
- Work on steam boilers
- Work on generators
- Work on bacteria filters
- Microbiology fume extraction cabinets + containment level 3 (CL3)

7.3. Incident Reporting & RIDDOR reporting

The Trust will have in place robust accident/incident reporting systems which requires that all accidents involving injury, however trivial, should be notified to the immediate supervisor on duty by or on behalf of the individual concerned. An incident report on datix must be completed without delay. The primary purpose of incident reporting is not to apportion blame but to enable prompt remedial action and share learning from the incidents.

It is important for managers to take statements/investigate as soon as possible from people who have witnessed an accident, to ensure that a full and accurate picture is obtained of why and how the accident occurred.

Where health and safety at work is concerned employers are bound by both common and statute law to take reasonable care of the health, safety and welfare of their employees at

work. It is important therefore for managers to bear in mind the possibility of a civil claim if an accident occurs. If the accident resulted from a breach of law, the organisation, or one of its officers, could face a criminal prosecution.

It is the line manager's responsibility to ensure that the system works and that staff involved in completing incident reports on the datix database have been shown how to access the datix database on the Trust extranet.

7.4. RIDDOR Reporting

The Trust, as an Employer and/or in control of premises has a duty to report 'specific* accidents and incidents at work under RIDDOR (the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995) to the Health & Safety Executive (HSE).

The report to the HSE Incident Contact Centre (ICC) will be made by the quickest means possible by the Trust Lead Health and Safety or Deputy to submit the RIDDOR report to HSE.

Online

Further information can be found: visit www.hse.gov.uk/riddor/index.htm.

*the following must be reported by the Trust Lead or Deputy:

- Deaths;
- Specified injuries;
- Over-7-day injuries – where an employee or self-employed person is away from work or unable to perform their normal work duties for more than 7 consecutive days;
- Injuries to members of the public or people not at work, where they are taken from the scene of an accident to hospital;
- Some work-related diseases;
- Some dangerous occurrences – a near miss, where something happens that does not result in an injury, but could have done;
- Gas Safe-registered gas fitters must also report dangerous gas fittings they find, and gas conveyors/suppliers must report some flammable gas incidents.

Deaths, major injuries and dangerous occurrences must be notified without delay, however only the following need to be notified out of normal working hours:

- Fatal accidents at work;
- Accidents where several workers have been seriously injured;
- Accidents resulting in serious injury to a member of the public;
- Accidents and incidents causing major disruption, such as evacuation of people, closure of roads, large numbers of people going to hospital etc.

Organisational arrangement

- All fatalities and near fatal injury must also be reported to the Executive lead or, if out of hours, the Director on call, to confirm that the incident will be entered on to the organisation Serious Incident STEIS database. The line manager for the service will carry out a formal investigation and complete a root cause analysis report.

- The process since the 6th April 2012 is that only 7-day plus days off sick whereby injuries were sustained as a consequence must be reported within 15 days.

- Cases of work related ill-health MUST also be reported on a referral form on line to both the Occupational Health and Health and Safety Departments and on their advice inform the HSE.

- It is the responsibility of the Clinical Unit /Directorate/Divisions to ensure that they inform the health and safety team where a member of staff is off sick due to an incident whereby the staff member has sustained an injury due to that incident whilst at work; so that a RIDDOR form can be completed and forwarded to the HSE.

- The reporting rules on specified injuries also apply to dangerous occurrences, even if no injury is caused.

- A copy of the RIDDOR Report will be attached to the appropriate datix incident by the Trust Lead Health and Safety or Deputy.

7.5. Patient RIDDORs

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

The Trust has a robust safe system of work captured within the Incident Reporting and Management Policy. This reporting structure within the organization has meant patient incidents where it is investigated to find the root cause for the incident does not have to be reported as a RIDDOR.

7.6. Accident / Incident Follow-ups

The Health &Safety Team triage all staff related incidents reported on the datix database and will contact the named handler to ensure that proper preventative action has been taken.

Where there are cases of work related ill-health these MUST be fully investigated by the Division Clinical Unit/Directorate in conjunction with Occupational Health and Wellbeing service and the Health and Safety Department as appropriate.

7.7. Occupational Health & Wellbeing Department

All staff have the facility for direct access to the Occupational Health Department through self-referral or Manager referral. Where necessary, managers may refer staff to the Occupational Health Department for an assessment of their abilities and/or fitness for work. The Occupational Health Department is responsible for assessing the capability of newly

appointed staff to undertake their role and recommend any reasonable adjustments (required due to health conditions due to on-going health surveillance, i.e. audiology) (for specific work related areas), latex glove usage – etc.

8. Training and Induction

The organisation is committed to ensuring employees are competent to do the job that they are required to do. Health and safety training is mandated and supported by the Trust Board and must be refreshed every three years.

Training of employees is fundamental to the organisation's approach to health and safety. The planned approach ensures:-

a) Identification of training needs
b) Training programme to ensure competence
c) Effective training records
d) Review and appraisal of employee performance

The Trust will undertake to provide adequate health and safety training and information to all employees to enable them to improve their knowledge and awareness of health and safety and to discharge their own health and safety responsibilities.

9. The following list of relevant Health and Safety policy arrangements that are in place:

- Asbestos Policy and Management arrangements;
- Assure (health and safety database) Policy;
- Contractors Policy;
- Control of Hazardous Substances to Health Policy(COSHH);
- Working with Display Screen Equipment (DSE);
- Driving for Work policy;
- Electrical equipment Policy
- Work Equipment and Machinery
- Fire safety Policy and relevant protocols;
- Dangerous Substances and explosive Atmospheres Regulations;
- First Aid Policy;
- Gas and Oil Fired Equipment Policy;
- Legionella Policy;
- Lone Worker Policy;
- Lifting Operations and Lifting Equipment Regulations (LOLER);
- Moving and Handling Policy;
- Medical devices Policy;
- New and Expectant Mothers Policy;
- Noise at Work Policy;
- Personal Protective Equipment (PPE) Policy;
- Radiation Policy;
- Pressurised Plant and Equipment Policy;
- Security Policy;
- Slip Trip falls for Staff Policy;
- Stress Policy;
- Violence and Aggression Policy;
- Workplace Health, Safety and Welfare Policy;

- Waste Management Policy;
- Working at Height Policy;
- Young Persons (in employment) Policy.

10. Equality and Human Rights Statement

This document has been assessed for Equality and Human Rights infringements and it is considered that it does not affect one group less or more favourably than another on the basis of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age or disability.

11. Monitoring Compliance with the Document

Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Policy Manual	Trust Lead H&S	Schedule of policies	Annually	HSSG	HSSG	HSSG
Health and Safety Quarterly reports	Deputy Trust Lead H&S	Performance report/s	Monitored quarterly	HSSG	HSSG	HSSG

Appendix A – EHRA Form

East Sussex Healthcare NHS Trust

Due Regard, Equality & Human Rights Analysis

Title of document:
Who will be affected by this work? E.g. staff, patients, service users, partner organisations etc. Staff, Patients and Visitors
Please include a brief summary of intended outcome: To comply consistently with the Health and Safety at Work and to effectively identify all significant hazards arising from our activities, to assess all the resultant risks to the health and safety of our employees, patients and visitors and other people who may be affected. To provide employees with relevant health and safety training and supervision and to take account of employees' capabilities as regards health and safety matters when assigning tasks to them. To provide employees with comprehensible information on health and safety risks identified by assessments and on the preventive and protective measures necessary to control these risks.

		Yes/No	Comments, Evidence & Link to main content
1.	**Does the work affect one group less or more favourably than another on the basis of:** (Ensure you comment on any affected characteristic and link to main policy with page/paragraph number)		
	• Age	No	
	• Disability (including carers)	No	
	• Race	No	
	• Religion & Belief	No	
	• Gender	No	
	• Sexual Orientation (LGBT)	No	
	• Pregnancy & Maternity	No	
	• Marriage & Civil Partnership	No	
	• Gender Reassignment	No	
	• Other Identified Groups	No	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	No	

3.	**What are the impacts and alternatives of implementing / not implementing the work / policy?**	Following the policy ensures the safety of staff, patients and visitors ensuring that all members of staff are complying with the Health and Safety at Work legislation and to effectively identify all significant hazards arising from our activities, to assess all the resultant risks to the health and safety
4.	**Please evidence how this work / policy seeks to "eliminate unlawful discrimination, harassment and victimisation" as per the Equality Act 2010?**	N/A
5.	**Please evidence how this work / policy seeks to "advance equality of opportunity between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	N/A
6.	**Please evidence how this work / policy will "Foster good relations between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	N/A
7.	**Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)**	N/A
8.	**Please evidence how have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?**	Consultation table – page 2
9.	**Have you have identified any negative impacts or inequalities on any protected characteristic and others? (Please attach evidence and plan of action ensure this negative impact / inequality is being monitored and addressed).**	N/A

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on
Wednesday 28th March 2018 at 1300
in the St Mary's Boardroom, EDGH

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

In attendance Dr Adrian Bull, Chief Executive
Dr David Walker, Medical Director
Mrs Lynette Wells, Director of Corporate Affairs
Ms Amy Collis, Head of Nursing, Urgent Care (for item 020/18)
Mr Stephen Hoaen, Head of Financial Services
Mr Chris Lovegrove, Counterfraud Manager, TIAA
Mrs Emma Moore, Clinical Effectiveness Lead
Mr Mike Townsend, TIAA
Ms Caroline Trevena Interim Deputy Director of Finance
Mr Darren Wells, Engagement Lead, Grant Thornton

Mr Pete Palmer, Assistant Company Secretary (minutes)

Action

016/18 Welcome and Apologies for Absence
Mr Nealon opened the meeting and introductions were made. Apologies for absence had been received from:

Ms Vikki Carruth
Mr Jonathan Reid, Director of Finance
Mr Adrian Mills, Audit Manager, TIAA

017/18 Minutes of the meeting held on 31st January 2018
The minutes of the meeting held on 31st January 2018 were reviewed and agreed as an accurate record.

018/18 Matters Arising
General Data Protection Regulation (GDPR) Requirements
Mrs Wells noted that a paper was being presented to the Committee under item 025/18.

Data Security and Protection Toolkit (DSPT) Requirements
Mrs Wells reported that a paper would be presented to the Committee on 25th July 2018.

Audit Fees for 2018/19
Mr Wells explained that inflation would be absorbed by Grant Thornton.

019/18 Board Assurance Framework and High Level Risk Register

Mrs Wells presented the Board Assurance Framework (BAF) and Risk Register. She explained that the BAF had been discussed at the previous week's Quality and Safety (Q&S) Committee who had supported the proposed updates. She asked the Audit Committee to consider the following updates:

2.1.2 – Emergency Department Reconfiguration

Mrs Wells proposed that the rating should be revised from amber to green, and that the risk be removed from the BAF, as effective controls were now in place.

Approved.

2.1.3 – Patient Flow

Mrs Wells proposed that the rating be revised from amber to green as robust controls were in place. She noted that the risk had been reviewed and recommended by the Quality and Safety Committee where additional supporting information had been provided by the Chief Operating Officer.

Approved.

2.2.1 – Mandatory Training/Appraisal Compliance

Mrs Wells asked the Committee to consider removing this risk from the BAF as improved and sustained compliance in both areas had been seen. She noted the concerns that Mr Stevens had expressed about appraisal rates in the past. Mrs Wells noted that in comparison to peer organisations the Trust's appraisal rate was good and further targeted work and actions were in place to improve further.

Mrs Bernhauser noted that appraisal rates had dipped slightly during the previous month. Mr Stevens noted that mandatory training levels had dropped below 80% during the previous month, but had since recovered. He agreed that the risk should be removed from the risk register, noting the importance of ensuring that the board remained appraised of performance moving forwards. Mrs Wells noted that performance was reported to the Board on a regular basis in Integrated Performance Reports.

Approved

2.2.2 – Developing and Supporting Clinical Leadership

Mrs Wells proposed that this risk was removed from the BAF as there was no longer a gap in assurance. Recent medical engagement scale results had shown the Trust to be one of the most improved organisations in the country and it was felt that the improvements had been embedded within the organisation.

Mrs Bernhauser reported that engagement levels in ophthalmology and gynaecology had been reported as slightly below other areas in the organisation, and engagement work was being undertaken in these areas.

Approved.

Mrs Wells noted that a Board Seminar session would be held in July to enable the Board to review the BAF.

Risk Register
Mrs Wells reported that six risks on the Risk Register were rated as 20 or above, and that they had reviewed in detail by the Q&S Committee the previous week. Q&S had considered that all of the risks were effectively controlled.

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. They approved the recommended changes to the Board Assurance Framework.

020/18 Clinical Audit and Risk Register Review

i) Urgent Care
Ms Collis explained the Urgent Care Division's risk register was reviewed on a monthly basis in divisional meetings. The risk associated with non-compliance with the four hour standard had recently been reduced from 20 to 12 due to improvements and actions that had been introduced. The highest remaining risk was rated at 16 concerning consultant and middle grade vacancies, with long term locums in place and robust future recruitment plans to mitigate the risk.

Risk 1506 – Delays for children and young people who require CAMHS assessments.
Ms Collis explained that this risk was currently rated at 12, but an increase in the rating would be discussed at the upcoming Urgent Care IPR meeting due to increased assessment delays.

Risk 1687 – Nursing Absence and the effects on service delivery and delivery of quality care
Ms Collis reported that the rating for this risk had recently been reduced due to work undertaken with HR and workforce teams since August 2017.

Risk 1696 – Risk of transferring patients to escalation area
Ms Collis explained that there were currently no plans to open the medical escalation area.

Risk 974 – Delays for patients awaiting mental health assessment
Ms Collis reported that robust escalation plans had been introduced for the reporting of any delays.

Risk 1324 – Immediate Handover SECamb policy
Ms Collis reported that escalation processes had been reviewed which had resulted in a reduction in ambulances queuing.

Mr Nealon asked about how the Trust was working with Sussex Partnership Foundation Trust (SPFT) to improve care of patients with mental health needs. Dr Bull reported that a joint ESHT/SPFT working group met to discuss issues. He noted that recent positive feedback had been received from the CQC about the parity of care offered between mental and physical health issues by the organisation. He noted that the Trust was also working with Child and Adolescent Mental Health Services to improve care for children.

Mr Wells asked why risk 1502, non-compliance with the four hour standard, had been downgraded. Ms Collis explained that there had been significant sustained improvement in performance against the standard, with measures in place to sustain the improvement.

ii) Clinical Audit

Ms Collis presented an update on Clinical Audit actions within the Urgent Care Division. She updated that since the report had been produced, only five guidelines requiring a response remained outstanding. These were reviewed during monthly meetings.

The Committee noted the report.

021/18 Clinical Audit Update

Mrs Moore provided an update on the National Audit of Breast Cancer in Older Patients explaining that an action plan for completing the audit during 2018/19 had been developed. Concerns remained about completion of the Endocrine and Thyroid National Audit with no resource available to complete the audit due to reduced levels of consultants and junior doctors in the department. She explained that narrative would be included in the Quality Account to ensure that the issue was explained and Dr Walker agreed to review this. Dr Walker noted that the issue had been discussed at length at Q&S, and a number of measures had been introduced to mitigate the issue.

Clinical Audit Forward plan for 2018/19

Mrs Moore reported that discussions had been held with each Division, where national priorities, risks, complaints, mortality and other factors had been considered in order to establish the key themes for audit. There were sixty nationally mandated audits that needed to be undertaken in 2018/19, and divisions needed to ensure that they had sufficient resources to complete these. High priority audits would remain a focus for the organisation.

Proposed low priority audits were scrutinised by Divisions prior to review by the Clinical Audit team in order to ensure that they were appropriate. Audits would not be approved until an appropriate lead had been identified and the Trust continued to aim to considerably reduce the number of low priority audits undertaken.

022/18 Internal Audit

i) Progress Report

Mr Townsend provided an update on internal audit progress. He reported that four final reports had been issued, three giving limited assurance and one giving reasonable assurance. He noted that the issue of regular Tender and Waiver reports not having been submitted to the Audit Committee had been rectified.

Dr Walker raised concerns about one of the actions that had arisen from the End Of Life Care (EoLC) audit, explaining that consultant review of patients on EoLC pathways was not always appropriate. Mr Townsend explained that the audit recommendations were always subject to management approval, noting that the agreed action was for a review of documentation to be undertaken to improve clarity.

Mr Stevens asked whether Mr Townsend was confident that repeating audits in the future would see improved outcomes. Mr Townsend noted that EOLC was included on the audit plan for 2018/19 and he hoped that improved outcomes would be reported. Other audits would be followed up via the tracker to ensure that agreed actions were completed.

Mr Townsend presented 2017/18's plan and updated on progress against it. He noted that the plan was close to completion and that three substantial outcomes had been issued along with a number of reasonable levels of assurance. He anticipated that the Trust would receive an overall level of reasonable assurance for the year.

ii) Audit Tracker

Mr Townsend presented the internal audit tracker. Mr Stevens explained that he felt that the process was working effectively.

iii) Forward plan for 2018/19

Mr Townsend explained that the plan had been discussed with Jonathan Reid, noting that it had been developed by reviewing the Trust's BAF, emerging risks amongst tiaa's client base and wider emerging risks.

Mrs Wells asked whether the 20 days of work assigned to auditing CQC compliance was too many due to the recent inspection that had been undertaken. Dr Walker noted that he felt that the 12 days of audit time assigned to mortality was too much due to the ongoing improvements being seen I this area. Mr Hoaen agreed to take these comments back to the regular review meetings that the Trust held with tiaa, and agreed that the final plan would be reviewed by Trust Executives. A revised plan would be presented to the Audit Committee for approval once agreed. The Committee approved the Quarter One work plan.

Dr Bull noted that large number of audit recommendations that required completion, and asked whether work was carried out to review these and ensure that they remained appropriate. Mr Hoaen agreed to meet with Mr Townsend in order to review the recommendations in order to ensure that they remained relevant and to remove actions that had been completed. **SH/MT**

023/18 Local Counter Fraud Service Progress Report

Mr Lovegrove reported that the annual self-review tool had recently been submitted, with an overall green rating. The counterfraud work plan for 2018/19 was awaiting approval by Jonathan Reid and would be presented to the Audit Committee for approval.

An update on a recently referred counterfraud case was presented and the good work between local security teams and LCFS was noted.

A major overhaul of induction training across the organisation was being organised, and LCFS had asked that they were incorporated into this. They continued to attend inductions across both sites.

Dr Walker asked that any future medically related fraud investigation outcomes be copied to him. Mr Nealon suggested that clear processes should be available about how investigations should be shared across the organisation. Mr Stevens reported that he had recently discussed sharing of outcomes with Monica Green who felt that processes and liaison with LCFS were working well.

024/18 External Audit

i) Progress Report

Mr Wells presented a progress report. End of year testing was complete, with the exception of the Trust's IT control environment and he felt that bot the Trust and auditors were well prepared to undertake end of year audits.

Highlights from early risk assessments were included within the report, along with sector updates. Mr Stevens noted that he felt that the report provided reassurance about the processes that had been undertaken.

ii) Audit Plan 2018/19

Mr Wells reported that the plan had been completed with a view of both the Trust and the environment that it operated in. The plan set out the assessment of materiality which would drive the level of testing to be undertaken. Heightened audit risks were set out, and these would be reflected in the final audit report. He explained that the Value for Money assessment was set out within the plan and that a pragmatic approach would be taken given the position of Trust, ongoing work with NHSI and the starting point of adverse conclusion.

Mr Hoaen explained that he didn't anticipate there would be a repetition of issues with CCGs had been seen during the previous year and hoped that the audit process would be much simpler as a result.

025/18 Information Governance Toolkit Report and Registration Authority Report

i) Mrs Wells explained that the IG toolkit had been submitted with an a year-end score of 72%, with all requirements at a minimum level 2. The IG toolkit would be replaced by the DSPT in 2018/19 which was more aligned to new data protection regulations. An update on progress would be presented to the Audit Committee in July.

She reported that 68% of the Trust's staff had been issued with a smartcard, and no record of misuse had been identified.

ii) General Data Protection Regulation (GDPR) Progress Report

Mrs Wells presented an update on GDPR progress, explaining that the general principles of GDPR were very similar to those of the data protection act. The IG Manager's role had been developed to include the data protection officer requirements, which was a requirement of GDPR. Guidance had been published in February and the Trust's existing consent processes were compliant. No NHS specific guidance was yet available about exemptions to GDPR that might be applied to the NHS.

She explained that data flows within the Trust were being mapped, with a member of staff reviewing the existing 200-300 systems. Information posters would be refreshed to reflect new legislation. A refreshed IGT would help the Trust to be compliant with GDPR, but she didn't anticipate that the Trust would be fully compliant by 25th May but could demonstrate the work in hand to achieve this. Non-compliance was included on the Trust's risk register and Mrs Wells explained that future reports submitted to the Audit Committee would be amended to make it easier to identify risks and assurances.

Mrs Wells explained that she anticipated that central guidance would be issued for NHS organisations, and that the issues faced by the Trust would be shared by many other organisations.

026/18 Draft Annual Governance Statement

Mrs Wells presented the draft Annual Governance Statement, noting that it was a statutory requirement. Gaps in control and assurance, and organisational risks were included. The Statement could not be finalised until after the year end as not all the required date was currently available. The Committee considered the document comprehensive and members were invited to forward any comments to Mrs Wells.

027/18 Changes in Accounting Policies

Mr Hoaen highlighted changes to accounting policies which had been set out within the Group Accounting Manual, noting that no material changes were included. Bad debt provision was being reviewed in the light of new guidance from NHSI.

A number of other changes were highlighted. Stocktaking and inventory was being checked prior to end of year testing. A review of PPE was being undertaken and would be an area of significant interest to auditors. A range of options were being considered to look at how site valuations could be adjusted. MS noted the importance of ensuring that any self-adjustments made in response to changes in accounting policies were made in a prudent fashion.

028/18 Tenders and Waivers

Ms Trevena presented the tenders and waivers report, explaining that increased levels of waivers were being reported due to a review of non-fundamental Purchase Orders that had been undertaken.

The main reasons for waivers being issued was because of compatibility of medical equipment. Mr Stevens asked whether the purchasing team clarified the fact that there was only one supplier in these instances, and Mr Hoaen confirmed that the head of procurement challenged waivers to ensure that he received appropriate assurance of their validity.

029/18 Annual Review of Board Effectiveness

Mrs Wells asked Committee members to provide responses to the Annual Review of Board Effectiveness. Responses would be collated and a report would be submitted to the Board.

030/18 Date of Next Meeting

The next meeting of the Audit Committee would be held on:
Thursday, 24th May 2018, 1000-1200, Seminar Room 3, EDGH

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on
Wednesday 28th March 2018 at 9.30am – 12.30am
St Mary's Board Room, Eastbourne DGH

Present:
Mr Barry Nealon, Non-Executive Director (Chair)
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Dr Adrian Bull, Chief Executive
Mr Jonathan Reid, Director of Finance
Miss Caroline Trevena, Interim Deputy Director of Finance
Miss Tracey Rose, Associate Director of Planning & Business Development (representing Catherine Ashton)

In attendance:
Ms Vikki Carruth, Director of Nursing
Mrs Sharon Gardner-Blatch, Deputy Director of Nursing, Eastbourne
Mr David Clayton-Smith, Trust Chairman
Mr Christopher Langley, NHSI Financial Improvement Director
Mr Nick Gerrard, Trust Improvement Director (part - by phone)
Miss Chris Kyprianou, EA to Director of Finance (minutes)

045/18	**Welcome and Apologies for Absence** Mr Nealon welcomed members to the Finance & Investment Committee. Apologies were received from Mike Stevens, Joe Chadwick-Bell and Lynette Wells	**Action**
046/18	**Minutes of the Meeting of 28 February 2018** The minutes of the meeting held on 28 February 2018 were agreed as an accurate record.	
047/18	**Action Log** (i) Choice of Pathology Network This was discussed and progress noted. (ii) Overarching Monthly Finance Review – Month 10 At the last meeting Mr Bourdon gave an interim update on the work that had been going on with regard to the weighted average cost of capital (WACC). 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 provided. Mr Reid will ask Mr Bourdon to circulate an update on this to the Committee.	**JR**

048/18	**Performance Highlights – Month 11** This item was not discussed.	
049/18	**Overarching Monthly Finance Review - Month 11** Mr Reid gave a brief overview on the financial position at month 11. It was noted that the Trust forecast year end position was £57.4m deficit, before STF. The Committee noted the key variances and analysis of movements in month and in-year. Mr Reid reported that the cash position was significantly improving as the Trust had received a cash draw-down of £20.5m from the Department of Health in March. The capital spend was on plan for delivery and the detail of that had been reviewed by the Capital Review Group the previous week. Mr Reid reported that the revenue position remained challenging. There were no significant disputes coming up with the commissioners. However there was an ongoing significant dispute with Sussex MSK and detailed discussions were currently taking place. Mr Nealon asked for an update on the MSK contract to be provided for the next meeting. Mr Langley made reference to the £57.4m deficit position and queried whether there was anything that showed the upside, risks and opportunities to that outcome and asked how certain the Trust was that this was the year end position. Mr Reid explained that there was nothing in the report setting out this information, however for the last few months, the Trust had been going through all the various components of the risks and opportunities. Mr Reid reported that the risk was the Sussex MSK dispute, however there were no further opportunities. It was agreed that further information would be provided setting all this out. Mr Clayton-Smith queried why DAS division income had been reducing, yet the division had a higher than expected agency usage. Mr Reid explained that income was below plan but above previous year's levels, however there were continuing recruitment challenges within the division who had been working for the last few months on a fixed income figure. Dr Bull explained that some of this also related to the balance of beds between divisions. A significant number of beds in surgical wards are taken up by medical patients so they are not receiving the income but are supporting the care of medical patients on surgical wards. Dr Bull reported that this was being addressed as part of the bed modelling for the coming year. Mrs Churchward-Cardiff noted that T&O income was also down. Dr Bull clarified that this was a consequence of the MSK contract.	**JR** **JR**

	Action **The Committee noted the finance update at month 11 noting the key messages.**	
050/18	**Financial Special Measures Update** The Committee received a copy of the draft Financial Recovery Plan which had been shared with NHSI early March. The presentation set out the latest Trust Financial Recovery Plan for 2018/19 and the emerging draft plans for 2018/19. This showed that the Trust had £9.9m of green rated efficiency schemes and it was noted that work was ongoing with the Divisions to move the amber and red schemes through to green. **The Committee noted the draft Financial Recovery Plan and the work summarised within.**	
051/18	**Financial Planning 2018/19** Mr Reid circulated some slides on the 2018/19 Financial Plan. He reported that the Trust had held robust internal challenge sessions with the divisional teams and NHSI on 27 March, prior to the divisions presenting their plans to the Board on 10 April 2018. The Trust went through the detail of the plan with NHSI colleagues on 23 March 2018. Mr Reid reported that the key challenge was that the Trust had set an ambitious CIP target of £23.5m. The Trust had currently identified £12m. Mr Reid explained that there was a range of variables in the financial plan. Mr Reid summarised the following context and background of the 2018/19 financial plan: • 2017/18 outturn was adverse to plan, driven by CIP shortfall, income loss and cost pressures. The forecast outturn was £57.4m deficit (excluding STF) – with an underlying position of £53.5m, adjusting for mediation and non-recurrent costs. These three elements were key to 2018/19 plan. • 2018/19 indicative plan was £47.7m deficit (excluding STF), compared to 2017/18 outturn of £57.4m deficit (excluding STF). The underlying position moved from £57m in 2016/17, through £53.5m in 2017/18 to £47.7m in 2018/19.	

	• The Trust was working on a three year financial plan, to be ready for June 2018 – this will map the route to sustainability through to 2020/21. Mr Reid summarised the following key decisions for the Trust: • The current plan was ambitious and sat alongside a programme of change across the organisation. There was contingency in the plan, but the CIP was not yet secured and there were risks to delivery. • The plan included significant baseline investments around urgent care, safe staffing levels and improvement capacity. These were a key part of the work to improve quality and safety. However, all investments needed to be scrutinised and demonstrated to deliver value for money. • As at end March 2018, identified CIP was £12.1m from a plan of £23.5m, with no risk adjustment. The remaining CIP is under development with the divisions and additional support had been secured to facilitate this. At the 10 April Trust Board Seminar, the Trust Board will need to form a view on the achievability of the overall plan. • It was likely that the plan would be impacted by STP or NHSI/E interventions around income levels and the continued work to develop a sustainable ESBT financial plan. The Committee reviewed the bridge that takes the Trust from the 2017/18 underlying position of £53.6m to the 2018/19 plan of £47.8m. Mrs Churchward-Cardiff queried what would need to done to move the Trust from the £47.8m to £22m. A brief discussion took place on what the key drivers of the deficit were. It was agreed that a detailed analysis would take place on this and an update would be provided at next month's meeting and that Catherine Ashton would be invited. There was discussion on what was required as a minimum to secure the £47.8m given current income and cost pressures. The CIP programme currently had £12.2m as 'green.' The Trust would need to deliver £18.5m of CIPs at the very least, this would still leave a £2m provision for risk. The pipeline of CIP schemes was significant (£22m) with the Trust focusing work on moving the balance to green over the next two months. Mr Langley asked Mr Reid's view on the actual level of 'green' rated CIPs required to get to £18.5m. Mr Reid responded that a reasonable estimate would be £23m CIPs but noted the high quality green rated CIPS. Dr Bull explained some of the issues that are stopping the remainder of	**JR**

	the programme going 'green'. He explained that the pipeline was progressing well. The Committee reviewed a number of CIP scenarios. These showed that by the end of April the additional CIPs needed to get to 'green' range from £1.9m to £11.4m. The Committee noted that PA Consulting were supporting the Trust over the next 5 weeks to develop existing schemes that were currently classified as amber, red or in the pipeline. Mr Gerrard gave an update on the progress of the CIP programme. He reported that the recent sessions with NHSI were useful in agreeing how the CIP programme will be developed in the next few weeks. He confirmed that the Programme Support Office was working well and that the divisions were fully engaged in the work that was being undertaken. There had been a number of specialty deep dives which had highlighted significant opportunities. He reported on the work that will be ongoing over the next few weeks leading up to the Trust Board Seminar on 10 April to move some of the 'red' and 'amber' schemes into 'green' and some of the pipeline schemes into 'red' and 'amber'. He explained that there was a much more rigorous process in assessing what could be moved to 'green'. With regard to the deep dives, Mr Nealon asked if the level of interrogation was as robust as it could be. Mr Gerrard confirmed that the majority of deep dives go down to specialty level detail. Mrs Churchward-Cardiff asked if any further help was required to focus on the 'red'/'amber' schemes to get to at least £18.5m. Mr Reid gave an update on additional support that had been provided and funded by NHSI to support this. Mr Nealon said it would be helpful to see what the divisions will be doing differently this year to make a difference from the previous year. Mrs Churchward-Cardiff queried what happens if the plan does not deliver. Mr Reid explained the escalation and support process and the actions put in place to ensure that the plan does deliver. Mr Clayton-Smith said that discussions were taking place about bringing someone in to ensure that these plans are developed. Mr Gerrard explained that this was a continuous process and the aim was to get a high proportion of 2019/20 CIPs in 'green' by September/December this year so that this becomes a rolling programme rather than a one off event. Mr Langley gave his view on the internal challenge sessions with the divisions on 27 March. It was helpful to see the interaction with the divisions and to get a sense of what was robust and what was still being worked on. The level of engagement from the divisions was encouraging. Mr Reid reported that a key variable for the Trust plan was income and	

	gave an update on the current contract status. It was noted that the Trust plan assumes that the overall income level of £271.3m is secured, although there was a small element of contingency in this plan. It was agreed that Mr Reid would circulate a table to show what funding is included in the contract positions, what was assumed in the plan and what the risks and opportunities were. The Committee reviewed the cost pressures. It was noted that the Trust had a £4.3m budget for cost pressures, with a further £1.3m set aside for financial improvement costs. It was anticipated that cost pressures would be contained within the planned levels. The Committee noted the next steps were to: • Present the draft plan to the Board in April 2018, setting out the options and recommending an overall plan value. A value of £47.8m would not be accepted by NHSI as an acceptable plan. The Trust may wish to consider a 'stretch' which is contingent on income levels and appropriate development of the CIP plan. • Continue to focus on the development of the CIP plans, aimed at getting to the £23.5m target at the earliest opportunity. PA Consulting were providing support into the divisions, and good progress was being made. The divisions will be presenting their trajectories at the Board Seminar on 10 April. • Work with the CCGs, NHSI and NHSE to agree a contract value for the year. The Trust had highlighted that the plan was contingent on the current contract value under discussion of £271.3m with the two key CCGs, although this value did include additional winter monies. Any plan agreed by the Trust Board will have to be contingent on the overall level of income. • Continue work with the Director of Strategy, the CCGs and NHSI/E on the three year financial strategy for the Trust. A small project team had been formed to ensure delivery of the strategy by June 2018. • Work with NHSI and external advisers to inform the 'underlying income' position – the Trust had estimated that income was under recovered by £15m/year, and actions are in train to recover the first £5.5m of this income into 2019/20. **Action** **The Committee noted the update on the progress on the 2018/19 financial plan.**	**JR**
052/18	**Efficiency Programme 2018/19** This item was discussed as part of 051/18 above.	

	Action **The Committee noted the efficiency update.**	
053/18	**Capital Planning 2018/19** Mr Reid presented a brief update on the development of the capital plan for the Trust for 2018/19 and updated the Committee on the detailed work arising from the Capital Planning Workshops. The capital plan will to be kept under development and review, reflecting the latest priorities from the Clinical Units and the state of play on securing the external finance. The Committee noted the following key priorities in the next few weeks • To secure agreement from FIC and NHSI on the fire business case, ensuring that at least the do minimum is funded (£4m, out of a preferred option of £12m) • To progress the development of the medical equipment loan with NHSI, and the MRI loan with ESCC to ensure early agreement on the funding for these key service developments (£4m) • To continue to work with Clinical Units to refine the list of priorities, and ensure that all key projects and programmes are mapped and included in the 5 year capital programme • To refresh the agree the 5 year capital programme update through the FIC and Trust Board, building on the financial and strategic modelling being undertaken by Catherine Ashton and Dan Bourdon. The capital plan will be kept under monthly review by the Finance & Investment Committee. **Action** **The Committee noted the update on the development of the capital plan for the Trust for 2018/19**	
054/18	**Establishment Review** Ms Carruth and Mrs Gardner-Blatch were welcomed to the meeting to present a 6 monthly review on Nursing and Midwifery staffing. It was noted that the Trust was required to undertake a 6 monthly review 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). Ms Carruth presented the report and highlighted the key issues. The aim was to provide assurance that a robust establishment review had been undertaken and set 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 provided assurance regarding the Trust processes in place for setting, monitoring, maintaining and escalating concerns regarding safe nursing and midwifery staffing levels. The report had been shared with the Executive Team and would also be shared with the Trust Board and the Workforce Committee.

Ms Carruth said she would like to thank Mrs Gardner-Blatch, and Mrs Graham in the Finance team, for the significant piece of work which had been undertaken.

Ms Carruth reported that the report related to nursing, and the detailed midwifery establishment review with Paediatrics will be presented in June. The next 6 monthly review will include information on outpatient nursing and theatres and a number of other areas.

Ms Carruth summarised the recommended changes to nurse staffing following the executive team review as part of the annual establishment review. The Committee reviewed a table showing the revised changes. Mr Reid confirmed that all of the assumptions within the table were included within the cost pressures.

Mr Nealon asked if there were things that had become apparent in the review where savings could be made that were being investigated. Mrs Carruth confirmed that there were areas that had been identified where cost and usage could be significantly reduced.

Ms Carruth provided a summary of the recommended changes to the roster controls to ensure that there is greater challenge and scrutiny.

The Committee received information on the uplift/headroom that was built into the budget. The uplift aims to provide the ward with the ability to cover some unplanned leave. It was noted that the 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 pressure as these posts also need uplift and this leaves very little flexibility in terms of planning rosters and also assumes that extra is always needed. It is recommended that the recruitment into headroom is capped.

Ms Carruth reported that the Emergency Department (ED) establishment review was a significant piece of work and, given the level of detail involved, was included in a separate section in part 2 of the report. Mr Clayton-Smith referred to the additional investment suggested in ED and queried how much of that was related to the way the Trust now operates with regard to streaming and ambulatory care. Mrs Carruth drew the attention of the Committee to a table which referred to this and Mr Reid confirmed that the cost of GP streaming

	was included in the financial plan for next year. Mr Reid gave a brief explanation on the assumption on tariff income. It was noted that the Trust was in discussion with the CCGs regarding funding for GP streaming. It was noted that Paediatric ED was not included as part of the review, due to ongoing discussions about Eastbourne. Ms Carruth reported that the Carter metrics were considered as part of the review and drew the attention of the Committee to some graphs. These showed that the Trust cost per care hour was below both the national median and that of the other providers in Kent, Surrey and Sussex. However, in terms of the amount or care hours per patient day, the Trust was significantly higher. Mrs Carruth explained that this was due to the current skill mix and likely due to use of specials. Ms Carruth explained that the net cost of the review was around £0.5m. Mrs Churchward-Cardiff expressed her concern that the Trust was doing something that needed to be done, but was to receive less income for doing it. It was noted this is a system wide discussion. Mrs Churchward-Cardiff queried whether the Trust would be using a specialing team. Ms Carruth confirmed that there had been some discussion on this, and also on having a rapid response team, and training health care assistants specifically for patients with special needs, but further analysis is required. Mrs Churchward-Cardiff queried the skill mix gap. Ms Carruth explained that this was lower that the Trust would want. However the Trust was also adding in additional health care assistants for specialling, which was somewhat 'distorting' the picture. Mrs Gardner-Blatch reported that there would be a focus on AMU and stroke with a view to reviewing the skill mix in those areas. The Committee were asked to support: • the recommended changes to staffing templates to deliver safer staffing • the proposal that recruitment into uplift/headroom be capped at 10% • the decision on the 18% uplift/headroom and agreement to accept the risks arising from this • the decision on the removal of ward level access below band 7 to create additional duties. **Action** **The Committee supported the above.**	
055/18	**ESBT/Alliance Executive Financial Plan 2018/19** Mr Reid explained that the Trust and CCG were working hard to try and reduce their deficit. It was noted that they were looking at collectively commissioning an organisation to do some review work on the financial plan for the Alliance Executive as a whole.	

	It was noted that the Financial Planning for 2018/19 at a system level continues to develop through the Alliance Executive. **Action** **The Committee noted the update on the Alliance Executive Finance Plan.**	
056/18	**Sussex and East Surrey STP Financial Plans** Mr Reid gave a brief update on the STP forecast overspend against plan in year. The STP leadership team were considering how this was to be managed across Sussex coming into next year. The STP were keen on crystallising the position. The Committee noted that there was a detailed piece of work that the STP had undertaken on the estates strategy for the next few years and capital investment. **Action** **The Committee noted the ongoing work within the STP.**	
057/18	**EBITDA Quarterly Report (Q3)** Mr Reid presented a report informing the Committee of the Trust's Q3 2017/18 EBITDA position, highlighting the top 5 specialties contributing the least/most to the Trust position. It was noted that the data was used to inform/assist with the Trust's annual planning process, financial recovery plan delivery, and commercial strategy. Mr Reid reported that the service line reporting, GIRFT and the Model Hospital data was being used in the specialty reviews to understand what the main areas of opportunities could be. **Action** **The Finance and Investment Committee noted the Q3 2017/18 EBITDA position.**	
058/18	**Market Developments Quarterly Report** Miss Rose gave an update on the current status of business cases and business opportunities. Business cases and tenders are monitored by the Business Development Group (BDG) and approval decisions are made in accordance with the governance structure by Executive Directors and F&I Committee as appropriate. The planning and business development team were supporting	

	divisions to align cases and tenders with Trust strategic priorities, divisional business plans and finance. The Committee noted that there were currently two tenders in the pipeline, and a number of business cases that were being worked on. **Action** **The Finance and Investment Committee noted the update on service and market developments**	
059/18	**Energy Performance Contract** Mr Reid reported that the Energy Performance business case had been drafted, however further work was required before this is presented to the Committee in April. **Action** **The Committee noted that this will be presented to the April Finance & Investment Committee.**	**JR**
060/18	**Fire Compartmentalisation** Mr Reid reported that this Business Case would be presented to the Finance & Investment Committee in April. **Action** **The Committee noted that this business case would be presented to the Committee in April.**	**JR**
061/18	**2018/19 Work Programme** The Committee received the draft 2018/19 work programme. It was agreed that MSK and a piece of work on the 'Drivers of the deficit' will be added to the work programme for April. **Action** **The draft Work Programme for 2018/19 was noted.**	**CK**
062/18	**Minutes to note** The Committee received the following minutes and progress report for information: • FISC – 24 January 2018 • Capital Review Group – 17 January 2018 & 28 February 2018 • Business Planning Group – 21 February 2018 • MRI Progress Report **Action** **The Committee noted the above minutes and progress report.**	

063/18	**Date of Next Meeting** The next meeting is scheduled to take place on Wednesday 25th April 2018 at 9.00am – 12.00pm in ***the Committee Room, Conquest.***	

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE & ORGANISATIONAL DEVELOPMENT (POD) COMMITTEE

Minutes of the People & Organisational Development (POD) Committee meeting held on Wednesday 14th March 2018 15:00 – 17:00 St Mary's Boardroom, EDGH

Present:
Mrs Miranda Kavanagh, Non-Executive Director (MK) – Chair
Dr Adrian Bull, Chief Executive (AB)
Mrs Dawn Urquhart, Assistant Director HR, Education (DU)
Mrs Joe Chadwick-Bell, Chief Operating Officer (JCB)
Mrs Karen Pamment, PA to Assistant Director of HR - OD
Mrs Lorraine Mason, Assistant Director of HR - OD (LM)
Mrs Moira Tenney, Deputy Director of HR (MT)
Ms Fran Edmunds, Head of Nursing, Women & Children(FE)
Ms Jeanette Williams, Staff Engagement & Programme Lead
Ms Monica Green, Director of HR (MG)
Ms Ruth Merrick, Workforce Systems Manager
Mrs Tina Lloyd, Assistant Director of Nursing (TL)

In Attendance:
Mr Charlie Bosher, Senior Consultant Quality Health (CB)
Mrs Nicky Hughes, PA to Director of HR (NH) (minutes)

No.	Item	Action
1)	**Welcome, introductions and apologies for absence** The Chair welcomed all to the meeting and noted a quorum was present. Apologies for absence were received from: Dr David Walker, Medical Director (DW) Mr Jamal Zaidi, Associate Medical Director – Workforce (JZ) Mr Jonathan Reid, Finance Director (JR) Mrs Jackie Churchward-Cardiff, Non-Executive Director (JCC) Mrs Jan Humber, Staff Side chair (JH) Mrs Kim Novis, Equality & Human Rights Lead (KN) Mrs Lesley Houston, Deputy General Manager – Medicine (LH) Mrs Michele Elphick, General Manager – DAS Division (ME) Mrs Sharon Gardner-Blatch, Deputy Director of Nursing (SGB) Ms Vikki Carruth, Director of Nursing (VC) Due to the number of apologies received, MK highlighted the importance of staff attending this meeting, which provides assurance for the Board.	

2)	**2.1 Minutes of the last meeting held on 17th January 2018** The minutes were reviewed and agreed as an accurate reflection of the meeting. **2.2 Review of Action Tracker:** The outstanding items on the Action Tracker were reviewed: WRES 2016-17 - BME MK reported that diary commitments had prevented the discussion taking place; date to be confirmed for feedback to the next meeting. Medical Engagement Further update to be provided at July 2018 meeting. HEE National Workforce Survey MG reported that the response to the Workforce Strategy had been written. **Action: Closed**	**MK** **LM/DW**
3)	**Staff Survey – Presentation of 2017 results** The Chair welcomed Mr Charlie Bosher (CB), Senior Consultant Quality Health to the meeting. CB reported that the national results had been published for September to December 2017; all figures reported in the presentation were an accurate reflection of ESHT performance nationally. All staff that did not respond had received two reminders. CB gave an overview of the ESHT 2017 Staff Survey Results and highlighted the key points: • 49% of staff had responded; above average. • Staff engagement score 3.74 out of 5; positive result. • 11 key findings significantly better than average. • 6 key findings significantly worse that average. • 5 key findings had shown significant improvement since 2016. • 0 key findings had shown significant decline since 2016. • The Trust was continuing to improve; positive result. • One of three most improved Trusts in 2016. • Improvement in the percentage of staff appraised; within top four Trusts. • An improvement in recognition and value of staff by managers. Recommendations: • Review staff motivation at work. • Examine all scores around staff contributing towards improvements at work. • Review provision of non-mandatory training.	

	• Investigate incidents of discrimination at work, particularly from managers. • Understand why some staff would not feel secure raising concerns about unsafe clinical practice. • Investigate staff satisfaction with resourcing and support. • Seek to improve visibility of senior managers across the organisation. • Investigate the high number of staff experiencing harassment, bullying and abuse. AB recommended a communication to all staff informing them of the improvements that had been made following previous feedback and areas for further development based on the feedback of this survey.	
4)	**Response to draft Health and Care Workforce Strategy** MG reported that the strategy had been discussed at the previous meeting 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.	**MG**
5)	**Appraisal Rates** DU gave an overview of the submitted report. A review and examination of appraisals and the appraisal process had been undertaken to understand the current compliance status for every service within each division and how poor compliance data would be managed. Key issues were highlighted: • Appraisal drop-in sessions and training sessions provided. • Compliance rate of 81.3%. • Assurance to committee – add additional resources out of existing budget. • Restructure Medical Education Department. • Source and invest in a technology based solution. • Development and implementation of more robust quality assurance/management process. • Continual appraisal non-compliance to be raised formally at divisional/executive level. • Review and overhaul the training programme. 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.	

	Some areas remained non-compliant and it was agreed that positive action would need to be taken for staff not fulfilling their responsibilities; to be escalated through divisions.	
6)	**The Nursing Workforce – House of Commons Health Committee Report** 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. MG to request update from VC. Further clarification required around some of the new roles. It was highlighted that nurse associate training seemed to be low in numbers. DU confirmed that there were 10 being piloted with a view to looking at March and September 2019 working in collaboration with Brighton. It was noted that Band 4 nurses would be seen as part of the registered workforce as they were being utilised to fill roles where there had been a lack of registered nurses. ***Post note - 28.03.18 - SGB**: These new nurse associates will be an entirely new registered profession and whilst they will undertake some tasks which have previously been performed by either registered nurses or HCAs they cannot fill roles of registered nurses.* A discussion took place regarding the current position of nursing both nationally and locally. It was agreed that a full strategy of supporting nurses in the workforce should be built into next year's plan. <u>Nursing & Midwifery Assurance Review</u> The Nursing & Midwifery Assurance Review paper had been circulated for information. To be a future standing agenda item under Items for Information.	**MG**
7)	**Physicians Associates** DU gave a brief overview of the Physicians Associates and explained that work was being undertaken on implementing the role within the Trust. The Physicians Associates role originated from America; healthcare professionals, trained within a medical model and used across primary care and acute trusts within all specialties; 260 qualified nationally and	

	over 300 in training. ESHT host 4 in training at the moment but do not automatically offer employment once completed. Currently within the UK the Physicians Associates are registered on a voluntary register (PAMVR) hosted by Royal College of Physicians. 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. A discussion took place regarding current students, doctors' views and how these roles would fit into ESHT workforce strategy. Further discussions to take place outside of this meeting.	
8)	**Items for information:** Leadership/Management Pathway Summary LM gave an overview of the summary and highlighted key areas: • Concentrated work had been undertaken clarifying expectations of leaders ensuring that they were supported within their role; more systematic approach to board development. • Leading Service and Leading Excellence programmes had been evaluated formally by Kingston University; to be received in June 2018. • Building on Management Essentials; had introduced a new manager's orientation programme, which clarify expectations and signposting with a follow up session after 6-8 weeks. • To introduce buddy programme for junior doctors. Feedback from sub-groups: 8.1 – Engagement & OD Group Item noted. 8.2 Education Steering Group Item noted. 8.3 – Workforce Resourcing Group Item noted. 8.4 – HR Quality & Standards Group Meeting postponed to 04.04.18.	
9)	**Any other business** No other business.	
10)	**The next meeting of the Committee will take place on:** **Wednesday 9th May 2018** **15:00 – 17:00** **Room 6, Education Centre, Conquest**	

Use of Trust Seal

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

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

26th April 2018 – Lease between Assura HC UK Ltd and ESHT for the lease of Health Centre at 21 Fairlight Road, Hastings.

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.