EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 7th August 2018, commencing at 09:30 in Hydro Hotel, Eastbourne

	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 5th June 2018	A		
4.	Matters arising	B		
5	Quality Walks Board Feedback	C	Chair	
6	Board Committee Feedback	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 3 (June) 1. Quality & Safety 2. Access & Responsiveness 3. Sustainability 4. Leadership & Culture 5. Finance	Assurance	G	DN/MD COO HRD	1015 - 1100

BREAK

STRATEGY

					Time:
10	ESHT 2020	Assurance	H	DS	1115 - 1140
11	ESBT Alliance Agreement	Assurance	I	DCA	

GOVERNANCE AND ASSURANCE

					Time:
12	Medical & Nursing Revalidation	Assurance	J	DN/MD	1140 - 1215
13	Annual reports: • Organ Donation • WRES • Complaints • Guardian of Safe Working Hours	Approval	K	Various	
14	Board sub-committee minutes: • Audit Committee • POD Committee • Quality & Safety Committee	Assurance	L	Comm Chairs	

ITEMS FOR INFORMATION

				Time:
15	Use of Trust Seal	M	Chair	1215 - 1230
16	Questions from members of the public (15 minutes maximum)		Chair	
17	Date of Next Meeting: Tuesday 2nd October 2018, Oak Room, Hastings Centre		Chair	

David Clayton-Smith

David Clayton-Smith

Chairman

4th July 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, 5th June 2018 at 09:30 in the St Mary's Boardroom, EDGH.

Present: Mr David Clayton-Smith, Chairman
Mr Barry Nealon, Vice Chairman
Mrs Sue Bernhauser, Non-Executive Director
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Mrs Miranda Kavanagh, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Dr Adrian Bull, Chief Executive
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
Mr Christopher Langley, Financial Improvement Director, NHSI
Dr James Wilkinson, Assistant Medical Director
Ms Sarah Blanchard-Stow, Assistant Director of Midwifery and Nursing (for item 054/2018 only)
Mrs Angela Ambler, NHSI Next NED Programme (observing)
Mr Pete Palmer, Assistant Company Secretary (minutes)

041/2018 **Welcome**

1. Chair's Opening Remarks
Mr Clayton-Smith welcomed everyone to the meeting of the Trust Board held in public. He announced that Mrs Bernhauser would be stepping down from her role as a Non-Executive Director at the end of August and that Mrs Churchward-Cardiff would be taking over as chair of the Quality and Safety (Q&S) Committee. Mrs Bernhauser's last Board meeting would be in August.

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

Ms Catherine Ashton, Director of Strategy
Dr David Walker, Medical Director and Dr Wilkinson was attending on his behalf.

3. Monthly Award Winners
Mr Clayton-Smith reported that the monthly award winner for April had been Robert Tricker, a bereavement officer based at the Conquest Hospital.

042/2018 **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.

043/2018 **Minutes**

The minutes of the Trust Board meeting held on 17th April 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.

044/2018 **Matters Arising**

028/2018 – IPR Month 11 - Access and Responsiveness – Admission Avoidance

Mrs Chadwick-Bell reported that data about admission avoidance was now included within the IPR. **Closed.**

028/2018 – IPR Month 11 - Access and Responsiveness – 62 day breaches

Mrs Chadwick-Bell confirmed that 62 day breaches had been added to the agenda of the Q&S Committee. **Closed.**

028/2018 – IPR Month 11 - Access and Responsiveness – Crisis Response Re-admissions

Mrs Chadwick-Bell reported that crisis response re-admission rates previously reported to the Board were correct. A clinical audit was being undertaken to fully understand the issue and she would report back to the Board once this had been completed. **To remain on Matters Arising.** **JCB**

028/2018 – IPR Month 11 – Leadership and Culture

Miss Green confirmed that a breakdown of Trust recruitment during 2017/18 had been presented to the People and Organisational Development (POD) Committee on 9th May 2018.

045/2018 **Quality Walks**

Ms Carruth reported that she undertook regular weekly visits to different areas within the Trust, explaining that these were not included within the formal Board report. She had recently visited A&E at EDGH and had been impressed by how clean and organised the department was. She explained that clinical orderlies played a key role in ensuring the cleanliness and organisation of departments and were key members of teams. Mr Clayton-Smith reported that he had also visited A&E departments on both sites and had been very impressed by the spirit and resilience he found amongst the staff.

046/2018 **Board Committees' Feedback**

1. Audit Committee

Mr Stevens reported that the recent meeting of the Audit Committee had reviewed the end of year accounts and annual report for the Trust. The Trust had recently appointed new external auditors and he felt that this change had been very positive. He thanked the finance team for the welcome and cooperation they had given to auditors.

He noted the strength of internal audit within the organisation, explaining that a programme of work was developed jointly by the finance team and internal auditors, who were very flexible in looking at areas of concern. He noted the good relationship that existed between internal and external auditors. Mr Reid explained that internal auditors were very helpful in identifying issues within the organisation. The Trust regularly asked auditors to review areas of concern.

2. Finance and Investment Committee

Mr Clayton-Smith reported that he had chaired the last Finance and Investment (F&I) Committee. The agenda and papers for the Committee had been lengthy and work was being undertaken to address the this.

He reported that the Committee had discussed year end outturn, Cost Improvement Programmes (CIPs) and the Trust's financial plan for the next 2-3 years. Three business cases had been presented and these would be considered by the Board in private following the Board meeting due to commercial confidentiality. The results of these discussions would be presented to the Board in public in the future.

3. People and Organisational Development Committee

Mrs Kavanagh reported that the People and Organisational Development (POD) Committee had discussed a wide ranging and full agenda during the recent meeting. She noted that nursing and medical revalidation continued to be a great success for the Trust. HR incidents resulting in a formal process had declined during the previous year, with revised HR processes proving effective. Discussions had also taken place about the gender pay gap, new roles within the organisation and the Guardian of Safe Working Hours annual report.

Mrs Kavanagh reported that flexible working for nursing staff was being reviewed at STP level. Miss Green explained that this was also a priority for the Trust and hoped it would improve staff wellbeing by moving some staff away from the default 11.5 hour shift that had been introduced some years before. Changes would be piloted to ensure that they were effective before being rolled out throughout the organisation.

4. Quality and Safety Committee

Mrs Bernhauser reported that membership of the committee had been reviewed at the end of 2017 and the attendance of Deputy Directors of Nursing now ensured that actions were quickly fed back into divisions.

The Trust's new End of Life Care policy had been audited and patients and relatives were happy with processes that had been introduced. The backlog of plain film reporting in radiology had been discussed at the last Committee and she thanked Justin Harris for his hard work in reviewing the backlog of work and ensuring that no harm to patients had occurred.

Mr Clayton-Smith thanked Mrs Bernhauser for the huge amount of work she had done in shaping and improving the Q&S Committee during her time as Chair.

The Board noted the Committee Reports.

047/2018 **Board Assurance Framework**

Mrs Wells reported that there were no proposals to add any new items on to the Board Assurance Framework (BAF). She explained that the Audit Committee had not discussed the BAF at their previous meeting as this had been a single item agenda to consider the annual accounts and annual report. She reported that the Q&S Committee had considered whether the risk concerning recruitment should have its rating changed to green or be removed. The Committee had considered that recruitment remained very challenging and that they would like further assurance prior to proposing any change.

The Q&S Committee had also considered the risk concerning young people with mental health conditions and had not felt that sufficient assurance was being given to change the rating. The Women, Children and Sexual Health division had been invited to attend the Committee to provide additional assurance about measures that had been introduced to address the issue. Consideration was being given to reframing the gap in assurance as it had changed since originally being put onto BAF and was now being resolved by working in partnership with Child and Mental Health Services.

Mrs Churchward-Cardiff asked whether the risked associated with the Trust's ability to develop a five year integrated business plan should be changed to red given the current pressures being felt by the healthcare system. Dr Bull explained that the Trust's long term strategic and financial plan would be presented to the Board at the Seminar in July and therefore the risk's rating was appropriate. System wide risks did exist, but a joint financial recovery board, chaired by Bob Alexander, had been established to address these.

Dr Bull provided an update on the risk concerning monitoring and recording of follow up appointments for patients with certain conditions, noting that work had been completed on a pilot of an adapted patient tracking list. Full implementation of the solution would be introduced when the PAS system was upgraded.

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.

048/2018 **Chief Executive's Report**

Dr Bull reported that the CQC's reports, following their inspection of the Trust in March, were due to be published the following day. The annual Trust Awards for staff were due to take place in July and a number of excellent nominations had been received. He reported that NHS Employers had used the Trust as a case study for improving staff engagement with an article recently published in national journal.

During the winter and Easter periods the Trust had seen a significant increase in demand compared to the previous year. Dr Bull praised staff for their response to the increased number of patients attending. Performance against the 4 hour A&E standard had improved significantly with the CQC recognising the Trust as one of most improved in England for operational performance. NHSI were carrying out a piece of work to better understand how the Trust had managed to achieve the improvements to performance in order to share learning with other organisations.

049/2018 **QUALITY, SAFETY AND PERFORMANCE**

Integrated Performance Report Month 1 (April)

Access and Responsiveness

Mrs Chadwick-Bell reported that the Trust's A&E performance had been 89.6% in April and 92.8% in May against the 95% standard. The Trust had seen performance above 95% during a couple of recent weeks and performance continued to improve. She noted that an incorrect figure was included within the IPR for "decisions to admit that had taken longer than 12 hours", and that there had been none in April.

The conversion rate of patients admitted to hospital following attendance at A&E had been reviewed. The rate at EDGH was lower than the Conquest and in line with national standards. The Conquest's figures were higher due to children and surgical patients being placed on existing pathways and while this was not a concern it would continue to be monitored.

Mrs Chadwick-Bell reported that the ambulatory unit had opened at EDGH at Christmas, and attendances continued to increase. Increases in attendances to A&E and non-elective pathways also continued and a clinical summit had been arranged to allow front line clinical review of data to better understand the reasons for this. Length of Stay and non-elective bed days continued to reduce along with numbers of stranded patients in the Trust.

Referral to Treatment performance was a nationally reducing trend, but the Trust was sustaining performance at around 90% against a 92% standard. Delayed Transfers of Care had stabilised within the Trust at around 1.5%, significantly lower than the national rate of 3%. The percentage of patients waiting more than six weeks for a diagnostic test had improved from 5% the previous year to 1%. Work was being undertaken to improve radiology booking processes which would support performance throughout organisation.

Mrs Chadwick-Bell reported that the Trust had failed to meet the two week wait target for cancer performance for the first time in two years during April. Numbers of cancer referrals received between March and May had been unprecedented and were not unsustainable and analysis of the issue had been shared with NHSI. The increased demand would impact on 62 day performance moving forward. An issue with patients on the 62 day pathway being transferred to the Trust from another provider after the 62 day target had elapsed had been identified and raised with the provider, NHSI and NHSE. Mrs Chadwick-Bell reported that increased colorectal and breast cancer referrals were being seen across the South East. Referrals from GPs continued to be appropriate, and conversion rates of cancer diagnoses hadn't increased as a result

Increased referrals continued to be seen by community services and the Trust was working with the CCG to look at work coming in and to rebase the contract as activity was double the originally anticipated levels.

Mr Nealon asked whether the increase in attendances to A&E had a financial

impact on the Trust. Mrs Chadwick-Bell explained that the Trust's previous investment in nursing staff had led to confidence that increased attendances could be managed without a financial impact. Primary care streaming had been introduced to help manage the additional demand.

Mrs Churchward-Cardiff praised the remarkable improvement in A&E performance seen by the Trust over the past year. She asked whether the number of different pathways available to patients was causing a fragmentation of community services. Mrs Chadwick-Bell explained that three reviews were being undertaken to identify whether pathways were correct for patients and if they provided value for money. Additional work was being undertaken to simplify pathways.

Mrs Chadwick-Bell reported that day case activity was ahead of planned levels and had increased since the previous year. Numbers of non-elective patients had also continued to increase. Work was being carried out to reduce the ratio of new to follow up outpatients appointments and weekly discussions took place with Divisions to address the issue.

Quality & Safety

Ms Carruth reported that during April the Trust had seen a slight increase in falls. A deep dive would be undertaken to understand why this had happened. A further reduction in Trust acquired pressure ulcers had been seen, and a deep dive into grade 2 ulcers would be presented to the Q&S Committee. Very positive feedback continued to be received from members of the public, although the Trust had seen a slight reduction in Family and Friends Tests received. A group had been established that would look at improving the experience of patients during discharge from hospital.

Mrs Churchward-Cardiff noted that complaint rate for the Women, Children and Sexual Health Division had been consistently higher than other divisions. She asked when information about the level of complaints was scheduled to be presented to the Q&S Committee. Ms Carruth reported that this was due to be presented at July's meeting. Dr Bull noted that a review of working relations and culture would be undertaken in order to realise improvements in areas that were of concern.

Mr Clayton-Smith asked why nursing levels were being reported at above 100% and Ms Carruth explained that 100% staffing levels represented planned levels of staffing. Anything above 100% represented that a hospital had been significantly busier than anticipated.

Dr Bull reported that a rolling log for Serious Incidents would be introduced to ensure that colleagues throughout the organisation were informed when Serious Incidents occurred, as well as the progress in investigating them and outcomes. This would be presented to the Board in private and the Q&S Committee for assurance in the future.

Dr Wilkinson reported that mortality levels had consistently improved during the previous couple of years. RAMI and SHMI had continued to reduce with the previous SHMI the lowest seen by the Trust in over a decade at 107. The Trust's RAMI was now markedly better than the average for acute Trusts in UK, and showed sustained improvement. The demographics of the local population

meant that Crude Mortality would always be above the national average, but this had reduced by 8.25% from previous year.

Mr Clayton-Smith asked how much more improvement to mortality could be realised. Dr Wilkinson explained that this was multi-faceted and included providing high quality care, undertaking and learning from mortality reviews, and capturing mortality data more accurately. His ambition was for the Trust to be in the top 10% in the country for mortality.

Mr Nealon noted that there were occasions when deaths could be avoided and asked how this was reviewed and addressed. Dr Wilkinson explained that the Trust had a robust structured system in place to review deaths and a mortality review group which looked for trends in mortality. Learning from reviews was shared throughout the Trust.

Leadership & Culture

Miss Green reported that an increased staff establishment for 2018/19 had led to an increase in vacancies being reported. A programme of work to develop staff and improve career progression had been introduced. Agency spend during April had reduced and bank spending had slightly increased. A continuing trend of reducing staff turnover within the Trust was being seen. Monthly sickness had reduced, but annual sickness levels remained consistent. Appraisal and mandatory training levels were slightly reduced, and this was being discussed with Divisions within IPRs. An increase in appraisal rates was anticipated if new national pay arrangements were approved.

Mr Clayton-Smith commended the encouraging trends that were being seen, noting that the improving reputation of the Trust was making recruitment of staff easier. He asked whether the increase in numbers of clinical staff being seen had increased the cost base for the organisation as new roles were established. Miss Green explained that the increases had been included within the budget for the year and Mr Reid noted that during the budget setting process, budgets had been rebalanced which allowed for an increase to budgeted posts. The investment in permanent A&E staff had been made using money previously allocated for use for bank and agency staff. Dr Bull explained that a vacancy control process was in place that approved new roles, and the Executive team reviewed approvals. Some of the additional roles were being funded by the CCG. Miss Green and Mr Reid agreed to present a report providing greater detail about increased staff numbers and budgeting at August's Board meeting. **MG/JR**

Finance

Mr Reid presented the Trust's financial position at the end of Month One to the Board, reporting that the Trust had been £100k ahead of their plan at the end of the month. He reported that the CIP programme had underperformed by £89k during the month due to the purchase of equipment with the issue now having been resolved. Weekly reviews of CIP progress were undertaken along with weekly confirm and challenge meetings with Divisions.

He reported that the Trust had not yet reached agreement with the CCG about the financial position for 2018/19 and that this remained a key risk to financial planning. The outstanding issues were well understood and regular meetings were held with the CCG in order to reach agreement.

The other key risk to the Trust's financial plans was in delivery of the Cost Improvement Programme (CIPs). The Trust had set a target of delivering a minimum of £18m of CIPs, with an ambition to reach £23.5m. Mr Reid reported that £14.2m of CIPs had been identified and rated as green. CIPs were only rated green when the Trust had assurance that they would be delivered. Work would be undertaken during the next month with PA Consulting to look at schemes where the rating could be moved to green more swiftly. Dr Bull reported that a number of CIPs had been identified that would take the Trust to over £19m. These 12-14 programmes would be given greater focus by the Trust

Mr Clayton-Smith noted that the F&I Committee had requested an increased focus on ensuring that planned efficiencies and CIPs delivered as planned. The Trust did not expect to receive any additional income during the year and would realise savings by increasing efficiency.

Mr Langley asked when the additional work with PA Consulting was scheduled to start and Mr Reid explained that this had already begun. Mr Langley asked whether the Trust had changed any other practices from the previous year in order to realise additional savings. Mr Reid reported that PA Consulting were providing additional support to the delivery of CIPs, and had undertaken a review of corporate back office functions and costs. Confirm and Challenge sessions with Divisions were a priority for the organisation and saw increased Executive input. The Executive team were hoping to recruit a new Financial Recovery Director to provide additional support, as the previous director had left the Trust at the end of March.

Mr Stevens asked what impact an increase in elective work would have on the organisation. Mrs Chadwick-Bell explained that elective work was not carried out at the expense of non-elective work, but was managed in parallel. Mr Reid noted that elective work made a greater contribution to the Trust's financial position than non-elective work. The Trust was already seeing levels of elective activity above the starting contract value agreed with CCG which had been based on national activity assumptions.

The Board noted the IPR Report for Month 1.

050/2018 **Learning from Deaths**

Dr Wilkinson reported that regular reports were presented to the Board on reviews of deaths and avoidable deaths within the organisation. Two separate systems were in place to review deaths. The LeDeR programme reviewed deaths of patients with learning difficulties, and one death in the first three quarters had been subject to this review. Deaths perceived as being definitely or probably avoidable were subject to internal review and seven deaths had occurred in the first three quarters of 2017/18 which had been subject to this review.

In an acute trust, it was expected that 5% of deaths would be potentially avoidable and it was important that the Trust was able to identify and learn from these. Dr Wilkinson anticipated that as identification processes within the Trust improved, numbers of reported avoidable deaths would increase.

He reported that nine concerns had been raised by families following the death of a relative during the quarter. None of the patients were identified as having received poor or very poor care.

Mr Clayton-Smith asked whether staff were finding the process helpful and Dr Wilkinson replied that the process was valuable as it made staff look differently at what they could learn when patients died. He explained that interest in Learning from Deaths had been high and anticipated that reviews of deaths would continue to improve.

051/2018 **Quality Improvement Priorities 2018/19**

Ms Carruth reported that the Quality Account was an annual report produced by the Trust which included the Trust's quality improvement priorities for the upcoming year. These were developed in conjunction with staff, public and stakeholders. Priorities recommended for 2018/19 would be:

- Reduction in the number of avoidable falls
- Reduction in avoidable grade 3 and 4 pressure ulcers
- Improved early recognition, escalation and treatment of the physiologically deteriorating patient
- Continued Implementation of the Excellence in Care programme
- Improving patient discharge
- Improving seven day services
- Continuing to improve End of Life Care
- Improving young people's experience of being in Hospital

Progress and assurance would be reported to the Q&S Committee.

Mrs Chadwick-Bell reported that Executives and the CCG had approved the priorities. Ms Carruth agreed to meet with Mrs Churchward-Cardiff and Mrs Bernhauser to discuss and agree the priorities and would report back to the Board in August. **VC/JCC /SB**

052/2018 **ESBT Update**

Mr Clayton-Smith presented a draft Impact and Learning Report on the ESBT Alliance Test Bed Year 2017/18. He explained that a further review of the document would be undertaken and that future iterations would be presented to the Board as they became available.

053/2018 **Six Month Update on Emergency Preparedness, Resilience & Response Standards**

Mrs Chadwick-Bell presented an update on the Trust's Emergency Preparedness, Resilience & Response (EPRR) standards. She explained that she had previously presented on EPRR to the Board in November 2017 when the Trust had assessed itself as being partially compliant against core standards. She hoped that the Trust would be substantially compliant by August 2018, noting that a new Head of Planning and Business Continuity had been employed by the Trust in March 2018. EPRR steering groups had been re-established and saw good membership with policies being updated and due for ratification shortly.

Mrs Chadwick-Bell explained that lessons learned following the major incident

at Birling Gap and a flood on Gardener Ward were reflected in new plans. Next steps had been agreed, including a full review of corporate business continuity plans, and further work on a mass casualty plan which would link to the trauma network. She noted that Ian Taylor, who had been the Emergency Planning Officer for the Trust for many years, would be moving to a new Trust and thanked him for his work during his time with the Trust.

Mr Stevens noted that he was the nominated NED for EPRR and felt that the Trust was much stronger in this area than had previously been the case. Reports that were produced following incidents were impressive. He noted the value of undertaking multi-agency practices of serious incidents if possible.

Mr Clayton-Smith asked whether cyberattacks were included within EPRR and Mrs Chadwick-Bell confirmed that measures were reviewed on an annual basis, or whenever new information was made available.

Mr Clayton-Smith asked whether the revised EPRR plans considered local authorities and ESBT. Mrs Chadwick-Bell explained that while the plan was the Trust's, regular interagency meetings were held at local and regional levels to ensure that plans of NHS organisations, local authorities, police and fire services all interlinked.

054/2018 **Clinical Negligence Scheme for Trusts Maternity Incentive Scheme**

Ms Blanchard-Stow reported that in January 2018 NHS Resolution had written to Trusts about the Clinical Negligence Scheme for Trusts (CNST) incentive scheme, available for Trusts compliant with ten different safety actions in maternity. The scheme allowed compliant Trusts to reclaim 10% of their contribution to CNST as a reflection of the improved quality within the organisation. She thanked the maternity team for their hard work in collecting and collating the evidence that was need to show that the Trust was compliant in all ten areas.

Mr Clayton-Smith asked how the Division were assured that the Trust was compliant with all ten measures and Ms Blanchard-Stow explained that the scheme was self-certified. PA Consulting had been involved in the process and had provided external assurance that the Trust's assessment was accurate. Mrs Wells suggested that the Trust could expect to be asked to submit evidence about the assessment at some point in the future, and Mrs Churchward-Cardiff asked whether peer review of the evidence had been considered. Mrs Blanchard-Stow explained that the deadline for submitting the Trust's return was the end of June, but agreed that peer review would be beneficial even post-submission.

Mr Clayton-Smith explained that he was happy with the assurances provided about the evidence. He agreed that arranging a peer review would be helpful.

055/2018 **Delegation of approval of Quality Account 2017/18**

Mrs Wells explained that the deadline for submission of the annual Quality Account was 30th June. She asked the Board to delegate authority to either Dr Bull or Mrs Churchward-Cardiff to sign off the Quality Account on behalf of the Board, noting that the document would be formally presented to the Board at the AGM in August.

Delegation approved

056/2018 **Health & Safety at Work policy**

Ms Carruth presented the updated Health and Safety at Work policy to provide assurance to the Board about the improvements that had been made in the organisation.

Mr Nealon asked whether the policy considered GDPR and data confidentiality. Mr Reid explained that GDPR was not included within the policy and updated that the Trust had not been 100% compliant with GDPR regulations at its launch, but that it had a detailed action plan for becoming compliant. Assurance about compliance would be received by the Audit Committee.

Mr Clayton-Smith asked whether appropriate resources and support were available to allow the Trust to comply with the policy. Ms Carruth explained that compliance would be challenging, in common with many other Trusts. Training was being reviewed to ensure that it was a priority for the organisation and she felt that the Health and Safety team were manging the challenge well.

Noted

057/2018 **Board Subcommittee Minutes**

The following sub-committee minutes were reviewed and noted:

- Audit Committee 28th March 2018
- F&I Committee 28th March 2018
- POD Committee 14th March 2018

The Minutes were received by the Board

058/2018 **Use of Trust Seal**

Mrs Wells noted that the Trust Seal had been used to seal a Lease Agreement Lease between Assura HC UK Ltd and ESHT for the lease of the Health Centre at 21 Fairlight Road, Hastings on 26th April 2018.

059/2018 **Questions from Members of the Public**

Drivers of deficit

Mr Smart explained that he had attended a CCG meeting in public the previous week and that the CCG had been given a target of a £32m deficit. He noted that the Board papers had explained that the Trust would be going out to tender for analyses of the drivers for the reasons for the deficit and asked for information about the tender. Dr Bull replied that the Trust already had a good understanding of the issues that drove the deficit, and the work, to be undertaken by PWC, would build on this existing information.

Ward reconfiguration

Mr Smart asked about plans to reconfigure wards within the Trust and Dr Bull explained that the reconfiguration was part of drive to make organisation as cost effective as possible. One of the biggest costs to the organisation was staff and beds, and the Trust had seen continued improvement for length of stay of non-elective patients from over six days on average to under four.

Extensive planning had been undertaken to review the use of beds in the organisation, and as consequence a rebalancing of beds between medical and surgical wards would be undertaken. Plans also included flexing the bed base on a seasonal basis, with less beds open during the summer.

Pevensey Day Unit Air Conditioning
Mr Campbell asked whether the air conditioning on Pevensey Day Unit at EDGH was operational and Mrs Chadwick-Bell agreed to check and to respond directly to Mr Campbell. **JCB**

Public Toilet Cubicles
Mr Cambell noted that space in cubicles in the public toilets at EDGH was very limited and raised concerns about how anyone who was taken ill could be helped. Mrs Chadwick-Bell said that she would work with the Estates and Facilities staff to review the issue.

Over Expenditure
Mr Campbell asked whether any over-expenditure incurred during the year could be absorbed during rest of year or if the forecast outturn would reflect negative figures moving forward. Mr Reid noted that the Trust had been £100k better than plan in month one. He explained that where there was deviation in expected performance, then planning was undertaken with Divisions to ensure that this would be recoverable.

Intranet
Mr Hardwick asked about the occasional references to the Intranet made during the meeting and whether this was just for employees. Dr Bull confirmed that the Intranet was for Trust employees, and included telephone directories, policies and other useful information.

060/2018 **Date of Next Meeting and AGM**
Tuesday 7th August 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 5th June 2018 Trust Board Meeting

Agenda item	Action	Lead	Progress
028/2018 – IPR Month 11 - Access and Responsiveness	Mrs Chadwick-Bell agreed to verify whether data about readmission rates for patients seen by crisis response teams was correct.	**JCB**	5th June 2018: Confirmation that data is correct given to Board. Clinical audit to be undertaken to fully understand issue and will then report back to Board. 7th August 2018: Update to be provided at Meeting
049/2018 – IPR Month 1 - Leadership & Culture	Miss Green and Mr Reid to update the Board on how establishment increases for 2018/19 have been budgeted.	**MG/JR**	Update to be provided at meeting
051/2018 – Quality Improvement Priorities 2018/19	Ms Carruth agreed to meet with Mrs Churchward-Cardiff and Mrs Bernhauser to finalise the Quality Improvement Priorities and would report back to the Board in August.	**VC/JCC/SB**	Complete

Quality Walks May and June 2018

Meeting information:			
Date of Meeting:	7th August 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?	

Summary:

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

16 services or departments have received visits as part of the Quality Walk programme by the Executive Team between 1st May and 30th June 2018. In addition to the formal programme the Chief Executive has also visited 18 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.

QUALITY WALKS REPORT, MAY AND JUNE 2018

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 May and 30th June 2018. In addition the Chief Executive also visited several departments and staff groups.

Date	Service/Ward/Department	Site	Visit by
1.5.18	District Nursing Service	Arthur Blackman Clinic St Leonards	Jackie Churchward-Cardiff
9.5.18	Jevington Ward	Eastbourne District General Hospital	Jonathan Reid
9.5.18	Irvine Unit	Bexhill Hospital	Jackie Churchward-Cardiff
11.5.18	Occupational Health Department	Conquest Hospital	Jonathan Reid
15.5.18	Special Care Dental Service	Ian Gow Health Centre Eastbourne	Miranda Kavanagh
21.5.18	Wellington Ward	Conquest Hospital	Jonathan Reid
29.5.18	Community Dental Service	Seaford Health Centre	Catherine Ashton
29.5.18	Scott Unit	Eastbourne District General Hospital	Monica Green
30.5.18	Health Visitors (Hastings Teams)	East Hastings Children's Centre Chiltern Drive	Miranda Kavanagh
31.5.18	Berwick Ward	Eastbourne District General Hospital	Catherine Ashton
4.6.18	Speech and Language Therapy Team	Conquest Hospital	Monica Green
5.6.18	Audiology Administration team	Avenue House Eastbourne	Jackie Churchward-Cardiff
12.6.18	Ambulatory Care Seaford 2 Ward	Eastbourne District General Hospital	David Clayton-Smith
18.3.18	Regional East Sussex Pulmonary Service (RESPS)	Conquest	Jonathan Reid
27.6.18	Community Dental Service	Arthur Blackman Clinic St Leonards	Lynette Wells
27.6.18	Tissue Viability Service	Eastbourne District General Hospital	Vikki Carruth

All 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 from the Executive Team has been received this has been passed on to the relevant managers for information.

Key Themes and Observations

Communication and Engagement

- There were good examples of multidisciplinary working observed and also good interagency working by the Health Visitors who work closely and effectively with East Sussex County Council staff and the District Nursing service that works positively with a number of different teams/agencies such as practice nurses, crisis response, care homes and Hospices.
- Audiology administration staff reported that being located away from the clinical and managerial teams can have a negative effect on planning and communication and the staff reported feeling somewhat removed from decision making.

Incidents Risks and Safety Issues

- Some staff commented that they are finding their uniforms uncomfortable as the material is too heavy and inflexible. The recent warm weather has increased this discomfort and many staff would like the opportunity to wear scrub uniforms instead.

Environment, Equipment and IT

- Storage remains a challenge for some areas leading to wards feeling cluttered and untidy.
- Community teams reported difficulties with the mobile tablets they are provided with citing issues such as dropped signals, slow or failure to upload information, freezing and transcription delays and felt this was their number one issue and a major cause of stress and clinical safety risk. They stated that the software was good but the tablets are unable to handle the data.
- Community staff also reported that the phones issued to them are very basic and do not enable email or internet access so for efficiency they revert to personal phones to contact each other. The trust phones do not allow tracking which is a safety issue as day staff work alone however they felt that if they had a phone with GPS it would offer greater safety for lone workers.
- Audiology staff reported constant very slow PC speeds and stalling so that it can take between 2-8 minutes to book a patient appointment. The department also has an audiology stand-alone IT system and their current PCs cannot cope with merging this with the Patient Administration System (PAS) nor are they able to include the new audit database that is a requirement of their recently awarded IQUIP accreditation

Staffing

- All staff spoken to commented that they felt well supported in their roles by senior staff
- The Clinical Orderly and Matron's Assistant roles are highly valued by staff.
- District Nurses raised a concern that they felt new initiatives implemented have done little to reduce their workload and have mainly resulted in a depletion of the skill mix in the teams, they felt that if the existing teams could be enhanced to cover the new initiatives rather than creating new teams they would be more efficient and effective.
- Health Visitors raised concerns that although there is currently enough staff a review is ongoing, and reported some anxiety about what the outcome might be, and if that might impact on the services they are able to offer to families.
- 18 months ago in the Speech and Language Therapy Department there was a 67% vacancy rate; this has now been reduced to 0 due to the efforts of the clinical lead who has developed the service to ensure there is a career pathway for staff and also became involved in national work in order to promote the department and service in East Sussex.

Good Practice / Service redesign

- The Irvine unit regularly takes nurses returning to practice and provides good support for those wishing to re-enter nursing. They also operate a flexible shift pattern to accommodate long days and shorter shifts and although this causes additional work for senior staff it provides greater flexibility for the nursing team, which is highly valued.
- It was noted that staff are generally keen to get involved in improvement projects

Education and Training

- Community staff felt that most study days available have a focus towards secondary care staff working in the hospitals and they felt issues and topics are not always tailored to their specific needs so would like the opportunity to review to ensure that the subjects offered are suitable for staff working in the community.

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.

Item 6Di - 25th July 2018 Audit Committee Summary

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. Board Assurance Framework
The Audit Committee discussed the proposal to amend the risk concerning CQC standards from amber to green in the light of the recent CQC inspection, and agreed to recommend this change to the Board.

3. Clinical Audit and Risk Register Review
The Diagnostics, Anaesthetics and Surgery Division reported that administrative support for governance and compliance remained a key issue. They explained that audit was becoming successfully embedded within nursing and clinical practice within the Division.

Estates presented their Risk Register, highlighting a number of areas of concern to the Committee. Prominent in these was the level of backlog maintenance within the organisation, and Estates provided assurance on how this issue was being managed.

4. Clinical Audit Update
The Committee discussed what actions were taken when Clinical Audits were abandoned within the organisation, a practice that had been greatly reduced as a result of improved processes. This was often a result of junior doctors leaving the organisation prior to completing audits, and the Committee was assured that any audits of clinical importance would be completed by colleagues.

5. Internal Audit
There had been eleven final audit reports issued, completing Internal Audit's work plan for 2017/18. . Two give "Limited" assurance, eight gave "Reasonable" assurance and one gave "Substantial" assurance demonstrating the trend of improved internal controls being seen within the Trust.

Internal Audit's Annual Plan for 2018/19 was approved by the Committee.

6. Local Counter Fraud Service Progress Report
A nationwide review of the risk of gambling addiction to both staff and patients was being undertaken. It was hoped that areas of weakness could be identified and a national plan of support developed.

7. DPST Toolkit Report
32 Information Governance breaches had been reported to date in 2018/19, an increase on the previous year. All of the breaches were low level, with none having to be reported, and it was felt that the increase was a result of improved awareness of Information Governance within the organisation.

8. Cybersecurity
Trust plans for improving cybersecurity were presented to the organisation. Cybersecurity was being reviewed across the region in the hope that a whole health economy approach could be taken. The effect that a breach of cybersecurity in a neighbouring organisation could have on the Trust was discussed.

9. Clinical Research Annual Report
Clinical Research presented their annual report to the Committee, and explained that the way that funding was assigned to the Trust by KSS would be changed in 2019/20. The Trust was performing well in meeting research targets in 2018/19, having almost met annual patient recruitment targets already. It was hoped that this would lead to additional funding in 2019/20.

Approved minutes of the meeting held on 24th May 2018 are attached for the Board's information.

Mike Stevens
Chair of Audit Committee

27th July 2018

Item 6Dii - 11th July 2018 People and Organisational Development Committee Summary

1. Introduction

Since the Board last met a POD Committee meeting was held on 11th July 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. CQC Well Led Domain Assessment

The Committee received a verbal overview from the Director of Corporate Affairs and the Assistant HR Director-OD & Staff Engagement of the submitted report. The CQC rated all services Good or Outstanding in the Well Led Domain following the report in March 2018, with an overall rating for the Trust as Good.

It was agreed that the Committee will continue to review the Trust progress in line with the Well Led Domain.

4. Medical Engagement Update

The Committee received a verbal overview from the Medical Director of the submitted report. It was highlighted that:

- Ophthalmology department were more engaged and working together, however the volume of work continued to be an issue
- Concerns remained with gynaecology; being addressed
- Schwartz rounds remain popular
- Improved CQC report led to more doctors applying for posts within the Trust
- Work underway with the BMA on the SAS doctors charter and autonomous working
- 2018 Junior Doctors survey results showed a reduction in red flags.

5. Retention of Allied Health Professionals (AHPs)

The Committee received a verbal overview from the Associate Director of AHPs of the submitted report. It was highlighted that the turnover rate for AHPs were increasing and a review of exit interviews would be undertaken on highest turnover areas; a full report to be presented at the September meeting.

6. Apprenticeship Update

The Committee received a verbal overview from the Assistant Director of HR - Education, of the submitted report. It was highlighted that the position had improved since last year (current numbers of staff on programme: 133), weekly team meetings were taking place to provide a better overview on the current position and the department were working closely with divisions. A decision had not yet been made regarding the suggested 10% Apprenticeship Levy Transfer to the STP to support the wider health economy partners who are not able to access the levy.

7. Integrated Workforce Planning update and Workforce return to NHSI

The Committee received a verbal overview from the Head of Workforce Planning, Information & Resourcing, of the submitted report. Key headlines discussed were:

- Successful integration of workforce planning within the ongoing Business Planning process
- New ways of working and a new suite of HR workforce reports introduced

- Improved engagement and confidence in workforce systems and tools
- Development of workforce plans with all divisions and support services
- Workforce analytics developed to support deep dive reviews
- Actively engaged in local and regional workforce planning.

8. The Workforce Race Equality Standard (WRES)

The Committee received a verbal update from the Director of Corporate Affairs, of the submitted report. The WRES is a national initiative and a contractual requirement that has been in place since 2015 to

ensure equity. The WRES is a self-assessment tool and is annually reportable. The risks identified were:

- Junior doctors and career grade doctors have a higher number of staff not declaring ethnicity; this is under review to identify whether this is an administrative issue or a reluctance amongst these groups to declare

- Slightly fewer than 16% of staff reported in the staff survey that they had experienced discrimination at work from their manager, team leader or other colleagues on the grounds of ethnicity. These results will be incorporated into a BME Networks Action Plan.

9. 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 9th May 2018 are attached for the Board's information.

Miranda Kavanagh
Chair of POD Committee

11th July 2018

Finance and Investment Committee – Annual Review of Effectiveness

Meeting information:			
Date of Meeting:	7th August 2018	Agenda Item:	6
Meeting:	Trust Board	Reporting Officer:	Barry Nealon, F&I Committee Chair

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?	

Summary:

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

It is considered good practice for every Committee of the Trust to conduct an annual self-assessment review of its effectiveness. The attached report sets out the outcome of this review which was conducted via a questionnaire to all Committee members in June 2018.

Members agreed the Committee has effectively discharged its responsibilities throughout the year and that there is nothing it is aware of at this time that has not been disclosed appropriately.

A small number of recommendations to the structure of the agenda and Terms of Reference have been suggested.

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

None.

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

The Board is asked to note the report and the updated Terms of Reference.

East Sussex Healthcare NHS Trust

Finance and Investment Committee - Annual Review 2017/18

1. Introduction

The purpose of this paper is to provide assurance to the Trust Board that the Finance and Investment Committee (F&I) has carried out its objectives in accordance with its Terms of Reference set by the Trust Board.

2. Authority and Duties

The F&I Committee is a sub-committee of the Board with responsibility for maintaining a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. Under delegated authority from the Trust Board, the Committee determines and reviews the:

- Financial strategy for the Trust
- Future financial challenges and opportunities for the Trust
- Future financial risks of the organisation
- Integrity of the Trust's financial structure
- Effectiveness and robustness of financial planning
- Effectiveness and robustness of investment management
- Robustness of the Trust's cash investment approach
- Investment and market environment the Trust is operating in
- Financial and strategic risk appetite that is appropriate for the organisation
- Process for business case assessments and scrutiny and the process for agreeing or dismissing investment decisions depending on the above

3. Membership

The Committee is chaired by a Non-Executive Director of the Trust and has 2 Non-Executive Directors as members who are appointed by the Trust Chairman. The Chief Executive, Director of Finance, Chief Operating Officer and Director of Corporate Affairs and Associate Director of Strategy are also members.

Quoracy for the meeting is 3 members of which one must be a non-executive director. The Committee met 12 times during the financial year and there was one additional extraordinary meeting. All meetings were quorate.

4. Annual review of terms of reference and work plan

The Committee's Terms of Reference (TORs) were considered as part of the self-effectiveness review and it was agreed they remain fit for purpose. Minor revisions were proposed; specifically that the attendance of the Director of Strategy should not be optional as the post manages strategic and business planning which are part of the remit of the Committee, Divisions should be in attendance in relation to business planning to provide assurance to the Committee on the financial aspects of their plans and that reference to the need for the Committee "to be satisfied as to the effectiveness and reliability of the recording of clinical procedures which underlie the Trust's claims to income from the CCGs".

The Annual Work Programme was set at the start of the year as a standing agenda item was reviewed at every meeting of the Committee.

Matters considered in 2017/18 included:

- Oversight of Financial Special Measures Requirements including a review of governance arrangements
- Reviewing monthly operational and financial performance against the Trust's Financial Recovery Plan

- Divisional updates on assurance as required
- Review of 2017/18 forecast outturn and agreement of a variance from plan
- Review of the Long Term Financial Model and its assumptions
- Financial and business planning including 2018/19 budget setting
- The annual capital programme and regular updates against plan
- Reviews of all Business Cases over £250k in value
- Approval of the annual reference cost collection process, updates on the Costing Transformation Programme (CTP) and the audit of processes
- IMT project updates
- NHSLA cost update
- Quarterly reviews of EBITDA (Earnings before interest, taxes, depreciation, and amortisation) and a programme of regular rolling reviews of specialties with negative EBITDA
- Estates and energy planning
- Regular review of the cash flow including aged debtors
- Tenders and Service developments
- Updates on Operational Productivity Programme (Lord Carter) bed modelling and Clinical Services Strategy
- Progress on Sussex and East Surrey STP and East Sussex Better Together

5. Annual Self-Assessment of Effectiveness

In June 2018 the Committee undertook an annual self-assessment of its effectiveness.

Members agreed that the number of Committee meetings held had been sufficient and that the financial position of the Trust means there is little opportunity to reduce the frequency at this stage.

It was agreed that the agenda is appropriately structured, however, it was noted that the agenda and reports are too long which can affect the Committee's ability to discharge its responsibilities effectively. It was considered that the new improved financial reporting in part has addressed the issue of the Committee receiving too much information. The issues reviewed were deemed appropriate however, further details should be made available on contract performance, the content and deliverability of Cost Improvement Programme and more focus should be given to financial risk as outlined in the TORs.

Members agreed matters considered and decisions made by the Committee were taken on an informed basis based on the information presented and where appropriate additional details were requested and provided. These decisions were understood, owned and properly recorded and would bear scrutiny. Subsequent implementation of decisions and progress had been reported back to the Committee although it was recognised this could be strengthened.

An effective feedback mechanism from the F&I to the Board is in place, with the minutes being received and matters highlighted by the Committee Chair at each Board meeting.

6. F&I Chair's Overview

In October 2016 the Trust was placed in Financial Special Measure by NHS Improvement. The Trust remained in deficit in 2017/18 and the financial recovery plan was updated. Close scrutiny by NHS Improvement of the financial plans has continued and the F&I Committee has closely monitored progress in delivering this.

Whilst acknowledging the scale of the financial challenge faced by the Trust, the F&I Committee have been clear in its position that all cost improvement and efficiency plans should have no adverse impact on quality or safety. The Committee received assurance that an effective quality impact assessment process was in place.

In previous years budget targets have not always been met and throughout the year the Committee continued to seek Executive assurance that effective grip and control existed and this will continue into the future to ensure the ownership and delivery of the demanding financial targets.

During 2017/18 the Trust continued with its involvement in East Sussex Better Together and the STP. In the coming year the wider health economy is also under significant financial pressure and a new System Financial Recovery Board is in place. The Committee will continue to take an interest in these developments and ensure potential financial risks to the Trust arising from these discussions are mitigated as much as possible.

On behalf of the Committee, I would like to place on record our thanks to the PA to the Finance Director, who so ably provides administrative support.

The Committee is of the opinion that it has effectively discharged its responsibilities throughout the year and that there is nothing it is aware of at this time that have not been disclosed appropriately.

Barry Nealon
Finance & Investment Committee Chairman
27 June 2018

Appendix

East Sussex Healthcare NHS Trust

Finance and Investment Committee - Terms of Reference

1. Constitution

The Trust Board has resolved to establish a committee of the Board to be known as the Finance and Investment Committee (the Committee). The Committee is a 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 Board of directors.

2. Purpose

The Finance and Investment Committee should provide recommendations and assurance to the Board relating to:

- Oversight of the Trust Financial Strategy including a review of future financial challenges and opportunities for the Trust
- The future financial risks of the organisation
- The integrity of the Trust's financial structure
- The effectiveness and robustness of financial planning
- The effectiveness and robustness of investment management
- The robustness of the Trust's cash investment approach
- The investment and market environment the Trust is operating in, and the process for agreeing or dismissing investment decisions
- The risk appetite that is appropriate for the organisation
- The process for business case assessments and scrutiny
- Review and approve business cases including tracking of delivery against plan and benefits realisation
- Monitoring the capital investment programme
- Undertake substantial reviews of issues and areas of concern.

3. Membership and attendance

The Committee and the Committee Chairman shall be appointed by the Chairman of the Board of directors. The membership of the Committee shall be as follows:

- At least three non-executive directors (one of whom shall be a member of the Audit Committee)
- Chief Executive
- Director of Finance
- Chief Operating Officer
- Director of Strategy, Innovation and Planning ~~(optional)~~
- Director of Corporate Affairs

4. Quorum

Quorum of the Committee shall be three members which must include a non-executive director and the Director of Finance (or his deputy). Nominated deputies will count towards the quorum.

5. Frequency

Meetings shall be held at least four times a year and at such other times as the Chairman of the Committee shall require.

6. Duties

The Committee shall review and monitor the longer-term financial health of the Trust.

In particular its duties include:

- Reviewing the financial environment the Trust is operating within, and supporting the Board to ensure that its focus on financial and business issues continually improves
- Supporting the Board to understand and secure the financial and fiscal performance data and reporting it needs in order to discharge its duties
- Understanding the market and business environment that the Trust is operating within and keeping the capacity and capability of the Trust to respond to the demands of the market under review
- Understanding the business risk environment that the organisation is operating within, and helping the Board to agree an appropriate risk appetite for the Trust
- Supporting the Board to agree an investment and business development strategy and process
- Supporting the Board to agree an integrated business plan
- Approval for business cases with a value between £250k-£500k and recommendation of business cases over £500k to the Board
- Ensure that business cases submitted for approval are in line with the priorities identified in the Board's agreed Development Plan
- Receive assurance and scrutinise the effectiveness of demand and capacity planning.

The Board may from time to time delegate to the Committee the authority to agree specific investment decisions over and above the annual financial plan provided that the amended plans:

- Do not compromise the Standing Orders and Standing Financial Instructions
- Do not adversely affect the strategic risk facing the Trust
- Do not adversely affect the organisation's ability to deliver its operational plans

The Committee will review the work of other Committees within the organisation whose work can provide relevant assurance to the Finance and Investment Committee's own scope of work; in particular this will include the Audit Committee and the Quality and Standards Committee.

At regular intervals, and particularly business planning, the Committee will receive updates from Divisions and seek assurance on the plans and actions in place.

7. Reporting arrangements

The minutes of the Committee meetings shall be formally recorded by the PA to the Finance Director 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 actions.

The Committee shall undertake a self-assessment of its effectiveness on at least an annual basis. The Director of Corporate Affairs will support the Committee to develop and implement an annual work programme

These terms of reference shall be reviewed by the Board of directors at least annually.

July 2017

Board Assurance Framework

Meeting information:			
Date of Meeting:	7th August 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?	

Summary:

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

Attached is the updated Board Assurance Framework (BAF). Revisions to the BAF are shown in red. The Board are asked to note the following:

2.1.1 Achievement of the 62 day cancer targets remains challenging and a number of actions are in place. It will be reviewed at Board under the performance section of the agenda.
4.1.1 There is only one area rated red related to Finance and this is reviewed at both F&I and Trust Board.
4.3.1 There has been positive progress in response to Fire regulations and East Sussex Fire and Rescue Service Trust have noted the Trust efforts to achieve the targets set and were impressed by the high standard of remedial works.

The following is recommended:

1.1.1 Following the publication of the CQC reports and the Trust's removal from special measures for quality it is proposed to move the assurance level from amber to green.

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

Quality and Safety Committee
Audit Committee

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

The Trust Board is asked to review and note the revised Board Assurance Framework and consider whether the main inherent/residual risks have been identified and that actions are appropriate to manage the risks. Agreement is sought for the gap in assurance related to quality move from amber to green.

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 Jul-18 CQC inspection report published; significant progress made in all areas inspected. Trust removed from Special Measures for Quality. Action plan developed for Must and Should Do identified by CQC. Ongoing work to continue with quality improvement to achieve "Outstanding" by 2020.	end Dec-18	▲ Jul-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-Sep 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. 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. Jul-18 62 day remains challenged particularly for colorectal and urology; additional adhoc activity continuing in both services. New Cancer Matron post to be appointed to in July to support surgical pathways. Contract Performance notice issued against 62 day performance; additional weekly OPEX call in place to monitor short term action plan. SCR upgrade to enable accurate monitoring of 38 day standard (applicable from 1st July) scheduled for deployment week commencing 16th July.	end-Dec18	◄►	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. Jul-18 Will be considered at the July Q&S meeting	end Aug-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. Scheduled 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. Jul-18 On track for end Aug go live as outlined above.	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. Participation in Acute Networks Steering group which is being facilitated by Carnall Farrar. Work ongoing to develop governance structures and framework for the ACO. 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 working together to consider provision of 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 to move system to a balanced financial position. Will be agreed by Alliance Exec and progress against plan 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 ongoing with commissioners and NHSi to agree and align our long term financial position and operational plan. Planning for 18/19 progressing with 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. Jul-18 First phase of the Long term financial plan and associated work on clinical sustainability is now complete and will be discussed at Trust Board seminar in July. This work has been shared with commissioners and NHSI whilst in development.	end Dec-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-Dec17 7 Day Service Steering Group established. Project support from PMO, with dedicated project lead assigned. Working closely with NHS England and NHS Improvement to gain best practice/lessons learnt from other Trusts 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. 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. 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 roll-out in Q1 2018-19. Guide to accessing investigations and interventions within Trust and with external providers 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. Jul-18 Further work with rheumatology and gastroenterology teams on pilot of patient stratification and ward round delegation at both sites. IT solutions to stratification and delegation currently awaiting the commissioning of new patient information system. Functionality for tendering specification currently being established to ensure that it is compatible with 7DS needs, including order comms. Simple signposting for teams on how to access specialist services inside and outside the Trust (eg neurosurgery, renal and radiotherapy). Medical rotas being redesigned to incorporate 24/7 (interventional) endoscopy. Visit to Southampton in August.	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.	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. Jul-18 NHSI have provisionally accepted the refreshed plan for 2018/19, which aims for a deficit of £44.9m and requires a minimum efficiency challenge of £19.2m. The Trust is working closely with PA Consulting and the Clinical Units to secure up to £23m of efficiency savings, and ensure delivery of the minimum requirement of £19.2m. As at M3, the identified pipeline is £29m, but only £15.5m of schemes are identified as green – with a route map in place to secure the balance. The Trust has appointed a Recovery Director, who commences work on 9th July, aimed at supporting delivery of the financial plan. At Month 2, and again at Month 3, the Trust is delivering plan, but with considerable additional activity, and hence income above baseline plan.	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. Jul-18 – The level of capital spend at Month 1-3 is below plan, reflecting the strategy of carefully managing capital approvals until the financial arrangements for each component of the plan are secured. The Trust is making good progress with a number of key stakeholders to secure the additional capital investment for the MRI and estates works, and it is anticipated that NHSI approval for the capital loan agreements will be sought in August with the aim of reaching agreement in September.	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. Jul-18 ESFRS visited 28th of June and noted Trust efforts to achieve the targets set and were impressed by the standard of fire stopping work noting the high standard of remedial works. Seaford and Hailsham on track for completion by the end of June18 when the risk of fire spread will be considerably lower. A business case was drafted with support from Arcadis and approved by the Trust Board in June 2018 and has subsequently been submitted in the STP wave 4 bids @ £11.16m.	end Dec-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. Jul-18 STP wide Cyber security framework being proposed with the aim to adequately address security concerns. If this does not get adopted STP wide it may be adapted and implement locally. Paper going to STP digital board July 2018 New Patching policy developed and approved. More aggressive patching regime for PCs and laptops in place, aim to be no further than 1 month behind Windows operating system patch release dates New process introduced to manage Carecert security alerts to improve response and action Signed up to the national Windows 10 licencing agreement. This also requires implementation of Microsoft advanced threat protection (ATP) which is a solution that will monitor for threats on PCs and Laptops. Threats are reported nationally to NHS digital along with local reporting. Letter from Will Smart to CIO's has stated that all Trust should ensure that every board has an executive director as data security lead	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	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. Jul-18 Continued Headhunter activity to address Hard to Recruit posts, particular emphasis on ED and Consultants. Ongoing International Nurse recruitment with 35 Nurses due to join the Trust between July-January 2019. All areas except Medical workforce showing declining vacancy percentage run rate May 2018 vs May 2017. Targeted social media activity for specific areas e.g. Endoscopy. A newt rust-wide group has been set up to look at Strategic Workforce issues with sub-groups for each profession. This will be developing a long-term workforce strategy related to the clinical strategy.	end Apr-19	◄►	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 National Staff survey; working on the three corporate priorities and each division has own action plan. Staff FFT identified increase in 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 about what they feel will make a difference. Renewed focus on medical engagement .Consultants and SAS doctors asked their views on working at the Trust via the national medical engagement survey. Divisions continue to look at different ways to improve staff engagement. Seeking to improve how we are involving staff in decisions. Nov-17 Continued work on ensuring staff feel valued and wellbeing is key priority. Unsung Heroes 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 Results will be shared with divisions and corporate priorities agreed at POD Committee in March-18 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. Jul-18 June CQC report highlighted positive engagement work that the trust was doing internally and externally had supported cultural change. We continue to increase our response rate to Staff FFT currently 27%. 80% of respondents would recommend the trust to a friend or family as a place to work. All divisions have action plans in place to respond to any issues raised and progress updated regularly. Organisation was one of three trusts out of 235 trusts to meet the CQUIN for Staff Health and Wellbeing.	end May-18	◄►	HRD	POD SLF

Chief Executive's Report

Meeting information:	
Date of Meeting: 7th August 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?	

1. Highlight issues

Mortality indices for the Trust have improved considerably over the last year. RAMI (Risk Adjusted Mortality Index) from May 2017 to April 2018 (rolling 12 months) is 78 compared to 89 for the same period last year (May 2016 to April 2017). SHMI (Summary Hospital-level Mortality Indicator) has fallen from 111 in March 2017 to a latest figure of 104. This improvement has been brought about by a variety of improvements to clinical care, in particular more rapid senior assessment. One of the most significant improvements has been in the treatment of sepsis. The vast majority of patients now get their antibiotic treatment within 1 hour. This has resulted in the RAMI for septicaemia falling from 124 in September 2016 to 79 in March 2018. This is a remarkable achievement - although there is room for further improvement in certain aspects of care such as recognition of sepsis developing after admissions.

The significant improvements in our operational performance for urgent care, ED attendance, and planned elective care have been maintained. In April our 2 week performance for cancer referrals fell below target for the first time in over 2 years although, thanks to the commitment of all relevant teams, this was recovered in May. Our 62 day performance remains below target. In part this is due to a significant increase in 2 week wait referrals into breast, colorectal and urology services, linked to capacity constraints in some specialties, notably Urology. There is more detail below and in the main report.

A core element of our Cost Improvement Programme (CIP) is to realise the benefits of our significant reduction in lengths of stay and resulting reduction in bed requirements. Analysis and recent experience shows that the Trust has reduced its bed requirement by over 10%, while needing to retain escalation capacity for periods of high demand. The plan to reduce beds by some 74 (3 wards) and re-align beds between medicine and surgery has been developed for implementation. A consultation with over 200 members of staff potentially affected by these changes has been held. (Note – it has been made clear that there is no risk of redundancy, nor of required transfer between sites). The final details of the proposals are being agreed for implementation in August. The rapid

reduction in bed requirement enabled the early closure of Folkington ward (for medically fit patients) although the recent surge in demand has necessitated reopening this for acutely ill patients as an escalation capacity.

The Trust remains on plan at month 3. Increased urgent admissions have driven both higher revenues and costs than plan. We are working with the CCG to address the challenges that this level of urgent care will cause the system. We have not yet reached our target of 'green rated' CIP initiatives. The work on this continues.

The Trust annual awards were held in July at the De La Warr Pavilion. Over 330 nominations had been made for the awards. 200 people attended the event including the shortlisted finalists, sponsors, representatives of the County Council and partner organisations, and other organisations such as HealthWatch. The event was enjoyed by all who attended. A number of people who have worked for the organisation or its predecessors for over 40 years were presented with their long service award. The occasion was a good opportunity to highlight the examples of excellent work that is done across the organisation by teams and individuals who are fully committed to excellent patient care.

2. Quality and Safety

The Excellence in Care programme continues to be rolled out across the wards, with twelve wards now live on the system. We have continued to see the rate of falls at 6.2 per 1000 bed days which is above last year's end of year figure of 5.6 per 1000 bed days. There were no acute or community acquired grade 3 or 4 pressure ulcers in May. VTE Risk Assessment compliance has recovered to above 95% in Q1. Newington ward was temporarily closed due to confirmed Norovirus in July. A locum NHS Consultant Microbiologist has been appointed to start at the end of August which will reduce pressure on this service.

3. People, Leadership and Culture

International recruitment is continuing in the Philippines and Indian sub-continent for Medical and AHP staff groups. 30 International Nurses will join the Trust by January 2019. 68 Nurses are in the recruitment pipeline.

NHSI Workforce Registered Nurse Retention Strategy Update – ESHT hosted an NHSI site visit on Friday 29th June to review workforce data. There was positive feedback and agreement of approach with ESHT workforce reporting techniques being adopted by National NHSI Data Team. From the latest model hospital data, retention of nursing staff is the highest in the country other than the north / north east and is the best within both KSS and the South region.

Use of the e-rostering system for doctors that was rolled out last year is increasing. Current job plans have been loaded on to the system and are being reviewed through annual cycle or service review. Tracking of total PA's used per service is to be included in FRP work. 73% of Doctors are actively using system to book leave or view rosters. Regular report provided to reflect weekly activity. Approval of annual and study leave requests is more efficient as a result.

The monthly compliance sessions for nursing staff continue, with new workforce profiling reports being implemented to promote effective planning and efficient deployment of resource for ward based nursing. Further controls have been put in place to manage tightly the additions of shifts above template.

4. Access and Delivery

The Trust has recovered its 4 hour standard through June and into May following the winter period, and as a system is performing within the top quartile and often top 20 Trusts in the country, now consistently achieving above 90%. This is in the context of increased demand on the previous year.

The hot weather has however affected some of our population and as such we have seen a large increase in admissions at EDGH, specifically with respiratory and stroke conditions. The escalation capacity created by the reduction in beds has been opened to accommodate this.

We are working with the CCGs to manage demand and will be focusing on ambulatory care, re-admissions and frailty through improving pathways and workforce models.

The challenge in meeting cancer performance targets is highlighted above. There has been an improvement in wait times through April and May, most noticeably in breast and colorectal services. Our key areas of focus remain:

a) colorectal (lower GI), where we are introducing a straight to test (endoscopy) pathway along with other efficiency initiatives. We are also working to introduce the Faecal Immunoglobin Test for haemoglobin which will significantly reduce the numbers of patients on the two week pathway for this condition

b) urology where a service re-design is being planned to introduce a new 28 day pathway (referral to diagnosis). Pathway redesign is also being undertaken to take full advantage of the new Urological Investigation Suite and improved inpatient facilities that are planned to be complete this year.

We are implementing the standard interventions recommended by NHSI to improve our cancer performance. A number of these (such as specialty specific patient waiting list reviews, root cause analysis of breaches, and direct management to avoid 104 day delays) are in hand. A fuller update will be provided to the Board at the next meeting.

5. Communication and engagement

The Trust received a significant amount of positive media coverage relating to the 70th birthday of the NHS. A number of double page features were published in the main local newspapers, including archive images and photographs of the Trust's celebrations during the week. The Cardiology department featured on a Meridian TV's 70th anniversary special broadcast, highlighting advances in cardiology. A nurse from the Philippines also featured in a BBC World Service 70th anniversary feature. Our 70th celebrations were supported by a number of wards and departments joining the NHS7tea party. Our giant birthday cards, made up of 1000 pictures of members of staff through the ages, were popular and generated hundreds of birthday wishes. An exhibition in Bexhill, Conquest and Eastbourne hospitals focused on national and local milestones over the past 70 years. We also published a 70th edition of ESHT news which included a 70th pull out. Dedicated webpages with information, images and video clips about the local NHS will form the basis of a historical archive.

Over this period we also sought to engage with members of the public about specific issues, we began a survey of teenagers, asking them about the ward environment and what they would like to change. We also held a forum with members of the public, including those from disability groups and older peoples groups to talk to them about our proposals for wayfinding and signage at Eastbourne DGH. During Experience of Care week we released short video clips of members of staff and patients talking about their experiences of care in our hospitals.

The Trust's social media presence continues to improve – we now have over 10,000 followers. We tweet a variety of news, public information and campaigns specific information aimed at members of

the public. We received nearly 20,000 impressions (people looking) at our tweets during the Trust awards night, with another 12,000 the next day. June was our best month so far with nearly 105,000 impressions in total.

We received positive coverage about our exit from special measures for quality following the Trust's most recent CQC report – this was also shared widely on social media and received over 13,000 impressions. We received a wide range of plaudits about this achievement, including from the former Secretary of State for Health, our local MPs and local Healthwatch.

East Sussex Healthcare NHS
NHS Trust

Month 3 – June 2018

TRUST INTEGRATED PERFORMANCE REPORT

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East Sussex Healthcare NHS Trust

Contents

1. Summary
2. Quality and Safety
3. Access and Responsiveness
4. Leadership and Culture
5. Finance
6. Strategy and Sustainability
7. Activity

East Sussex Healthcare NHS
NHS Trust

June 2018

Key Successes

- The Trust achieved the 95% standard for 4 hours.
- Improvements in performance were seen in diagnostics and cancer 62 days.

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

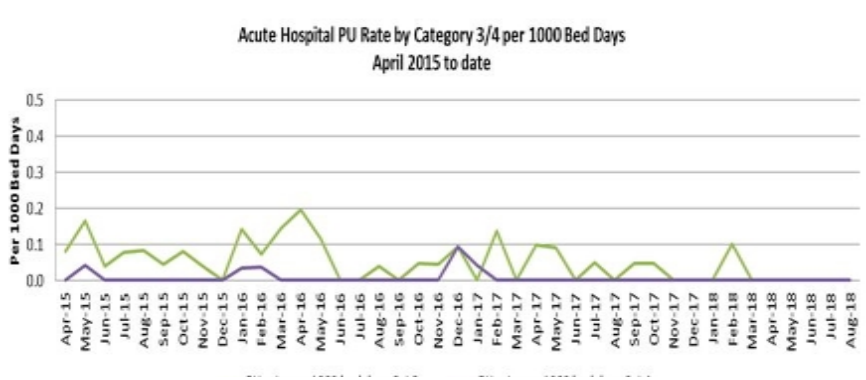
East Sussex Healthcare NHS
NHS Trust

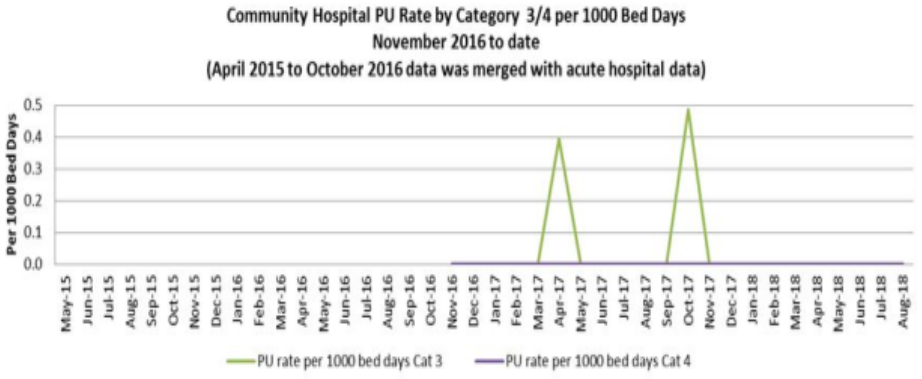
Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-17	Jun-18	Var	2017/18	2018/19	Var		
Total falls	M	139	126	-9.4%	427	392	-8.2%	131	
Number of no-harm falls	M	104	74	-28.8%	323	278	-13.9%	96	
Number of minor/moderate falls	M	35	52	48.6%	104	113	8.7%	34	
Number of major/catastrophic falls	0	0	0	0	0	1	1	1	
All patient falls per 1000 Beddays	5.5	6.2	6.1	0.0	6.0	5.9	-0.11	5.4	
All patient falls with harm per 1000 Beddays		1.6	2.5	1.0	1.5	1.6	0.14	1.5	
Falls assessment compliance	M	88.5%	92.9%	4.4%	89.7%	92.1%	2.5%	83.5%	
Total grade 2 to 4 pressure ulcers per 1000 Beddays	M	2.0	1.0	-50.2%	2.3	1.6	-30.4%	1.9	
Number of grade 2 pressure ulcers	M	40	20	-50.0%	149	111	-25.5%	42	
Number of grade 3 to 4 pressure ulcers	M	4	0	-4	12	1	-11	2	
Pressure ulcer assessment compliance	M	88.5%	96.8%	8.3%	87.9%	98.0%	10.1%	83.8%	
Safety Thermometer overall score	92.0%	90.8%	91.1%	0.2%	92.3%	91.4%	-0.9%	92.3%	
VTE Assessment compliance	95.0%	96.8%	96.4%	-0.4%	97.0%	96.2%	-0.8%	95.9%	

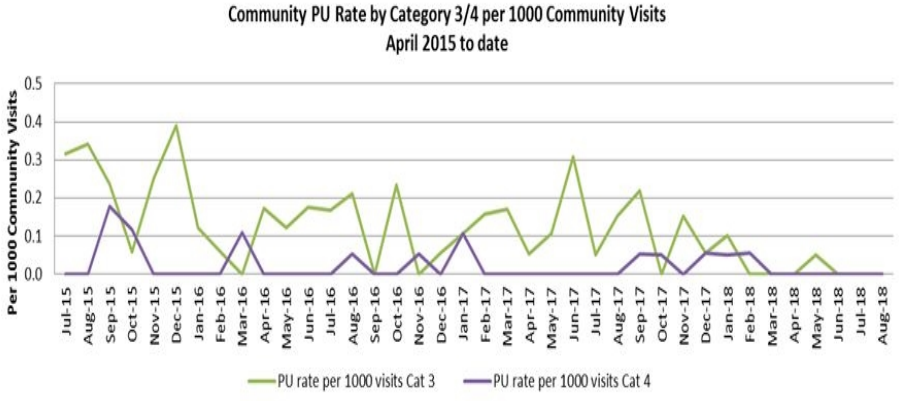
- Please note: The falls and pressure ulcers by bed days are still subject to change as the bed day figures change for at least 4 months after the initial report.
- The percentage of no harm/near miss patient safety incidents is 77% (national figure 73%).
- The number of patient falls reported in June has increased from May. The wards using the new combined assessment and care plan has increased and roll out continues. There needs to be a focus on the highest reporting areas to ensure they are doing all possible to prevent a patient from falling. These wards are Irvine Unit, Acute Medical Unit, Rye, Baird, Newington, Berwick and Benson Ward.
- As from July 2018 the Trust has ceased the collection and reporting of Safety Thermometer Data and will rely on the Excellence in Care data alongside other measures of falls, pressure ulcers and patient safety incidents.
- There was 1 Clostridium Difficile Infection (CDI), and 5 Ecoli Bacteraemia's during June . The reviews are on-going.

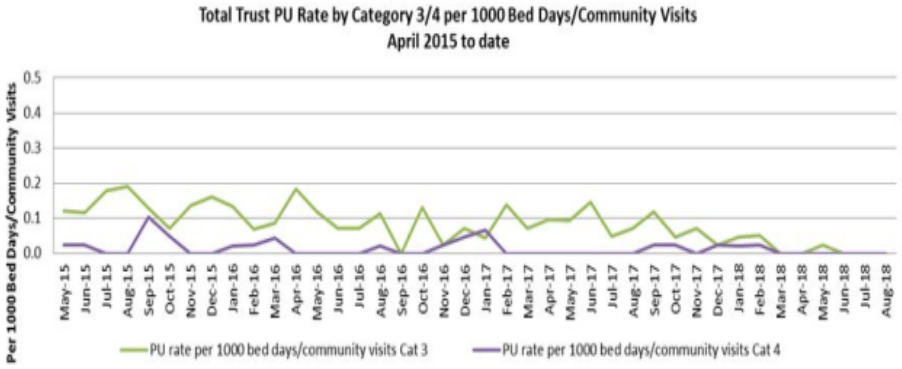
PRESSURE ULCERS – Grade 3 & 4 – June 2018

East Sussex Healthcare NHS
NHS Trust









Total ESHT acquired for June (cat 2s, 3s and 4s) = 21; a significant decrease from 58 in May.
Snapshot deep dive for grade 2 PU completed and report went to Quality and Safety Committee in July 2018.
The graphs above detail the total Trust category 3 and 4 pressure ulcers for April 15 to date.

Acute hospital acquired - cat 3/4 = 0
Community hospital acquired - cat 3/4 = 0
Overdue RCAs for grade 3/4 - three not yet sent.

East Sussex Healthcare NHS
NHS Trust

Serious Incidents (SI) reported in June

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-17	Jun-18	Var	2017/18	2018/19	Var		
Number of Serious Incidents	M	5	1	-4	13	9	-4	4	
Number of Never Events	0	1	0	-1	2	0	-2	0	

There was **1 serious incident** reported during June 2018 which involved a delay to diagnosing a potential cancer that was identifiable back in 2015. This investigation is underway by the Governance Team.

General themes from Serious and Amber incidents involve the robustness of documentation along the patient pathway and incomplete risk assessments (such as falls).
A full breakdown of all Serious Incidents reported over the last 6 months was presented to the Quality and Safety Committee for scrutiny in July.

Serious and Amber (Moderate) Incident Management and Duty of candour
There are currently 15 Serious Incidents open in the system all within the correct timescales. The Amber incident backlog is receiving increased scrutiny from the Quality and Safety Committee and the Patient Safety and Quality Group to drive down the number overdue.
Duty of Candour compliance for all moderate and above harm incidents is at 87% informed verbally, 95% followed up in writing and 93% findings shared with patient or family upon completed investigation.

Excellence in Care
Thirteen wards now live on the system. Leadership and Culture measures produced and will be in the dashboard for August with July data. Monthly reports sent out to the wards and their leadership team to review and act on the findings.

PATIENT EXPERIENCE

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-17	Jun-18	Var	2017/18	2018/19	Var		
Inpatient FFT response rate	45.0%	36.2%	45.7%	9.5%	34.1%	41.7%	7.6%	42.2%	
Inpatient FFT score	96.0%	97.4%	97.9%	0.5%	97.1%	97.9%	0.7%	97.4%	
A&E FFT response rate	22.0%	7.8%	3.9%	-3.9%	8.1%	4.4%	-3.7%	7.3%	
A&E FFT score	88.0%	85.4%	91.5%	6.1%	87.4%	94.1%	6.6%	90.8%	
Outpatient FFT Score	M	96.3%	98.9%	2.6%	95.9%	97.6%	1.7%	96.4%	
Maternity FFT response rate	45.0%	37.3%	13.6%	-23.7%	41.0%	5.2%	-35.8%	22.5%	
Maternity FFT score	96.0%	97.4%	100.0%	2.6%	98.2%	100.0%	1.8%	98.4%	

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

The A&E response rate remains low therefore reducing the quality of feedback. Inpatient has high response rate and high satisfaction score so a good indicator of quality.

NHS Choices

- Overall rating at EDGH = 4 Stars Overall rating at Conquest = 4.5 Stars

Examples of FFT/ questionnaire comments in June:

Positive;

- All the team were caring and friendly. Nothing was too much trouble. Thank you. (Hailsham 4)
- All care. Everyone was fantastic. Maddie gave me a particularly warm welcome. Immediately put me at ease and made me feel special. The best experience out of my 3 hospital stays (Irvine Unit)
- All staff were so cheery helpful and supportive. All staff on shift worked wonderfully together (Mirrlees)

Negative;

- Communication about treatment and diagnosis could be better. No one seemed to know and at times this was stressful and confusion about what and was/wasn't allowed to do using bathrooms etc (Baird Ward);
- Doctors should come when they say they will because I was told the day I asked 5 times to see the doctor and I didn't see one all day in the end (Seaford 1)

MIXED SEX ACCOMMODATION

East Sussex Healthcare NHS
NHS Trust

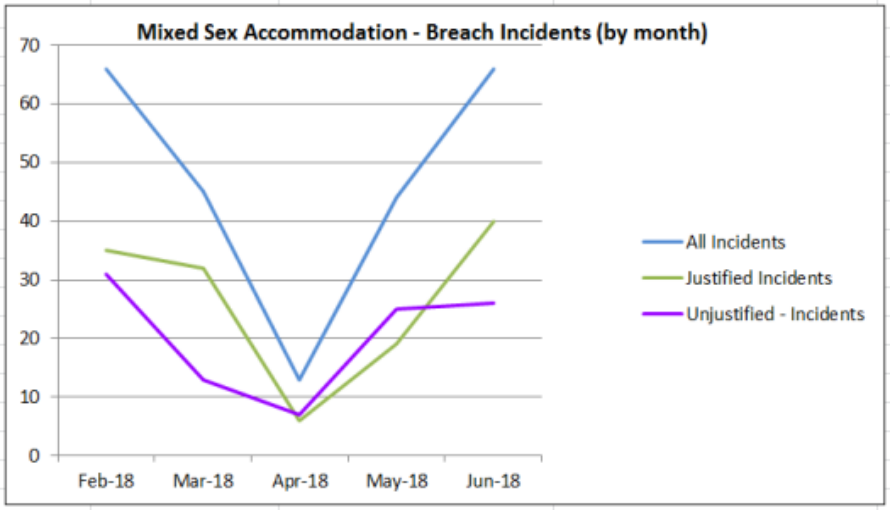
In June the total number of incidents (justified and unjustified) was 66

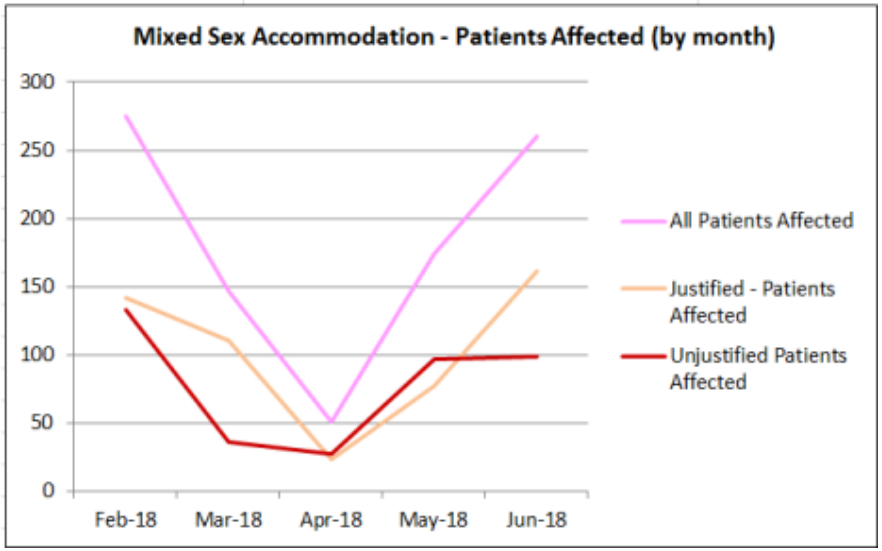
Following the validation process the number of unjustified incidents reported to the Unify system was 26, affecting a total of 99 patients.

ESHT is currently participating in the NHSI Mixed Sex Accommodation Collaborative.

Enhanced discharge work on the wards has been implemented and this should assist in reducing the number of MSA breaches due to increased bed availability on both sites.

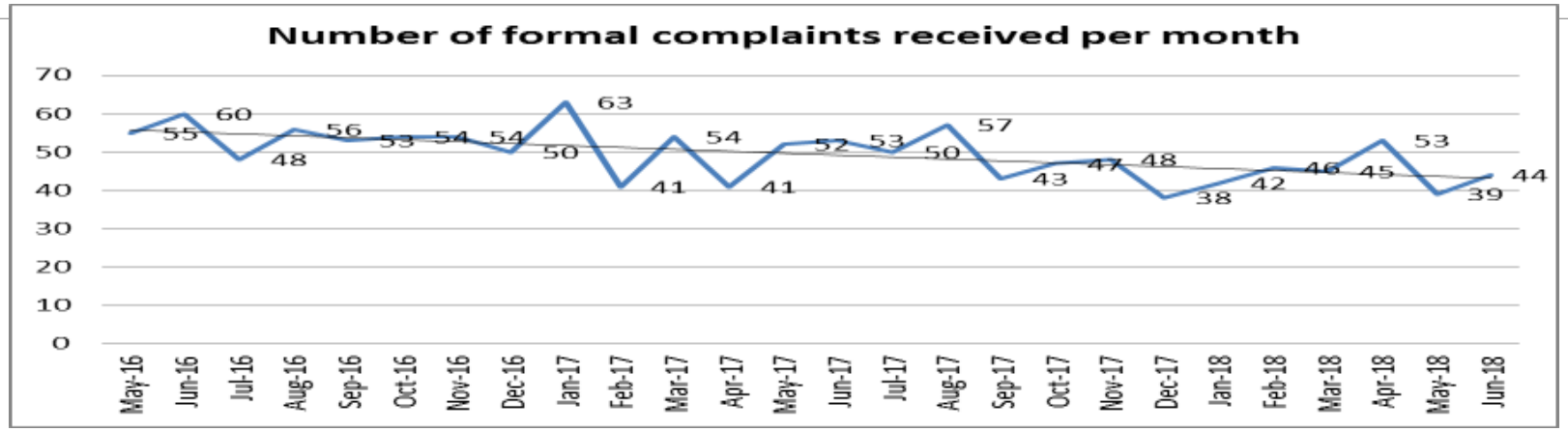
No complaints were received in the month and plans are underway to design quarterly patient surveys.





Complaints

East Sussex Healthcare NHS
NHS Trust



44 new complaints were received in June and at the end of the month there were no overdue complaints.

There was a total of 2.2 complaints per 1000 bed days for the trust, and by Division it was the following:

- Medicine – 1.3 per 1000 bed days (15 complaints)
- DAS – 1.9 per 1000 bed days (10 complaints)
- Out of Hospital – 0.6 per 1000 bed days (1 complaint)
- Women, Children and sexual Health – 2.6 per 1000 bed days (4 complaints)
- Urgent Care - 10 complaints.
- OOH – 1.8 per 1000 bed days (3)

The main themes in complaints remain as communication, attitude, lack of diagnosis and problems /complications with treatment.

Parliamentary and Health Service Ombudsman (PHSO);

In June there were 3 complaints partially upheld.

Nursing and Midwifery Workforce - including Safer Staffing

East Sussex Healthcare NHS
NHS Trust

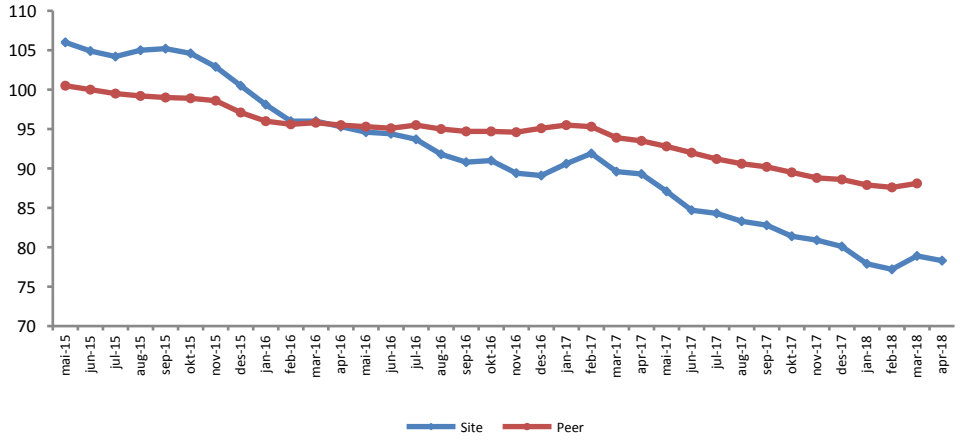
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
BEXHILL HOSPITAL - RXC03	92.3%	127.0%	97.3%	189.2%
EASTBOURNE DISTRICT GENERAL HOSPITAL - RXC02	93.5%	114.6%	96.5%	125.7%
CONQUEST HOSPITAL - RXC01	85.6%	115.6%	89.2%	121.9%
Totals	89.5%	115.9%	92.8%	126.7%

1. July has seen enormous changes in relation to nurse rostering.
•The new staffing templates for all wards not directly impacted by the bed remodelling consultation are live in health roster. The nursing teams in each division have undertaken extensive work to review the already published rosters and ensure that shifts reflect the agreed staffing templates .
•The Director of Nursing launched, from 1st July, the revised additional duty process which will ensure the staffing resource is more effectively matched to patient acuity
•The site staffing meetings continue to implement the use of CHPPD, professional judgement and staffing numbers as the way of matching staff to patient need on each site. This is preparing the Trust for September 18 where CHPPD will be the way staffing is reported by the NHS as it will replace fill rate.
2. The Director of Nursing has put in place revised additional safety monitoring processes for 4 weeks from the 1st July to ensure the Trust has in place a mechanism for identifying any negative impact on patient safety arising from the new staffing templates and additional duties processes.
3. Fill rates for June for RNs remain slightly below the planned levels. HCA fill rate remains higher than planned due to patients requiring special observations / enhanced care. There was an expected impact from the closure of Folkington ward during June as initially this led to cancellation of TWS – however the surge in demand which led to it being re-opened led to rebooking of TWS shifts to ensure safe staffing on wards at EDGH.
4. The fill rates for July are being closely monitored using CHPPD to best measure staffing to patient need. Daily reporting in place is evidencing reduced additional HCA shifts and no evidence, at present, of increased risk to patients.

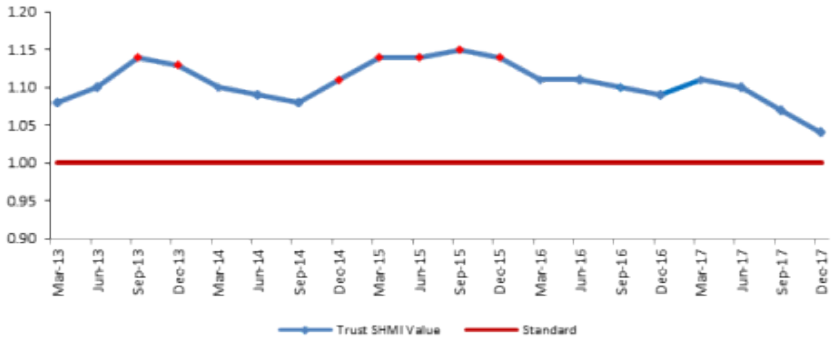
Mortality Metrics

East Sussex Healthcare NHS
NHS Trust

RAMI 17 (Rolling 12 months)



SHMI (Rolling 12 months)



SHMI for the period January 2017 to December 2017 is **1.04**. The Trust remains within the EXPECTED range.

RAMI 17 - May 2017 to April 2018 (rolling 12 months) is **78** compared to 89 for the same period last year (May 2016 to April 2017). April 2017 to March 2018 was 79.

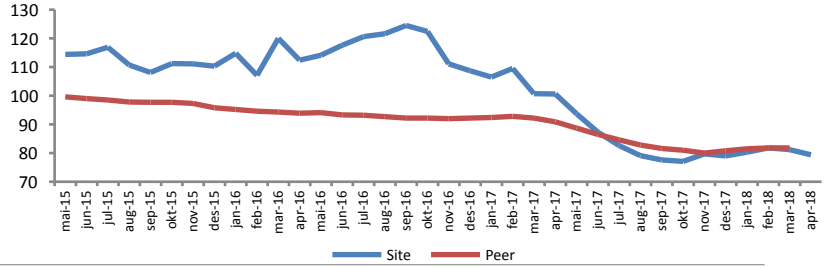
RAMI 17 shows an April position of 76. The peer value for April is not yet available. The March position was 95 against a peer value of 91.

Crude mortality shows May 2017 to April 2018 at 1.8% which is equal to the same period the previous year.

The percentage of deaths reviewed within 3 months was 67% in March 2018, compared to 65% in February 2018.

Main causes of death during June 2018 (Mortality Database)	
Pneumonia	30
Cancer	22
Cerebro-vascular incident	9
Sepsis/Septicaemia	8
Heart failure	6
Liver Disease	3
Myocardial Infarction	3

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
		Jun-17	Jun-18	Var	2017/18	2018/19	Var		
Four hour standard	95.0%	88.0%	95.7%	7.7%	83.2%	92.8%	9.6%	89.9%	
A&E Minor Performance	98.0%	98.1%	99.0%	0.9%	95.6%	98.9%	3.4%	98.5%	
Four hour standard (Local System)	95.0%		96.7%			94.5%			
12 Hour DTAs	0	0	1	1	0	2	2	0	
Unplanned re-attendance to Emergency Department	5.0%	2.9%	3.0%	0.1%	3.0%	2.9%	-0.1%	2.8%	
% Patients waiting less than 15 minutes for assessment in ED	M	85.4%	86.5%	1.1%	82.3%	85.8%	3.5%	83.6%	
% Patients waiting less than 60 minutes for treatment in ED	M	46.0%	52.1%	6.1%	42.5%	51.3%	8.8%	48.4%	
% Patients waiting less than 120 minutes for treatment in ED	M	75.4%	85.6%	10.2%	70.5%	82.8%	12.3%	78.9%	
% Patients that left without being seen in ED	M	1.1%	1.7%	0.6%	1.3%	2.0%	0.6%	1.9%	
% Patients admitted from ED (Conversion rate)	M	26.6%	29.0%	2.5%	26.3%	29.2%	2.9%	29.9%	
Emergency Department attendances	M	10050	10773	7.2%	29684	32024	7.9%	10099	
Ambulance conveyances	M	3106	2961	-4.7%	9596	9234	-3.8%	3197	
Admissions via A&E	M	26.6%	29.0%	2.5%	26.3%	29.2%	2.9%	29.9%	

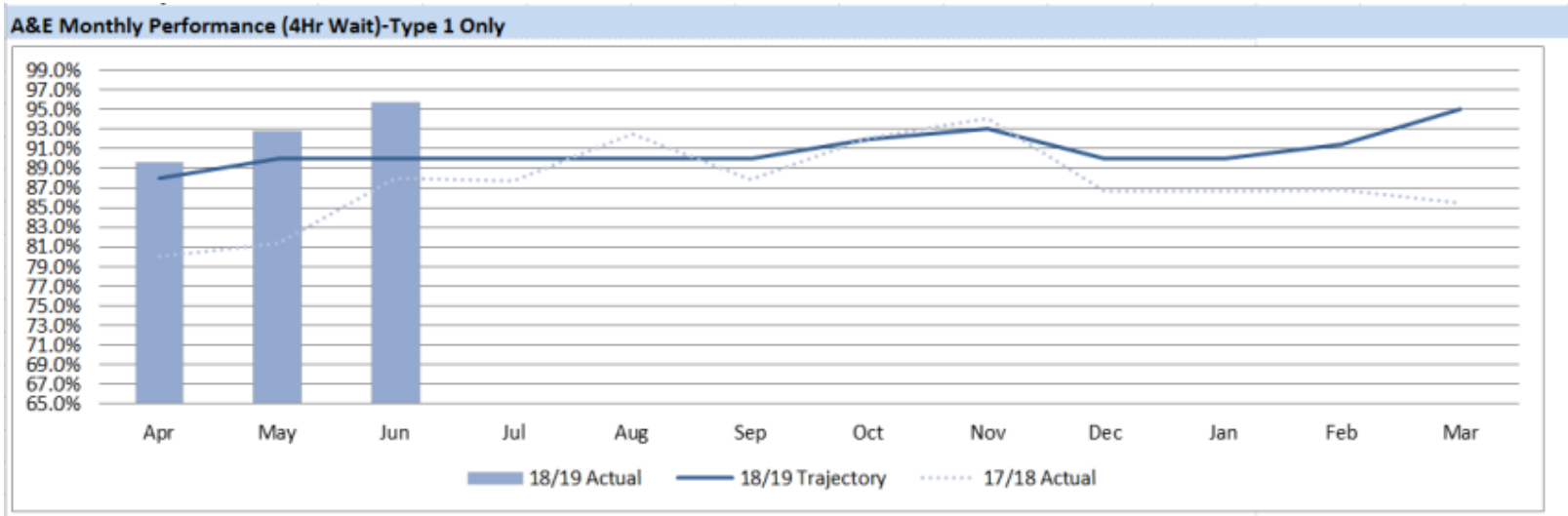
The Trusts' 4 hour performance was 95.7% for June (7.7% improvement on the previous year)

The system, walk in centres and the acute trusts combined performance was 96.75%.

Activity continues to increase on the previous year, A&E attendances up 10% and on non-elective spells up 19%. A system wide review is being undertaken to assess the causes for the continued increases. This includes assessing increasing A&E and emergency admissions, increases in emergency patients being seen or admitted on an ambulatory or short stay basis and delayed transfers of care, stranded and super stranded patients as well as other system indicators.

A&E Trajectory

East Sussex Healthcare NHS
NHS Trust



	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%	92.8%	95.7%									
17/18 Actual	80.1%	81.4%	88.0%	87.7%	92.5%	87.8%	92.1%	94.1%	86.7%	86.7%	86.8%	85.5%

The Trusts' 4 hour performance for June was 95.7%, 5.7% above trajectory.
EDGH – 94.9%
Conquest – 96.6%

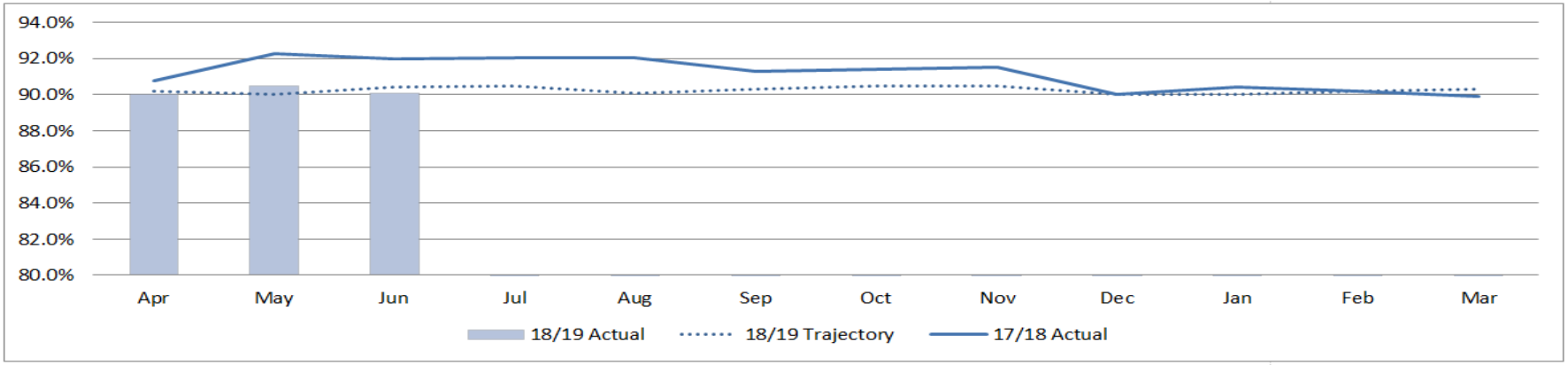
- Minors performance for May is 99%
- Attendances in June increased by 7.2% on the previous year.
- Ambulance conveyances decreased by 4.7% against June 2017.

East Sussex Healthcare NHS
NHS Trust

RTT

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-17	Jun-18	Var	2017/18	2018/19	Var		
RTT Incomplete standard	92.0%	92.2%	90.1%	-2.1%	91.8%	90.2%	-1.6%	90.8%	
RTT Backlog (Number of patients waiting over 18 weeks)	M	2351	2921	570	2351	2921	570	2680	
RTT Total Waiting List Size	28221	30179	29426	-753	30179	29426	-753	29462	
RTT 52 week waiters	0	0	0	0	0	0	0	0	
RTT 35 week waiters	M	236	211	-10.6%	236	211	-10.6%	179	

RTT (Referral to Treatment 18 Weeks)

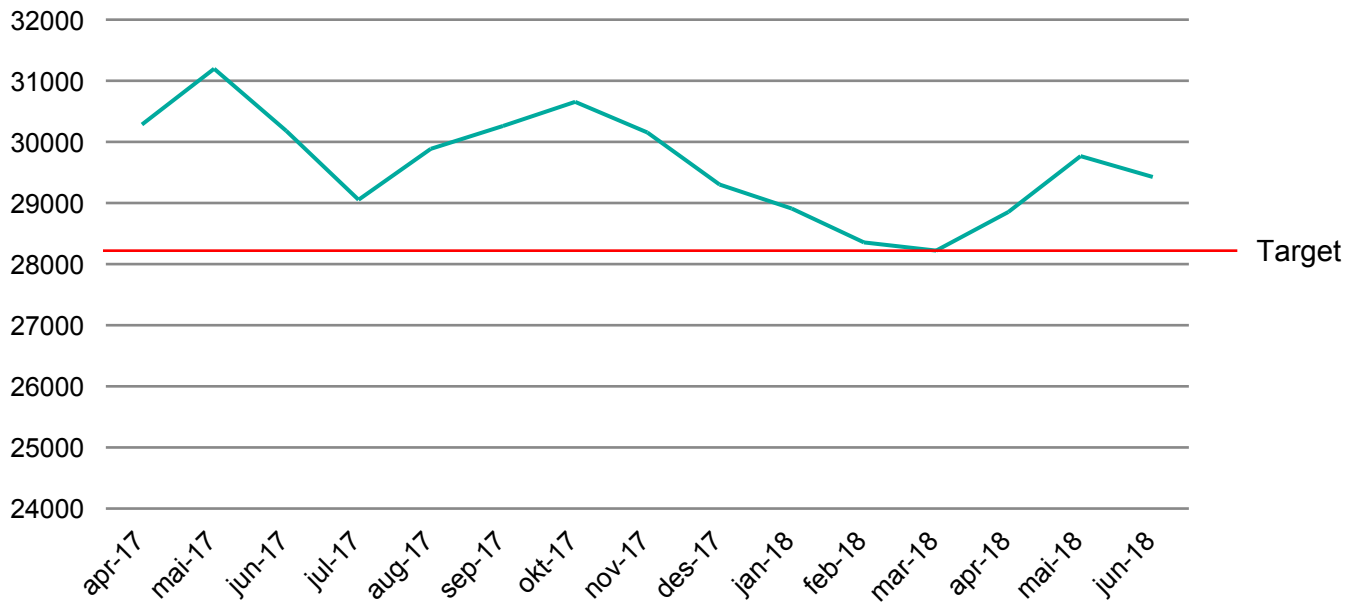


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	90.20%	90.03%	90.40%	90.50%	90.10%	90.30%	90.50%	90.50%	90.03%	90.03%	90.20%	90.30%
18/19 Actual	90.0%	90.5%	90.1%									
17/18 Actual	90.8%	92.3%	92.0%	92.0%	92.0%	91.3%	91.4%	91.5%	90.0%	90.4%	90.2%	89.9%

- The Trust performance for June was 90.1%. This is marginally lower than May and slightly below trajectory.
- Elective activity has remained fairly consistent. The level of referrals received in May and June were marginally lower than last year.
- Focus is on out-patient and theatre productivity to better manage demand and capacity without additional costs.

RTT Waiting list

East Sussex Healthcare NHS
NHS Trust

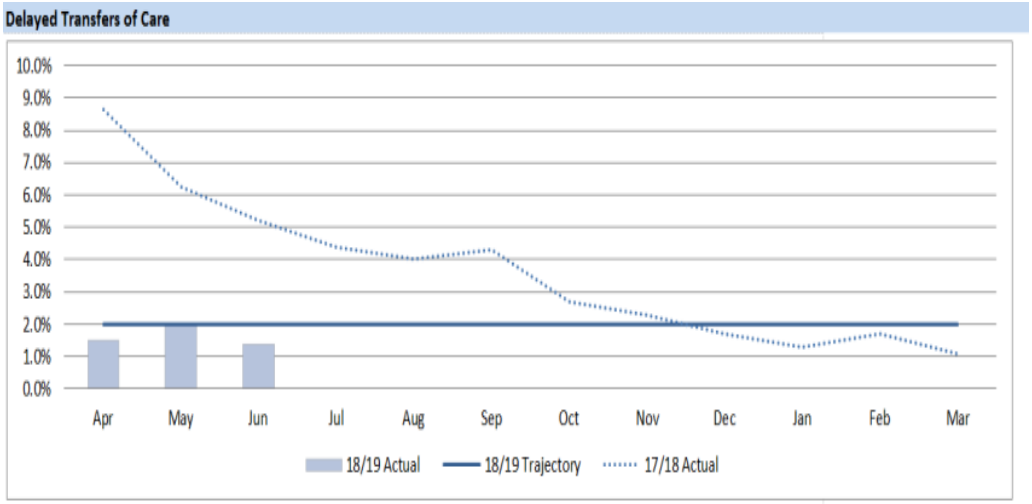


- June saw the expected reduction in the waiting list following a peak in May which is as a result of reduced activity due to Bank Holidays. The June waiting list was 29,426 which remains above the end of March figure of 28,221 which is the target.
- Increases in the waiting have been seen across specialties with the largest increases in gastroenterology and oral surgery. The majority of other specialties reduced the waiting list from May to June.

CANCELLATIONS AND DTC

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-17	Jun-18	Var	2017/18	2018/19	Var		
Delayed transfer of care national standard	3.5%	4.9%	1.4%	-3.5%	6.6%	1.6%	-5.0%	2.4%	
Cancellations									
Urgent operations cancelled for a second time	0	1	0	-1	1	2	1	0	
Proportion of last minute cancellations not rebooked within 28 days	0.0%	0.0%			0.0%	0.0%	0.0%	98.8%	
Outpatient appointment cancellations <6 weeks	M	46	33	-28.3%	134	84	-37.3%	40	
Outpatient appointment cancellations >6 weeks	M	1344	1423	5.9%	3976	3973	-0.1%	1365	



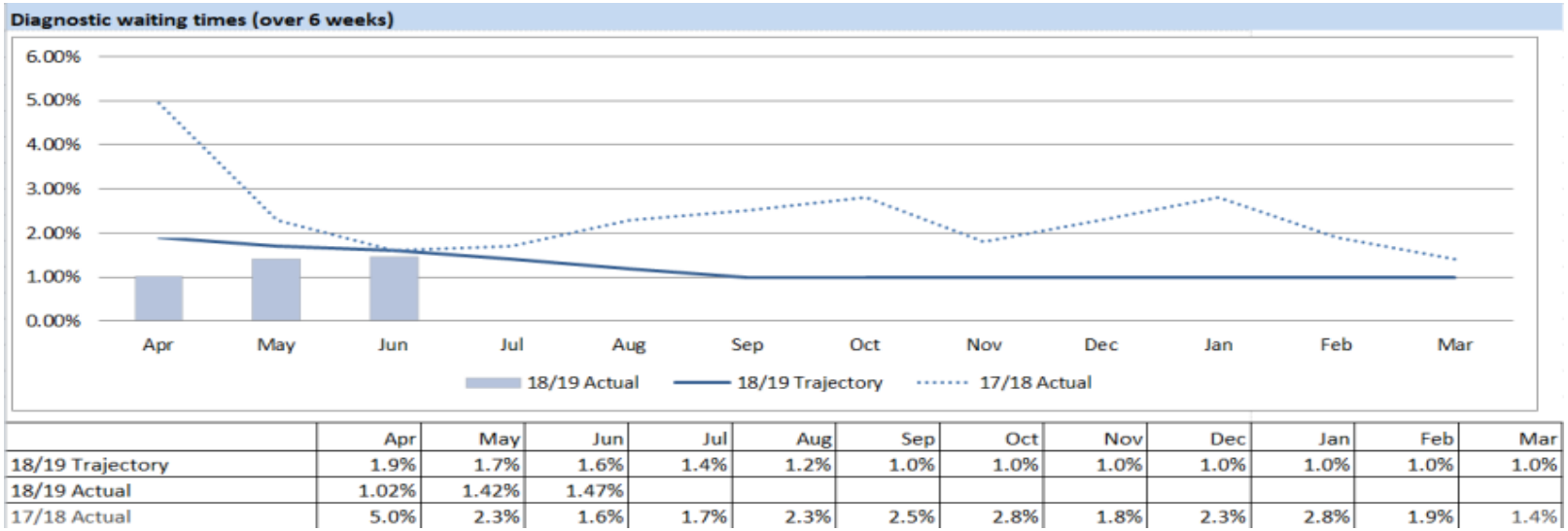
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
18/19 Actual	1.5%	2.0%	1.4%									
17/18 Actual	8.6%	6.3%	5.2%	4.4%	4.0%	4.3%	2.7%	2.3%	1.7%	1.3%	1.7%	1.1%

- DTC are currently at 1.4%, under 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 7% year to date versus last year

Diagnostics

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-17	Jun-18	Var	2017/18	2018/19	Var		
Diagnostic standard (% patients waiting more than 6 weeks)	1.0%	1.61%	1.47%	-0.1%	2.9%	1.2%	-1.7%	2.0%	



	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	1.02%	1.42%	1.47%									
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%	1.4%

Diagnostics performance across all specialties apart from radiology improved. Radiology remains a challenge for the organisation until the new equipment is installed. The new CT scanner is due in August and this should improve performance. The specialty had 65 breaches, (4%) which meant the Trust total came to 1.47%. Performance remains better than trajectory at month 3 but further work is required to achieve the <1% target by or before September, ensuring sustainable delivery.

Breaches 6 weeks and over	Number	%
Computed Tomography	65	4%
Non-obstetric ultrasound	20	0.85%
Colonoscopy	2	0.57%
Gastroscopy	1	0.46%

Key areas for improvement are radiology (CT).
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.

East Sussex Healthcare NHS
NHS Trust

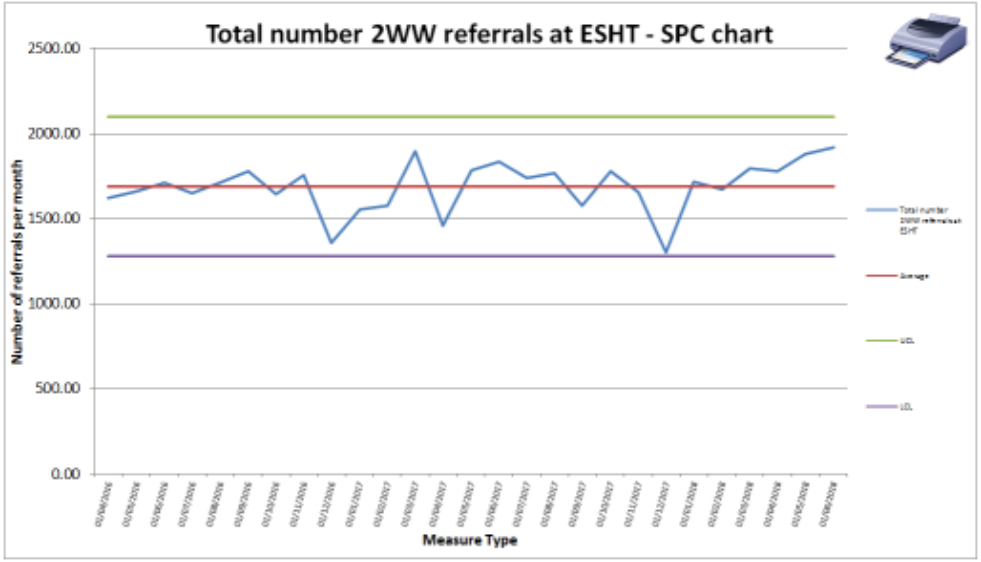
CANCER STANDARDS

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		May-17	May-18	Var	2017/18	2018/19	Var		
Cancer 2WW Standard	93.0%	96.0%	95.1%	-0.9%	96.3%	93.6%	-2.7%	95.5%	
Cancer 62 day urgent referral standard	85.0%	72.4%	81.9%	9.5%	73.8%	81.0%	7.2%	77.3%	
Cancer 2WW Standard (breast symptoms)	93.0%	97.6%	95.9%	-1.7%	96.0%	94.5%	-1.5%	95.5%	
Cancer 31 day standard	96.0%	96.8%	95.5%	-1.3%	98.0%	96.5%	-1.5%	96.9%	
Cancer 31 day subsequent drug treatment	98.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Cancer 31 day subsequent surgery	94.0%	100.0%	92.3%	-7.7%	100.0%	96.3%	-3.7%	97.8%	
Cancer 62 day screening standard	90.0%	78.6%	31.3%	-47.3%	80.5%	40.0%	-40.5%	57.4%	

- The cancer data is reported a month in arrears.
- The Trust recovered the 2ww Standard in May. 2ww referrals are up 7.2% against 17/18 YTD.
- The additional 2 week wait referrals in April/May had a knock on effect to the 31 day standard in June, which reduce by 1.2% coming in marginally under the target of 96%
- In May the 62 Day standard increased further to 81.9% showing continued signs of improvement. Urology remains a key area of focus requiring complex pathway redesign. The 62 day screening standard still requires further improvement to meet the 85% target. All except one patient were received after 38 days. Referrals for this specific area are often received late in the pathway which affects achievement of the 62 days
- Cancer 31 day standard continues to meet the standards.

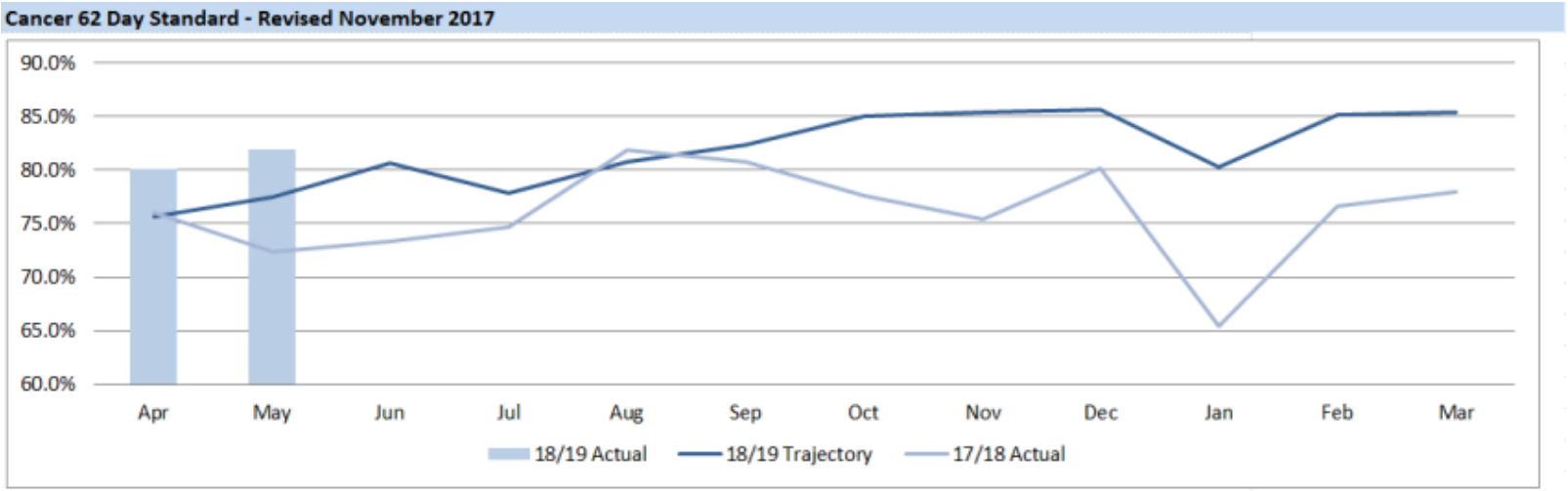
Cancer Referrals

Suspected Cancer Site	Jun	17/18 YTD		June	18/19 YTD		June Var %	Yr var %
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	170	491		129	477		-32	-3
Other suspected cancers	4	10		1	4		-300	-150
Suspected brain/central nervous system tumours	7	22		3	10		-133	-120
Suspected breast cancer	196	530		275	756		29	30
Suspected childrens cancer	2	4		0	2			-100
Suspected gynaecological cancers	139	386		157	438		11	12
Suspected haematological malignancies (excluding acute leukaemia)	14	31		13	44		-8	30
Suspected head & neck cancers	213	629		165	523		-29	-20
Suspected lower gastrointestinal cancers	276	732		368	1,071		25	32
Suspected lung cancer	55	194		77	190		29	-2
Suspected sarcomas		0			0			
Suspected skin cancers	390	975		395	1,023		1	5
Suspected testicular cancers	12	45		10	39		-20	-15
Suspected upper gastrointestinal cancers	203	568		154	413		-32	-38
Suspected urological cancers (excluding testicular)	152	460		171	591		11	22
Grand Total	**1,833**	**5,077**		**1,918**	**5,581**		4	9



Cancer 62 Days

East Sussex Healthcare NHS
NHS Trust



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	75.7%	77.5%	80.6%	77.8%	80.8%	82.4%	85.1%	85.4%	85.6%	80.3%	85.2%	85.4%
18/19 Actual	80.1%	81.9%										
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%

Urology, Lung and Head and Neck are the highest breaching specialities this month.

Actions to deliver improvements include :

- Cancer Pathway Matrons to be recruited
- New booking processes for Breast and Colorectal
- Implementation of straight to test for colonoscopy
- 7 day booking implementation plan for radiology and 24 hour reporting for cancer pathways

East Sussex Healthcare NHS
NHS Trust

Cancer Standards – 62 days (target 85%)

May 2018 2WW Referral to First Treatment 62 Days

Tumour Site	Total treated	Treated within 62 days	Breaches	% meeting standard
Breast	14.0	13.0	1.0	92.9%
Gynaecology	2.5	1.5	1.0	60.0%
Haematology	6.0	4.0	2.0	66.7%
Head and Neck	6.5	5.0	1.5	76.9%
Colorectal	9.0	8.0	1.0	88.9%
Lung	13.5	10.5	3.0	77.8%
Skin	17.5	16.5	1.0	94.3%
Upper GI	6.5	6.5	0.0	100.0%
Urology	40.5	30.0	10.5	74.1%
Totals:	**116.0**	**95.0**	**21.0**	**81.9%**

Community

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-17	Jun-18	Var	2017/18	2018/19	Var		
Community Nursing									
Community nursing referrals	M	4235	3890	-345	12297	11900	-397	4101	
Community nursing total contacts	M	35437	34495	-942	105456	107449	1993	35631	
Community Nursing face-to-face contacts	M	20135	18943	-1192	60089	58302	-1787	19570	
Community nursing ALOS	M	20.8	2.7	-18	21.0	7.1	-13.9	15	
Waiting Times									
% SALT patients waiting less than 13 weeks	M	100.0%			100.0%	96.5%	-3.5%	99.3%	
Total SALT patients waiting	M	141	0	-141	440	332	-108	133	
% Podiatry patients waiting less than 13 weeks	M	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Total podiatry patients waiting	M	255	264	9	895	1022	127	258	
% Dietetics patients waiting less than 13 weeks	M	100.0%	100.0%	0.0%	99.2%	100.0%	0.8%	99.0%	
Total dietetics patients waiting	M	46	63	17	237	346	109	73	
% MSK patients waiting less than 13 weeks	M	96.2%			91.7%			63.5%	
Total MSK patients waiting	M	1062	0	-1062	4020	0	-4020	604	

Activity

ACTIVITY

Activity Headlines

East Sussex Healthcare NHS
NHS Trust

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- Year to date to the end of June shows non elective and follow ups either on, or up, against plan. Electives and first outpatients remain below anticipated levels. Performance in day cases is marginally under plan.

- Daycase: Year to date under plan (133 cases under plan). Under performance in Ophthalmology, Dermatology and T&O offset against over plan performance in Endocrinology, Gastroenterology and Clinical Oncology.
- Elective: Year to date -6% under plan (111 cases). Under performance in General Surgery, T&O, Gastroenterology.
- First: Year to date -4% under plan (1114) driven by ophthalmology, max-fax, dermatology
- Follow up: Year to date 1% over plan (602) – under performance in a number of areas (predominantly DAS) off set by substantial over performance in cardiology
- NE: Year to date 9% over plan (752)

Variations in performance are being driven by combinations of capacity, referrals and staffing. Recovery plans are in development with the key specialties affected.

Acute Activity

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-17	Jun-18	Var	2017/18	2018/19	Var		
Emergency Department attendances	M	10050	10773	7.2%	29684	32024	7.9%	10099	
Ambulance conveyances	M	3106	2961	-4.7%	9596	9234	-3.8%	3197	
Admissions via A&E	M	26.6%	29.0%	2.5%	26.3%	29.2%	2.9%	29.9%	
Elective spells	M	612	600	-2.0%	1862	1688	-9.3%	589	
Day Cases	M	4163	3886	-6.7%	11868	11523	-2.9%	3881	
Elective Beddays	M	1520	1608	5.8%	4897	4761	-2.8%	1623	
Total Non-Elective Spells	M	4027	4469	11.0%	11817	13595	15.0%	4404	
Number of Emergency spells	M	3430	3919	14.3%	9958	11867	19.2%	3801	
Number of Maternity spells (ante and post partem)	M	319	291	-8.8%	1008	910	-9.7%	323	
Number of other non-elective spells (Births/Transfers from other hospitals)	M	278	259	-6.8%	851	818	-3.9%	280	
Non-Elective beddays	M	20749	18753	-9.6%	65898	61401	-6.8%	21565	
LOS									
Elective Average Length of Stay	M	2.5	2.7	0.2	2.6	2.8	0.2	2.8	
Non-Elective Average Length of Stay	M	5.8	4.4	-1.4	5.8	4.7	-1.1	4.9	
Inpatient Average Length of Stay at intermediate care units	M	29.7	23.8	-5.9	32.2	29.3	-2.9	27.7	

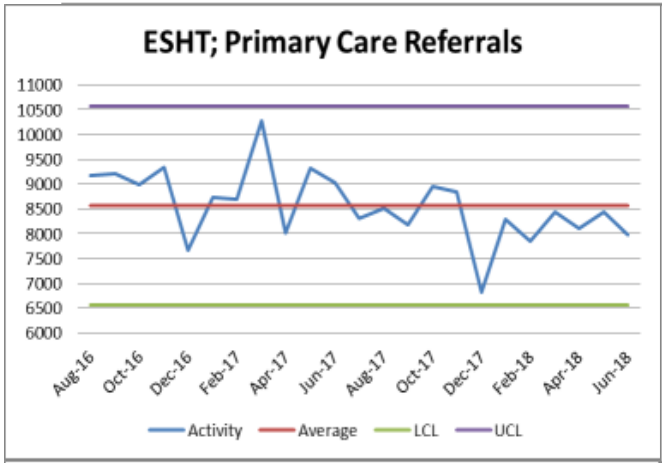
YTD and Year End forecast activity is shown in the table below against last year's outturn and against the plan.

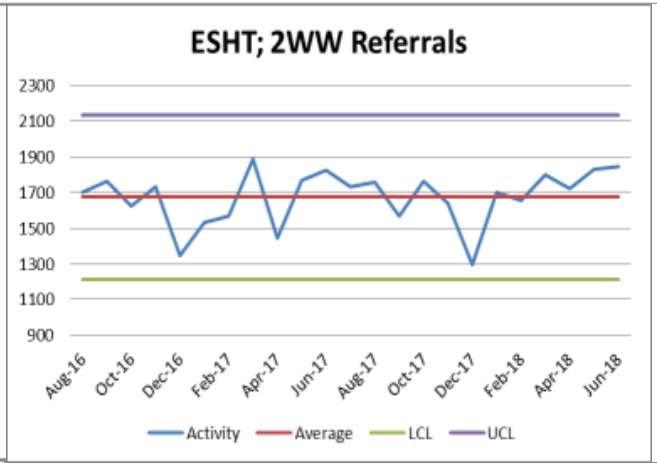
YTD (End June)	Actual 18/19	Actual 17/18	Plan 18/19	Variance to last year	Variance to plan
Daycase	11,537	11,858	11,670	-3%	-1%
Inpatient	1,690	1,872	1,801	-10%	-6%
Elective (Total DC/IP)	13,227	13,730	13,471		
Non Elective	12,932	11,132	11,838	16%	9%
First OP	28,708	29,911	29,822	-4%	-4%
Follow Up OP	74,202	72,528	73,600	2%	1%

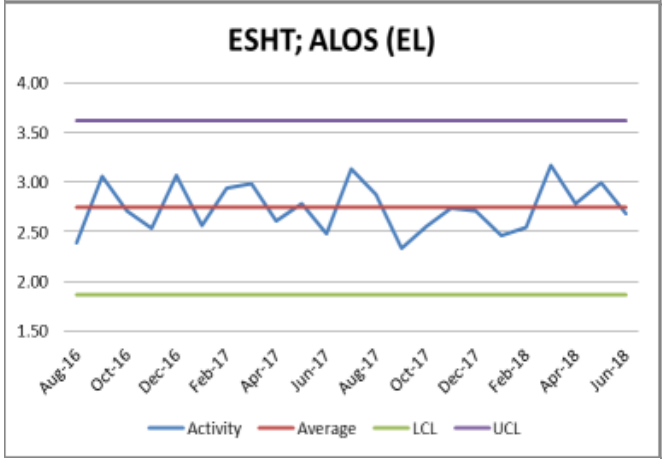
excludes well babies and neonatals

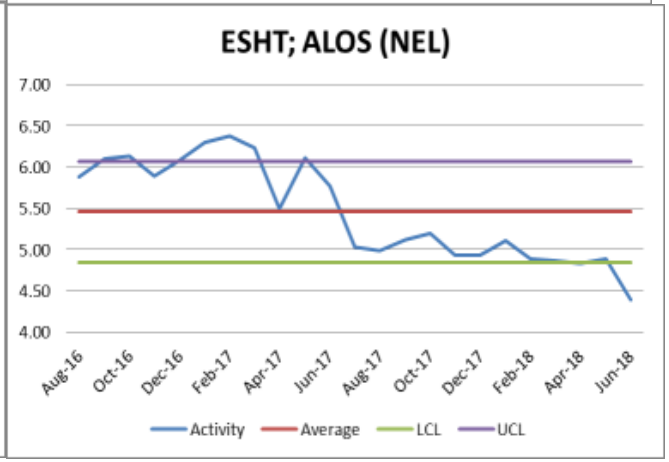
YTD (End June)	Year End Plan	Year end forecast	Variance to Year end forecast
Daycase	47,446	46,905	-1%
Inpatient	7,330	6,871	-6%
Elective (Total DC/IP)	54,776	53,776	
Non Elective	47,475	51,870	9%
First OP	121,261	116,715	-4%
Follow Up OP	299,247	301,675	1%

East Sussex Healthcare NHS
NHS Trust









Primary care referrals remain below the long term average. When taken with the increase in consultant to consultant referrals (pathway change) the variance reduces.

The referrals for two week waits increased since March.

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
		Jun-17	Jun-18	Var	2017/18	2018/19	Var		
Primary Referrals	M	9022	7971	-11.6%	26360	24509	-7.0%	8227	
Consultant to Consultant referrals	M	1698	1796	5.8%	4890	5614	14.8%	1846	
2WW Referrals	M	1825	1844	1.0%	5035	5399	7.2%	1693	

Leadership & Culture

LEADERSHIP & CULTURE

CONTENT

East Sussex Healthcare NHS Trust

TARGET AREA	CONTENT
Trust Overview	Key Metrics
Executive Summary	Headlines
Workforce Expenditure	Substantive, Bank, Agency split by fte
Turnover Trend by Staff Group	Turnover % by Staff Group
Leavers & Stability by Staff Group	Leavers & Stability measure by Staff Group
Trending Net Vacancies	Trending Net Vacancies by staff Group
Absence Mgt – Sickness Rates	Annual & Monthly
Absence Mgt – Sickness Reasons	Sickness Reasons Top 6 annual and Top 10 by % Jan 2018
Wellbeing & Engagement	Latest update from Wellbeing & Engagement
Training & Appraisal by Division	Training & Appraisal Compliance by Division by end of month
APPENDIX	Supporting Documents

TRUST OVERVIEW

TRUST														
WORKFORCE CAPACITY	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Trend line
Budgeted fte	6,904.3	6,827.9	6,824.5	6,893.0	6,852.0	6,879.3	6,873.2	6,859.5	6,859.8	6,859.1	7,060.0	6,981.2	6,993.4	
Total fte usage	6,679.0	6,663.4	6,672.3	6,695.4	6,756.7	6,813.8	6,846.7	6,888.7	6,716.4	6,875.5	6,910.5	6,681.7	6,707.4	
Variance	-225.3	-164.4	-152.3	-197.6	-95.3	-65.5	-26.5	29.2	-143.4	16.4	-149.5	-299.5	-286.0	
Permanent vacancies	788.6	706.8	706.4	745.9	647.0	622.0	609.9	577.7	537.1	527.6	644.6	605.2	651.3	
Fill rate	88.3%	89.4%	89.4%	89.0%	90.4%	90.8%	91.0%	91.4%	92.0%	92.2%	90.5%	91.0%	90.4%	
Bank fte usage (as % total fte usage)	8.9%	8.9%	9.3%	9.3%	9.3%	9.3%	9.7%	9.7%	6.7%	9.1%	10.1%	7.3%	8.1%	
Agency fte usage (as % total fte usage)	2.7%	2.4%	2.2%	2.2%	1.8%	2.1%	1.8%	2.0%	1.9%	1.9%	1.6%	1.9%	1.8%	
Turnover rate	11.0%	11.2%	11.2%	11.6%	11.3%	11.3%	11.3%	11.2%	11.1%	11.0%	10.9%	11.0%	10.9%	
Stability rate	92.0%	91.4%	91.7%	91.1%	91.6%	91.5%	92.1%	92.2%	91.9%	92.7%	92.1%	91.9%	89.5%	
SICKNESS ABSENCE														
Annual sickness rate	4.2%	4.2%	4.3%	4.3%	4.3%	4.3%	4.4%	4.4%	4.5%	4.5%	4.5%	4.5%	4.5%	
Monthly sickness rate (%)	3.8%	4.4%	4.2%	4.3%	4.8%	5.0%	5.3%	5.6%	4.6%	4.1%	3.6%	3.7%	3.5%	
Short term sickness (<28 days)	57.3%	61.8%	59.5%	63.4%	58.6%	61.6%	59.0%	65.4%	48.4%	57.5%	45.9%	44.3%	46.0%	
Monthly long term sickness (28 days+)	42.7%	38.2%	40.5%	36.6%	41.4%	38.4%	41.0%	34.6%	51.6%	42.5%	54.1%	55.7%	54.0%	
MANDATORY TRAINING & APPRAISALS														
Appraisal rate	81.0%	81.5%	81.6%	82.2%	82.3%	81.4%	81.3%	81.8%	81.3%	79.6%	79.5%	79.2%	78.1%	
Fire	84.2%	85.5%	85.9%	85.5%	85.8%	86.0%	85.8%	86.4%	86.5%	86.6%	86.2%	87.4%	87.1%	
Moving & Handling	89.7%	90.2%	90.2%	89.7%	89.1%	89.3%	89.4%	90.4%	90.3%	90.1%	89.4%	89.9%	89.8%	
Induction	95.5%	95.0%	95.0%	94.3%	91.9%	93.5%	92.5%	95.1%	95.1%	94.8%	94.4%	95.0%	94.3%	
Infec Control	88.1%	89.0%	89.6%	89.3%	88.8%	88.8%	88.7%	89.8%	89.9%	90.2%	89.9%	90.5%	90.1%	
Info Gov	84.4%	85.8%	85.3%	85.7%	85.0%	85.8%	84.6%	86.8%	86.5%	86.3%	85.8%	85.1%	83.8%	
Health & Safety	88.8%	89.6%	88.8%	88.1%	87.9%	88.8%	87.9%	88.0%	87.4%	88.0%	88.8%	89.1%	88.6%	
MCA	96.2%	96.5%	96.0%	95.8%	94.8%	94.8%	95.1%	95.0%	95.3%	95.8%	95.8%	96.1%	96.1%	
DoLs	97.8%	98.0%	97.6%	97.5%	95.5%	95.5%	95.8%	95.1%	96.3%	96.4%	96.4%	96.8%	96.9%	
Safeguarding Vulnerable Adults	89.6%	90.3%	90.1%	88.9%	88.0%	87.8%	87.4%	86.2%	85.2%	84.7%	84.2%	85.8%	86.0%	
Safeguarding Children Level 2	87.2%	87.4%	86.4%	86.1%	85.9%	86.0%	85.7%	85.0%	85.4%	85.3%	84.7%	86.4%	87.4%	

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

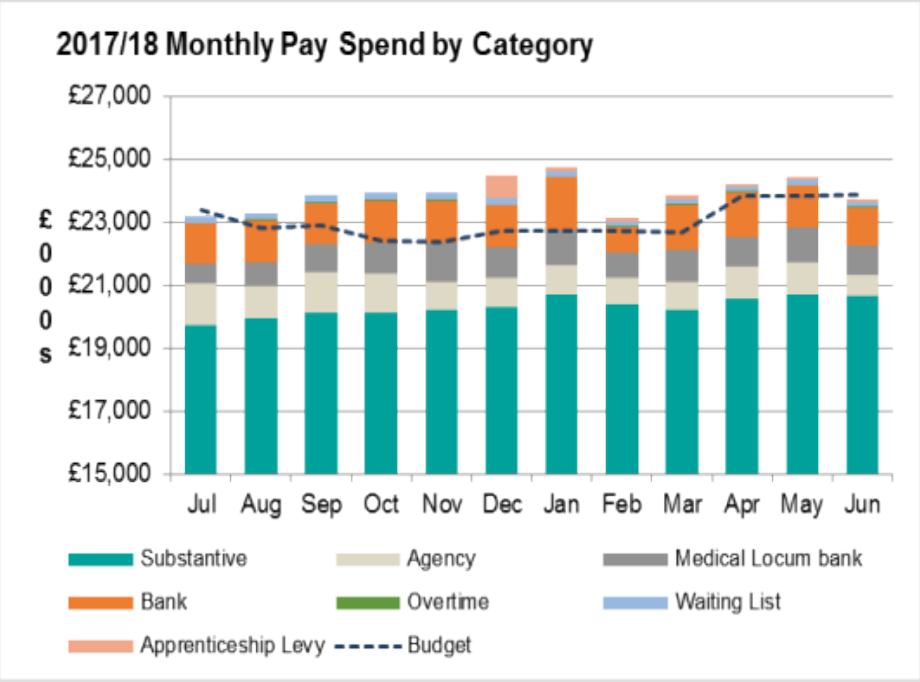
MONTHLY HEADLINES

HEADLINES – JUNE 2018

- Actual workforce utilisation 6,707.4 fte, -286.0 fte below the budgeted establishment
- June '18 monthly budget £23,875k against monthly actual expenditure £23,715k (-£160k)
  - Substantive expenditure £20,635k
  - Temporary staff expenditure £2,987k (12.6% of total pay expenditure) as follows:
    - Bank expenditure £2,132k
    - Agency expenditure £697k
    - Overtime £30k
    - Waiting List payments £128K
- Vacancies in June have increased to 651.3 fte (9.6%), this is an increase of 46.1 ftes (this is partly due to budget adjustments in Out of Hospital Care).
- Annual turnover reduced slightly by -0.1% to 10.9%, which represents 639.1 fte leavers in the last year
- Annual sickness rate unchanged at 4.5%
- Monthly sickness reduced by -0.2% against May to 3.5%.
- Mandatory Training rate and Appraisal rates:
  - Mandatory Training rate down by -0.3% to 88.5%. Compliance decreased for Fire, Moving & Handling, Infection Control, Information Governance and Health & Safety but increased for Deprivation of Liberties and all Safeguarding training. Appraisal compliance decreased again by -1.1% to 78.1%

WORKFORCE EXPENDITURE

Actuals in Month (£000s)													
Category	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Trend line
Budget	£23,400	£22,825	£22,912	£22,390	£22,366	£22,726	£22,733	£22,733	£22,657	£23,830	£23,824	£23,875	
Substantive	**£19,725**	**£19,931**	**£20,126**	**£20,096**	**£20,189**	**£20,306**	**£20,679**	**£20,401**	**£20,228**	**£20,540**	**£20,683**	**£20,635**	
Apprenticeship Levy						£744	£123	£128	£126	£94	£100	£92	
Agency	£1,342	£1,043	£1,269	£1,269	£889	£907	£929	£848	£863	£1,053	£1,037	£697	
Medical Locum bank	£609	£745	£909	£968	£1,249	£976	£1,145	£796	£1,014	£911	£1,086	£923	
Bank	£1,267	£1,332	£1,268	£1,321	£1,347	£1,329	£1,663	£801	£1,448	£1,451	£1,343	£1,210	
Overtime	£38	£39	£45	£44	£32	£31	£31	£45	£34	£46	£28	£30	
Waiting List	£222	£184	£210	£235	£238	£195	£153	£108	£135	£110	£151	£128	
Total Temp Expenditure	**£3,478**	**£3,343**	**£3,701**	**£3,837**	**£3,755**	**£3,438**	**£3,921**	**£2,598**	**£3,494**	**£3,571**	**£3,645**	**£2,988**	
Total Spend	**£23.203**	**£23.274**	**£23.827**	**£23.933**	**£23.944**	**£24.488**	**£24.723**	**£23,127**	**£23,848**	**£24,205**	**£24,428**	**£23,715**	



- Increase in budgeted fte establishment (by 12.2 ftes overall), in part due to realignment of ESBT and IMSK budgets as agreed with the CCG.
- Bank & Locum expenditure reduced by £296K due to reductions in sickness & specialling at Community Hospitals, planned reduction in locum doctors in Women & Childrens, and no requirement for additional junior locums in MAU. .
- Agency expenditure down by £340K overall, due to medical appointments in Paediatrics, reductions in agency usage in Pathology and Theatres and all agency usage ceased in Payroll, Contracting, Company Secretary and Financial Services. This month also saw the conversion to capital of agency expenditure accrued in respect of capital projects, for the year to date.
- The Apprenticeship Levy is a top sliced budget for apprenticeship training programmes calculated at 0.5% of pay expenditure each month.

***Source data**: Finance Ledger*

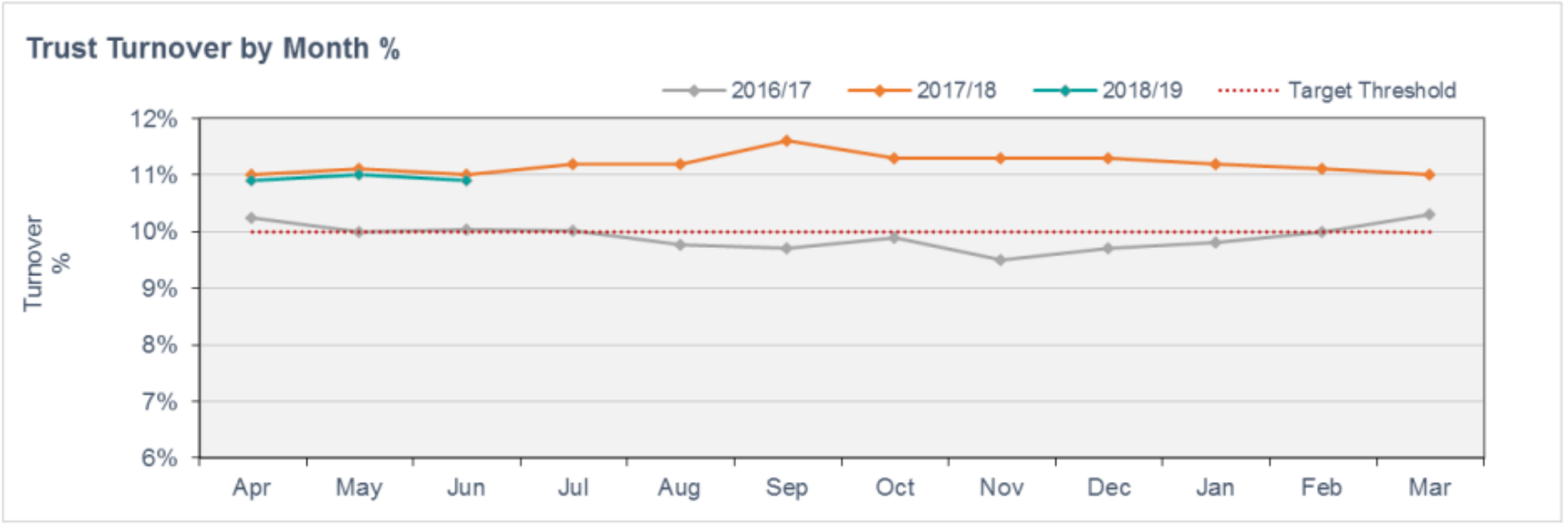
East Sussex Healthcare NHS
NHS Trust

TURNOVER TREND – STAFF GROUP

- Turnover rate of 10.9% in June equates to 639.1fte leavers.
- Increase in Medical & Dental turnover rate equates to additional 2 fte leavers (33.5 fte leaver overall in last 12 months).

TRUST TURNOVER BY STAFF GROUP (%)

Year on Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Trend line
Additional Clinical Services	12.4%	12.8%	13.7%	13.9%	14.5%	13.8%	13.5%	13.5%	13.5%	13.4%	13.5%	13.4%	
Administrative and Clerical	11.1%	11.2%	11.5%	11.3%	10.8%	11.1%	11.4%	11.1%	11.3%	11.7%	12.5%	11.7%	
Allied Health Professionals	11.5%	11.2%	11.3%	11.0%	11.6%	12.7%	12.7%	12.9%	13.2%	12.1%	10.6%	10.0%	
Estates and Ancillary	10.2%	10.7%	11.0%	11.5%	11.4%	10.4%	10.7%	10.3%	9.9%	8.9%	8.6%	9.1%	
Healthcare Scientists	9.9%	9.5%	12.0%	11.8%	12.4%	11.0%	9.7%	10.9%	12.1%	11.8%	10.8%	12.3%	
Medical & Dental	13.0%	12.1%	11.4%	9.7%	9.4%	10.0%	9.1%	9.7%	10.8%	10.4%	11.1%	11.7%	
Nursing & Midwifery Registered	10.8%	10.6%	11.1%	10.3%	10.2%	10.4%	10.2%	10.0%	9.4%	9.2%	9.4%	9.3%	
Prof Scientific and Tech	10.2%	10.2%	6.7%	8.2%	8.8%	8.8%	8.3%	9.7%	8.8%	8.7%	8.6%	8.7%	
TOTAL TRUST TURNOVER	**11.2%**	**11.2%**	**11.6%**	**11.3%**	**11.3%**	**11.3%**	**11.2%**	**11.1%**	**11.0%**	**10.9%**	**11.0%**	**10.9%**	



***Source data**: ESR*

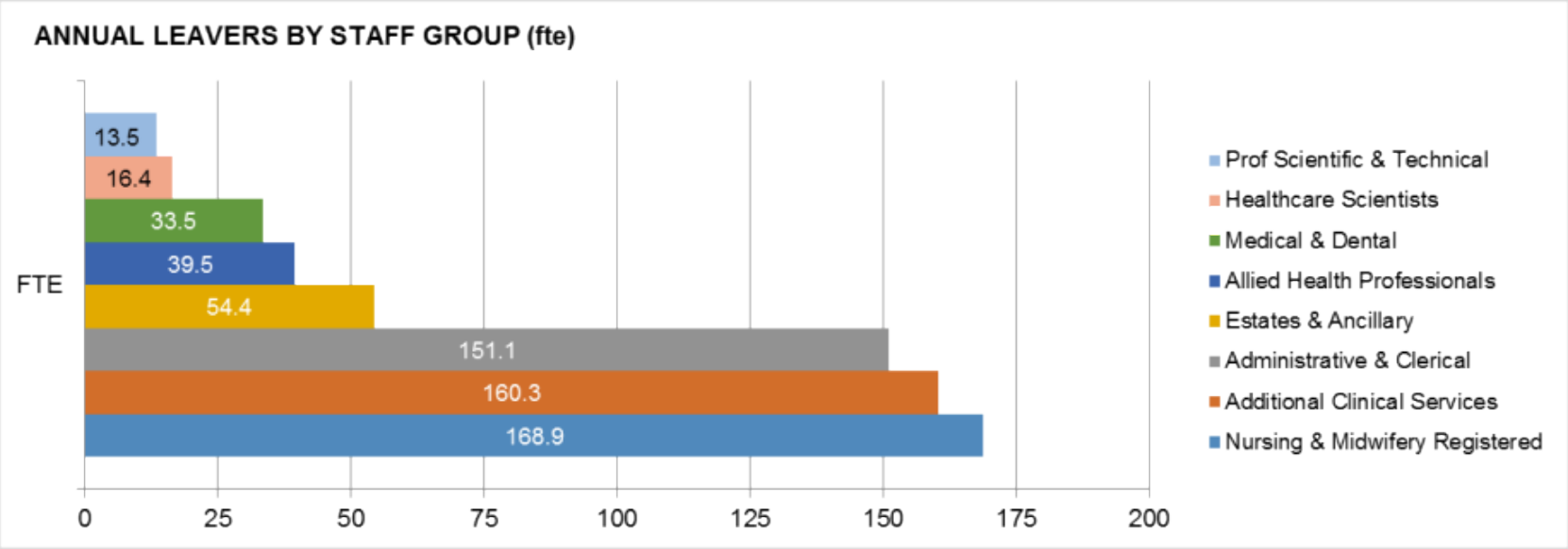
LEAVERS & STABILITY – STAFF GROUP

STAFF GROUPS	STABILITY > 1YR
Medical & Dental	88.6%
Prof Scientific & Technical	95.3%
Administrative & Clerical	88.8%
Nursing & Midwifery Registered	92.0%
Estates & Ancillary	90.1%
Additional Clinical Services	87.8%
Healthcare Scientists	87.3%
Allied Health Professionals	83.5%
TRUST	**89.5%**

Overview

- The Stability Rate measures the number of current staff who have more than 1 year's service with ESHT
- ESHT stability has reduced this month by 2.4% with Medical & Dental (which excludes Junior Doctor rotation) down by 2.6%.
- Latest available comparisons show stability for NHS organisations at 91.2% and for Kent, Surrey & Sussex Trusts at 87.9% (April 2018)

Source: ESR June 2018; NHS Digital iView.

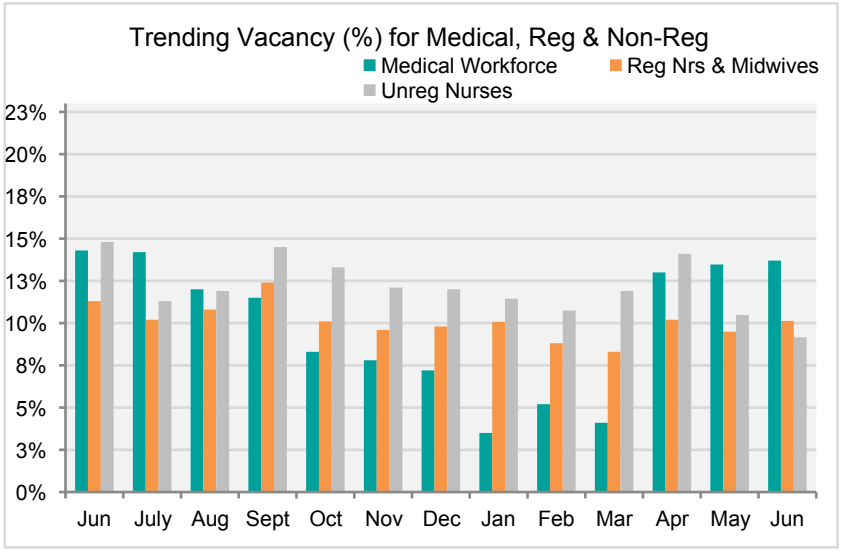


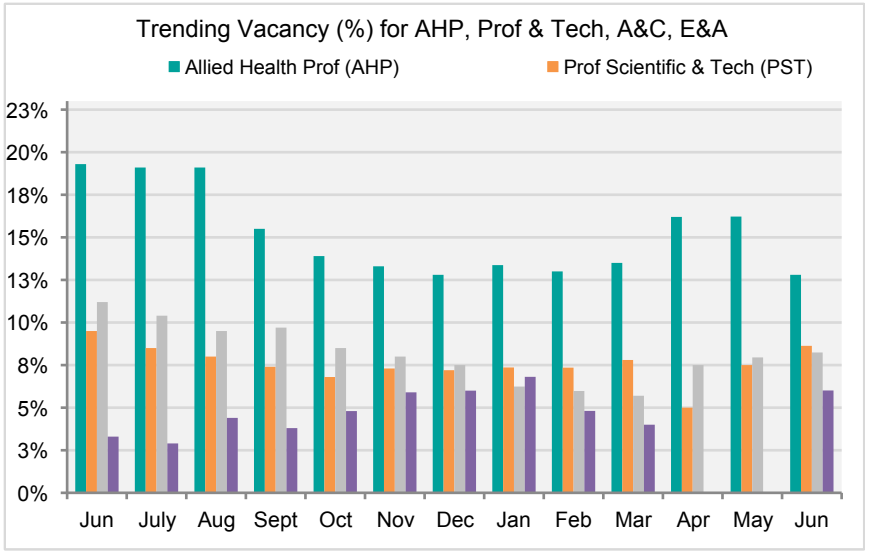
***Source data**: ESR*

RECRUITMENT – TRENDING NET VACANCIES BY STAFF GROUP (%)

- Vacancy rate increased by 0.6% which equates to 46.1 ftes. Total fte vacancies for the Trust is 651.3
- Continued focus on hard to recruit posts including Histopathology and Haematology
- Two additional Headhunters engaged to assist with “hard to fill” posts.
- Regular meetings commenced with Department Service Managers to agree action plans for addressing vacancies

JUN 2017 TO JUN 2018	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Trend line
Medical Workforce	14.3%	14.2%	12.0%	11.5%	8.3%	7.8%	7.2%	3.5%	5.2%	4.1%	13.0%	13.5%	13.7%	
Reg Nrs & Midwives	11.3%	10.2%	10.8%	12.4%	10.1%	9.6%	9.8%	10.1%	8.8%	8.3%	10.2%	9.5%	10.1%	
Unreg Nurses	14.8%	11.3%	11.9%	14.5%	13.3%	12.1%	12.0%	11.4%	10.7%	11.9%	14.1%	10.5%	9.2%	
Allied Health Prof (AHP)	19.3%	19.1%	19.1%	15.5%	13.9%	13.3%	12.8%	13.4%	13.0%	13.5%	16.2%	16.2%	12.8%	
Prof Scientific & Tech (PST)	9.5%	8.5%	8.0%	7.4%	6.8%	7.3%	7.2%	7.4%	7.4%	7.8%	5.0%	7.5%	8.6%	
Admin & Clerical	11.2%	10.4%	9.5%	9.7%	8.5%	8.0%	7.5%	6.2%	6.0%	5.7%	7.5%	8.0%	8.2%	
Estates & Ancillary (E&A)	3.3%	2.9%	4.4%	3.8%	4.8%	5.9%	6.0%	6.8%	4.8%	4.0%	-1.5%	-2.7%	6.0%	
TRUST	**11.7%**	**10.6%**	**10.6%**	**11.0%**	**9.6%**	**9.2%**	**9.0%**	**8.6%**	**8.0%**	**7.8%**	**9.5%**	**9.0%**	**9.6%**	





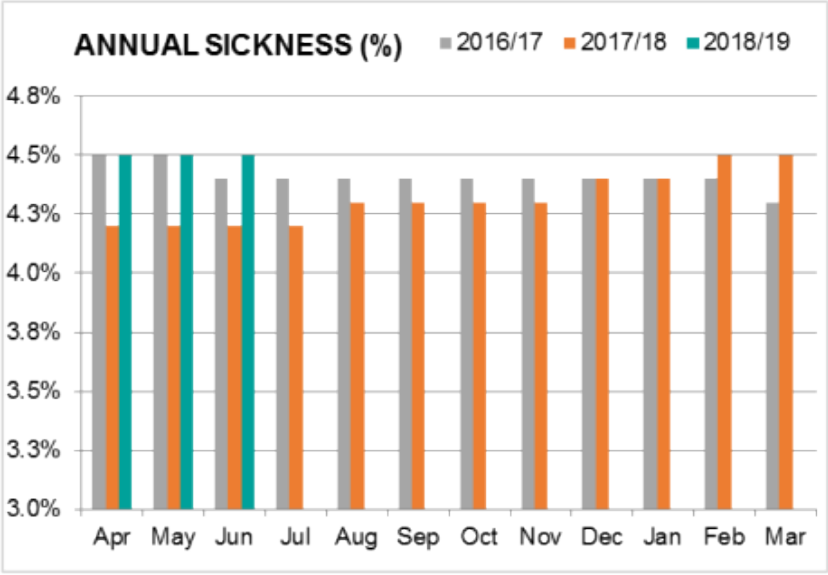
***Source data**: ESR & Finance Ledger*

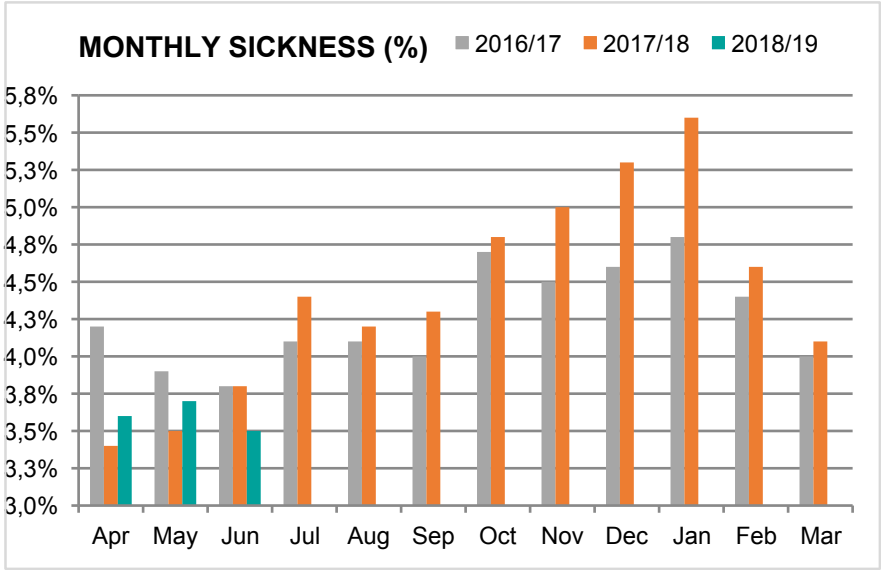
ABSENCE MANAGEMENT – SICKNESS RATES

- The monthly sickness rate has reduced by -0.2% to 3.5% (the lowest rate since May 17 and -0.3% lower than for June 17), whilst the annual sickness rate is unchanged at 4.5%
- The largest monthly drop is amongst Allied Health Professionals (-1.0% to 2.7%).

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%	4.5%	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%	3.7%	3.5%									



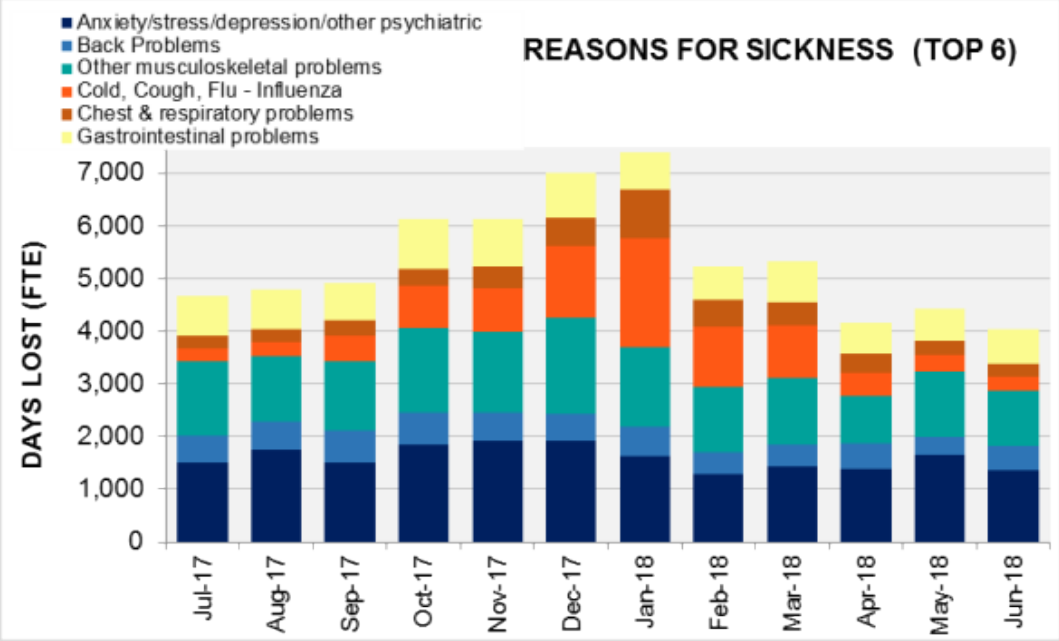


***Source data**: ESR*

ABSENCE MANAGEMENT – SICKNESS REASONS

- Anxiety/stress/depression illnesses have reduced by -297 fte days this month whilst Other Musculoskeletal problems have reduced by 199 fte days. Overall, fte days lost in June were 6,533 which equates to 217.8 fte staff off sick.

TOP 6	Fte Days Lost by Month												
Reason for sickness	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Trend line
Anxiety/stress/depression/other psychiatric	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	1,660.3	1,363.5	
Back Problems	510.4	546.3	611.0	599.0	548.2	532.2	553.9	396.6	415.1	490.1	346.1	462.9	
Other musculoskeletal problems	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	1,231.1	1,032.2	
Cold, Cough, Flu - Influenza	258.6	260.2	472.3	789.5	829.0	1,360.5	2,070.4	1,139.0	990.8	442.9	313.0	275.3	
Chest & respiratory problems	243.5	248.6	299.4	325.2	409.5	555.1	920.1	499.6	438.6	353.0	264.0	235.8	
Gastrointestinal problems	747.9	747.5	699.8	930.7	895.1	831.8	723.1	647.3	777.1	587.5	604.9	657.3	



Jun 2018 - Top 10 in descending order (%)		%
1	Anxiety/stress/depression/other psychiatric illnesses	20.9%
2	Other musculoskeletal problems	15.8%
3	Unknown causes / Not specified	10.5%
4	Gastrointestinal problems	10.1%
5	Back Problems	7.1%
6	Injury, fracture	4.4%
7	Cold, Cough, Flu - Influenza	4.2%
8	Chest & respiratory problems	3.6%
9	Other known causes - not elsewhere classified	3.2%
10	Headache / migraine	3.0%
	TOP 10 REASONS	**82.8%**

***Source data**: ESR*

WELLBEING & ENGAGEMENT

HEALTH & WELLBEING (Corporate priority – stress identification and support)

- Stress Less pilot workshops completed at Conquest working with Health in Mind – 91.7% of attendees moved from experiencing mild or moderate stress to below the threshold we would regard as recovered
- Second cohort of Healthy weights is full, with a waiting list for the future – 97% of attendees would recommend the programme to a colleague

STAFF ENGAGEMENT (Corporate priority – demonstrating values based behaviour)

- All divisions have an action plan from the staff survey with a focus on 5 specific areas for improvement
- Team have supported a number of away days to complete staff survey action plans
- Trust awards took place 12th July with over 250 attendees

WELL LED (Corporate priority – Improve and deliver excellence in care)

- Masterclasses delivered across East Sussex Better Together / Organisational Development Practitioners Programme, with attendance by over 50 people at each
- Team development sessions run for specific wards / departments to enhance communication, behaviours and foster a positive culture
- Leading Excellence / Leading the Service masterclass delivered on both sites – Leading Change in Complex Adaptive Systems
- First Line Managers course (updated and refreshed) starts this month with a full cohort of 16 attendees

East Sussex Healthcare NHS
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TRAINING & APPRAISAL COMPLIANCE BY DIVISION

MANDATORY TRAINING

- Overall mandatory training compliance reduced by -0.3%. A big factor in this was the reduction of -1.3% in Information Governance (IG) compliance. This was the last month in which staff could complete the IG workbook, and going forward it can only be completed through E-learning to meet the requirements of the Data Protection and Security Toolkit. All areas have been notified and Learning & Development will support any staff experiencing difficulties with access.

- Compliance with End of Life Care training increased by 2.4%. As this is a new 3 yearly requirement , it has been agreed that there is a compliance target of 33% for the first year.

APPRAISAL OVERVIEW

- The Trust appraisal rate has reduced by -1.1% to 78.1% as not all appraisals expiring in June were renewed.

DIVISION	APPRAISAL COMPLIANCE
Urgent Care	76.6%
Medicine	83.3%
Out of Hospital	72.9%
Diag/Anaes/Surg	78.4%
Womens, Child, S/Health	76.6%
Estates & Facilities	78.8%
Corporate	78.2%
TRUST	**78.1%**

										SAFEGUARDING		
DIVISION	FIRE SAFETY	MANUAL HANDLING	INDUCTION	INFECTION CONTROL	INFO GOV	HEALTH & SAFETY	MENTAL CAPACITY ACT	DEPRIV OF LIBERTIES	END OF LIFE CARE	VULNERABLE ADULTS	CHILDREN (LEVEL 2)	CHILDREN (LEVEL 3)
Urgent Care	81.7%	82.5%	90.2%	82.9%	79.0%	90.9%	92.3%	86.0%	17.1%	82.7%	84.1%	85.5%
Medicine	85.6%	88.7%	97.9%	87.5%	80.4%	89.3%	94.4%	93.9%	27.1%	85.3%	87.2%	N/A
Out of Hospital	85.9%	90.5%	97.1%	92.9%	81.0%	86.6%	97.7%	99.5%	23.0%	83.8%	82.4%	4.2%
Diag/Anaes/Surg	85.4%	89.2%	89.7%	87.6%	82.8%	84.7%	97.2%	97.3%	15.5%	87.9%	89.2%	N/A
Womens, Child, S/Health	87.6%	87.2%	91.9%	89.7%	85.2%	90.2%	95.8%	95.3%	0.3%	88.1%	91.8%	91.1%
Estates & Facilities	88.9%	87.5%	89.4%	95.7%	90.9%	88.3%	n/a	n/a	n/a	n/a	n/a	n/a
Corporate	92.8%	96.2%	96.4%	93.6%	88.5%	95.2%	97.0%	96.5%	5.7%	82.2%	87.7%	100.0%
TRUST	**87.1%**	**89.8%**	**94.3%**	**90.1%**	**83.8%**	**88.6%**	**96.1%**	**96.9%**	**19.5%**	**86.0%**	**87.4%**	**66.5%**

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

***Source data**: ESR*

May 2018

FINANCE

Jonathan Reid, Director of Finance

East Sussex Healthcare NHS
NHS Trust

Finance Report Summary - Month 3

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

Overall Financial Performance vs Plan

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(11,555)	(13,371)	(13,352)	19
Year End Forecast	(68,422)	(45,000)	(45,000)	0

M3 reflects the revised financial plan submitted to NHSI in June. The Trust is £19k ahead of plan year to date at M3. This is a deterioration of £15k from the previous month.

Agency Usage

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(4,440)	(2,879)	(2,787)	92
Year End Forecast	(13,799)	(2,400)	(2,400)	0

Agency spend has reduced in M3. Overall spend on agency YTD was £92k lower than planned despite continued vacancies. From M4 the Trust will continue to focus on reducing its agency usage to ensure delivery of the plan.

Income

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	97,658	98,821	98,893	72
Year End Forecast	387,935	397,467	397,467	0

Activity over performance in NEL, critical care and A&E are offset by underperformance in elective and day cases.

Operating Costs

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(107,306)	(110,253)	(110,312)	(59)
Year End Forecast	(448,948)	(434,713)	(434,713)	0

Overall costs are £59k overspent compared to plan. These arise from YTD overspends in pay (£819k), largely attributable to medical locum premiums and utilisation of nursing agency above establishment; this is offset by YTD underspends in non-pay (£760k).

Cost Improvement Programme

	Plan £k	Actual £k	Variance £k
Year to Date	3,115	2,702	(413)
Year End Forecast	19,266	19,266	0

Under delivery against bed modelling, endoscopy scopes offset by audiology and drugs over delivery. Plan amended in month to reflect revised target. Continued focus to identify remaining CIP balance and review of further opportunities to mitigate the schemes that are behind plan.

Cash

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Current Balance	2,100	2,100	1,864	(2,098)
Year End Forecast	2,100	2,100	2,100	0

Payments to creditors in month £14.4m taking cash balance under planned balance of £2.1m at month end.

Capital Plan

	Plan £k	Actual £k	Variance £k
Year to Date	5,964	2,301	3,663
Year End Forecast	23,856	12,838	11,018

Current CRL is £12.8m. 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	81.15%	88.48%	51.36%	62.06%
NHS Invoices	93.88%	95.47%	76.15%	95.23%

81% of trade invoices were paid within 28 days which equates to 88% of the total value paid in month.

94% of NHS invoices were paid within contract or within 28 days of receipt which was 95% of the total NHS invoices paid.

Divisional Performance

Division	In the Month Plan FTE	In the Month Actual FTE	In the Month Variance FTE	In the Month Plan £k	In the Month Actual £k	In the Month Variance £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Outturn Plan £k	Forecast Outturn Actual £k	Forecast Outturn Variance £k
Diagnositcs, Anaesthetics & Surgery	1,798.40	1,723.46	74.94	(103)	(815)	(712)	(2,106)	(2,391)	(284)	(2,104)	(2,104)	0
Medicine	1,437.63	1,398.44	39.19	3,551	2,250	(1,301)	8,080	7,377	(703)	34,712	34,712	0
Urgent Care	322.73	299.51	23.22	679	832	153	2,386	2,624	238	8,835	8,835	0
Out of Hospital Care	1,084.87	1,017.88	66.99	(755)	(150)	605	(1,745)	(1,720)	25	(5,290)	(5,290)	0
Women's, Children's & Sexual Health	689.55	640.44	49.11	1,131	927	(203)	3,187	3,342	155	13,922	13,922	0
Estates & Facilities	639.07	623.78	15.29	(1,942)	(1,986)	(43)	(6,060)	(6,153)	(93)	(22,924)	(22,924)	0
Corporate	1,021.11	1,003.85	17.26	(4,275)	(4,110)	165	(13,108)	(12,745)	363	(48,992)	(48,992)	0
Central	0.00	0.00	0.00	(2,433)	(1,112)	1,321	(4,005)	(3,685)	320	(23,159)	(23,159)	0
Total	**6,993.36**	**6,707.36**	**286.00**	**(4,148)**	**(4,164)**	**(15)**	**(13,371)**	**(13,352)**	**19**	**(45,000)**	**(45,000)**	**0**

Key Risks

Key Risk 1	Drugs overspend
Key Risk 2	Medical pay (locums) and Nursing pay (special observations and additional shifts)
Key Risk 3	CIP under delivery and increase in savings required from M4 onwards
Key Risk 4	Fines and Penalties/ readmissions and commisioner challenges

Mitigations

Mitigtion 1	Correction made for Q1 High cost drugs tariff exclusions. Work is ongoing to identify inflationary pressures and mitigate overspends.
Mitigation 2	Temporary staffing controls are being reviewed to ensure that they are in line with NHSI grip and control
Mitigation 3	Divisions continue to be held accountable via Confirm and Challenge sessions and IPR
Mitigation 4	Ongoing discussions with CCGs, including an escalation process to DoF and CEO

Income & Expenditure Summary - Month 3

	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	26.5	27.9	26.9	(1.0)	78.3	82.0	81.0	(0.9)	332.8	332.8	0.0
Tariff-Excluded Drugs & Devices	3.2	2.7	3.3	0.6	8.3	8.2	8.9	0.8	32.7	32.7	0.0
Private Patient / ICR	0.3	0.3	0.2	(0.0)	0.7	0.8	0.8	0.0	3.7	3.7	0.0
Other Non-Clinical Income	3.1	2.5	2.6	0.0	9.1	7.9	8.2	0.2	28.3	28.3	0.0
Total Income	**33.1**	**33.3**	**32.9**	**(0.4)**	**96.4**	**98.8**	**98.9**	**0.1**	**397.5**	**397.5**	**0.0**
Pay - Substantive	(20.1)	(20.8)	(20.9)	(0.1)	(59.9)	(62.1)	(62.6)	(0.5)	(250.2)	(250.2)	0.0
Pay - Bank	(2.0)	(2.2)	(2.1)	0.0	(5.5)	(6.6)	(6.9)	(0.4)	(22.8)	(22.8)	0.0
Pay - Agency	(1.5)	(1.0)	(0.7)	0.3	(4.4)	(2.9)	(2.8)	0.1	(9.3)	(9.3)	0.0
Total Pay	**(23.5)**	**(23.9)**	**(23.7)**	**0.2**	**(69.9)**	**(71.5)**	**(72.3)**	**(0.8)**	**(282.2)**	**(282.2)**	**0.0**
Drugs	(3.8)	(3.5)	(3.7)	(0.2)	(10.5)	(10.6)	(10.9)	(0.3)	(42.2)	(42.2)	0.0
Supplies & Services - Clinical	(3.3)	(2.8)	(3.2)	(0.4)	(8.9)	(8.8)	(9.3)	(0.5)	(35.3)	(35.3)	0.0
Supplies & Services - General	(0.4)	(0.4)	(0.4)	(0.0)	(1.1)	(1.2)	(1.2)	(0.1)	(4.8)	(4.8)	0.0
Purchase of Healthcare (non-NHS)	(0.4)	(0.5)	(0.5)	(0.0)	(1.3)	(1.3)	(1.4)	(0.1)	(5.8)	(5.8)	0.0
Services from Other NHS Bodies	(0.4)	(0.6)	(0.5)	0.1	(1.3)	(1.9)	(1.4)	0.5	(7.5)	(7.5)	0.0
Consultancy	(0.1)	(0.3)	(0.2)	0.2	(0.2)	(0.4)	(0.5)	(0.1)	(1.0)	(1.0)	0.0
Clinical Negligence	(1.2)	(0.9)	(0.9)	(0.0)	(3.7)	(2.6)	(2.6)	(0.0)	(10.3)	(10.3)	0.0
Premises	(1.1)	(1.1)	(1.2)	(0.1)	(3.4)	(3.5)	(3.7)	(0.2)	(14.6)	(14.6)	0.0
Depreciation	(1.1)	(2.0)	(1.0)	0.9	(3.2)	(4.1)	(3.1)	1.0	(12.9)	(12.9)	0.0
Other	(1.3)	(1.8)	(1.1)	0.7	(4.0)	(4.3)	(3.7)	0.5	(18.3)	(18.3)	0.0
Total Non-Pay	**(13.1)**	**(14.0)**	**(12.8)**	**1.2**	**(37.4)**	**(38.7)**	**(38.0)**	**0.8**	**(152.6)**	**(152.6)**	**0.0**
Total Operating Costs	**(36.7)**	**(37.9)**	**(36.5)**	**1.3**	**(107.3)**	**(110.3)**	**(110.3)**	**(0.1)**	**(434.8)**	**(434.8)**	**0.0**
Net Surplus/(Deficit) from Operations	**(3.6)**	**(4.5)**	**(3.6)**	**0.9**	**(10.9)**	**(11.4)**	**(11.4)**	**0.0**	**(37.4)**	**(37.4)**	**0.0**
Financing Costs	(0.7)	(0.6)	(0.5)	0.1	(1.9)	(1.9)	(1.9)	0.0	(7.6)	(7.6)	0.0
Total Non-Operating Costs	**(0.7)**	**(0.6)**	**(0.5)**	**0.1**	**(1.9)**	**(1.9)**	**(1.9)**	**0.0**	**(7.6)**	**(7.6)**	**0.0**
Total Costs	**(37.3)**	**(38.5)**	**(37.1)**	**1.4**	**(109.2)**	**(112.2)**	**(112.2)**	**(0.1)**	**(442.5)**	**(442.5)**	**0.0**
Net Surplus/(Deficit)	**(4.2)**	**(5.2)**	**(4.2)**	**1.0**	**(12.8)**	**(13.4)**	**(13.4)**	**0.0**	**(45.0)**	**(45.0)**	**0.0**
Donated Asset/Impairment Adjustment	0.1	1.0	(0.0)	(1.0)	0.2	0.0	0.1	0.1	0.0	0.0	0.0
Operational Surplus/(Deficit)	**(4.2)**	**(4.1)**	**(4.2)**	**0.0**	**(12.6)**	**(13.4)**	**(13.3)**	**0.1**	**(45.0)**	**(45.0)**	**0.0**
Provider Sustainability Funding	0.3	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0
Net Surplus/(Deficit)	**(3.9)**	**(4.1)**	**(4.2)**	**0.0**	**(11.3)**	**(13.4)**	**(13.3)**	**0.1**	**(45.0)**	**(45.0)**	**0.0**

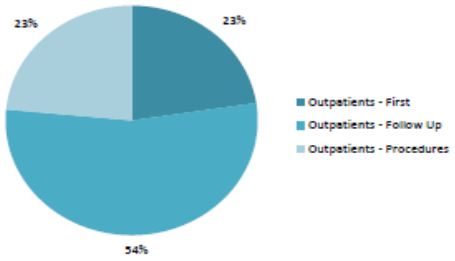
Summary & Next Steps

M3 reflects the revised financial plan of £45m deficit budget submitted to NHSI in June. The Trust's YTD financial performance at M3 is slightly above plan (£19k) but has deteriorated (£15k) from M2. In month underspends in non-pay (£1.2m) and pay (£0.2m) are offset by underperformance in income (£0.4m) and donated assets (£1.0m), these are related to YTD adjustments in the month to reflect the revised plan. In month non-pay continued to rise on trend in M3, continuation of trend will create a YTD overspend from M5 onwards. Agency underspends in month (£0.3m) partially offset YTD overspends in bank pay (£0.4m) arising primarily from nurse specialing costs. Continued identification and delivery of pay and non-pay CIP schemes remains critical to delivery of the financial plan.

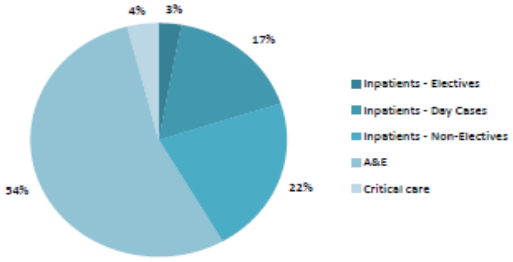
Income & Activity Summary - Month 3

	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	612	604	600	(4)	1,777	1,796	1,753	(43)	1,858	1,784	1,681	(103)	5,346	5,304	5,028	(275)	21,643	21,643	0
Inpatients - Day Cases	3,482	3,318	3,726	408	2,545	2,493	2,556	63	9,901	9,797	10,117	320	7,336	7,362	7,075	(287)	30,041	30,041	0
Inpatients - Non-Electives	3,689	4,038	4,239	201	7,969	8,501	8,703	202	10,812	12,249	12,880	631	22,666	25,786	26,293	508	103,427	103,427	0
Outpatients	35,412	33,812	34,448	635	3,749	3,613	3,581	(32)	97,760	99,827	102,147	2,320	10,295	10,667	10,749	82	43,528	43,528	0
A&E	10,082	10,046	10,820	774	1,353	1,350	1,445	95	29,860	30,472	32,152	1,680	3,962	4,095	4,316	222	16,424	16,424	0
CQUIN	0	0	0	0	517	914	626	(288)	0	0	0	0	1,560	1,743	1,850	107	7,101	7,101	0
Critical Care	709	726	812	86	748	796	899	103	2,079	2,201	2,340	139	2,251	2,415	2,631	216	9,687	9,687	0
Direct Access	9,276	8,620	8,316	(304)	373	347	308	(38)	26,261	25,450	25,468	18	1,054	1,024	974	(51)	4,180	4,180	0
ESBT	0	0	0	0	382	588	591	4	0	0	0	0	1,062	1,764	1,732	(32)	7,055	7,055	0
Excess Bed Days	1,734	1,454	472	982	413	354	234	(120)	5,837	4,401	2,512	1,889	1,391	1,071	730	(341)	4,301	4,301	0
Exclusions	0	0	0	0	3,117	2,994	3,057	63	0	0	0	0	8,276	9,082	8,911	(171)	36,426	36,426	0
IMSK	0	0	0	0	211	118	118	(0)	0	0	0	0	239	355	355	(0)	1,421	1,421	0
Maternity Pathway	543	556	562	6	541	566	588	22	1,646	1,641	1,719	78	1,629	1,672	1,825	153	6,822	6,822	0
Other	319,319	301,733	319,828	18,096	6,593	5,816	5,679	(138)	886,870	914,925	938,521	23,597	20,187	17,157	17,471	313	70,410	70,410	0
Contract Income Total	384,858	364,907	383,823	20,879	30,287	30,247	30,140	(107)	1,072,884	1,102,747	1,129,537	30,568	87,255	89,496	89,940	444	362,463	362,463	0
Divisional Income					3,408	4,103	2,772	(1,331)					9,787	9,325	8,953	(372)	35,004	35,004	0
Total Income	384,858	364,907	383,823	20,879	33,695	34,349	32,911	(1,438)	1,072,884	1,102,747	1,129,537	30,568	97,041	98,821	98,893	72	397,467	397,467	0

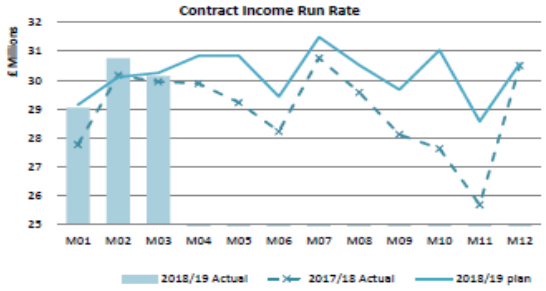
YTD Outpatients Activity by POD



YTD Inpatient & A&E Activity



Contract Income Run Rate



Summary & Next steps

Inpatients - Electives & Day cases (YTD) — £562k below plan — -4.4%

Trauma and Orthopaedics have underperformed by £237k YTD against plan. Reported activity levels continue to rise with an increase of 15% from May to June 2018. Ophthalmology (£212k) and Gynaecology (£176k) have under-performed YTD against plan.

Inpatients - Non-Electives (YTD) — £507k above plan — 2.0%

Overperformance of £1,222k YTD in General Medicine.

Outpatients (YTD) — £82k above plan — 0.8%

Trauma and Orthopaedics have overperformed by £161k YTD against plan, offset by underperformances in Ophthalmology (£80k) and Paediatrics (£83K).

A&E (YTD) — £221k above plan — 5.4%

Financial overperformance of £222k YTD. Reduction in activity of 3% from May to June 2018.

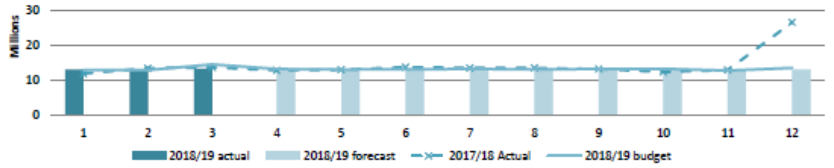
Financial Risks (YTD) — £234k

£234k of risk relating to Winter, palliative care, CQUIN, MRET and data challenges has not been included in YTD contract income figures.

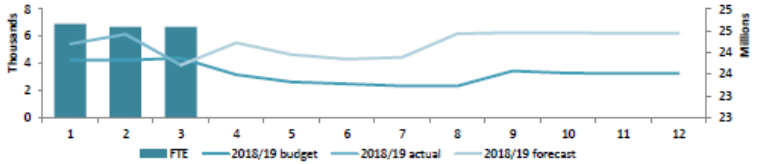
Operating Expenditure & Workforce Summary - Month 3

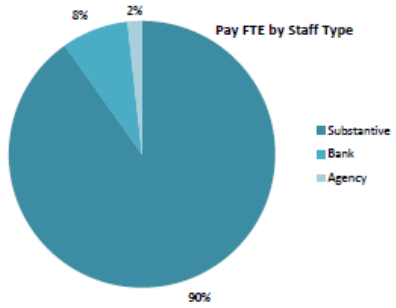
Cost Element	In Month								Year to Date				Forecast Outturn			
	17/18 WTE Actual	18/19 WTE Plan	18/19 WTE Actual	WTE Variance	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	18/19 Expenditure Variance (£k)	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	18/19 Expenditure Variance (£k)	18/19 Plan (£k)	18/19 FOT (£k)	Variance (£k)	
Administrative & Management	1328.71	1398.83	1325.81	73.02	3,557	3,704	3,522	182	10,561	11,204	10,863	340	44,724	44,724	0	
Ancillary	693.59	705.59	679.49	26.10	1,431	1,427	1,432	(5)	4,287	4,283	4,272	11	17,135	17,135	0	
Medical	662.50	708.98	667.27	41.71	5,817	5,564	5,778	(213)	17,003	16,812	17,635	(822)	67,027	67,027	0	
Nursing & Midwivery	3056.10	3170.32	3068.63	101.69	9,523	9,151	9,479	(328)	28,481	28,490	28,826	(335)	114,624	114,624	0	
Prof, Scientific & Tech	522.33	535.73	519.10	16.63	1,748	1,685	1,662	23	5,214	5,025	5,201	(176)	20,004	20,004	0	
Professions Allied to Medicine	411.32	513.91	447.06	66.85	1,438	1,617	1,501	116	4,304	5,136	4,512	624	20,377	20,377	0	
Other	0.00	-40.00	0.00	(40.00)	12	727	342	385	38	578	1,039	(461)	(1,664)	(1,664)	0	
Total Pay	**6674.55**	**6993.36**	**6707.36**	**286.00**	**23,527**	**23,875**	**23,715**	**159**	**69,888**	**71,529**	**72,348**	**(819)**	**282,227**	**282,227**	**0**	
Services from Other NHS Bodies					435	518	505	14	1,260	1,327	1,393	(66)	5,856	5,856	0	
Clinical Negligence Premium					1,218	877	877	0	3,654	2,632	2,632	0	10,270	10,270	0	
Consultancy					78	30	160	(130)	182	400	505	(105)	861	861	0	
Drugs					980	823	647	176	2,984	2,469	2,740	(271)	9,374	9,374	0	
Drugs - Tariff Excluded					2,818	2,676	3,078	(402)	7,509	8,118	8,140	(22)	32,563	32,563	0	
Education and Training					125	129	46	83	322	381	238	143	1,549	1,549	0	
Establishment Expenses					608	881	535	347	1,824	1,897	1,860	37	7,594	7,594	0	
Premises					1,124	1,007	1,217	(211)	3,370	3,428	3,739	(311)	14,580	14,580	0	
Purchase of Healthcare from Non NHS Bodies					435	518	505	14	1,260	1,327	1,393	(66)	5,856	5,856	0	
Supplies and Services - Clinical					3,318	3,003	3,218	(215)	8,875	8,881	9,313	(452)	35,016	35,016	0	
Supplies and Services - General					359	336	446	(110)	1,111	1,011	1,244	(234)	4,044	4,044	0	
Other Non-Pay					1,630	3,190	1,585	1,605	5,066	6,876	4,769	2,107	25,050	25,050	0	
Total Non-Pay					**13,129**	**13,990**	**12,820**	**1,170**	**37,418**	**38,728**	**37,969**	**760**	**152,614**	**152,614**	**0**	
Total Expenditure	**6675**	**6993**	**6707**	**286**	**36,656**	**37,865**	**36,535**	**1,330**	**107,306**	**110,257**	**110,316**	**(59)**	**434,841**	**434,841**	**0**	

Non-Pay Monthly Run rate



Pay Monthly Run Rate vs FTE





Summary & Next Steps

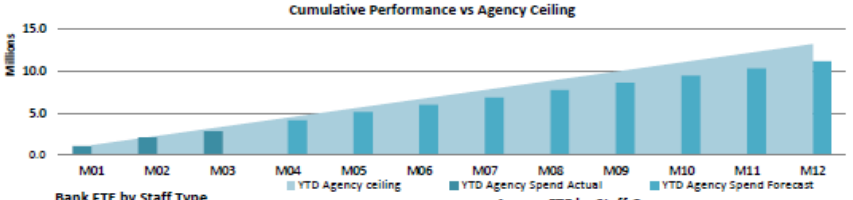
Pay costs have reduced £0.7m compared to the previous month, of which £0.3m is due to a YTD adjustment in month. A&E doctors received a recruitment and retention payment in month. Waiting list initiative payments reduced £23k compared to the previous month.

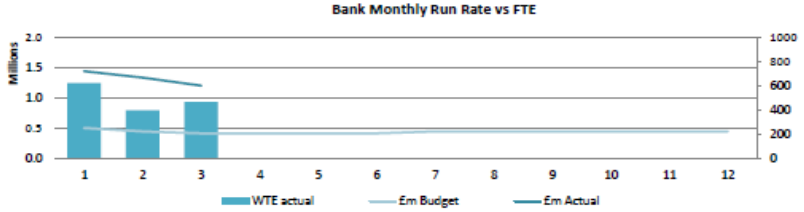
Pharmacy Manufacturing Unit continued to incur £0.1m pay costs and £0.1m non pay costs which were partially offset by income received, the staff are in the process of being redeployed. A review of drugs spend has highlighted an issue with mapping of tariff excluded drugs to be recharged to commissioners and a YTD adjustment has been made in M3. Establishment Expenses overspend relates to COIN and income has been received to offset this.

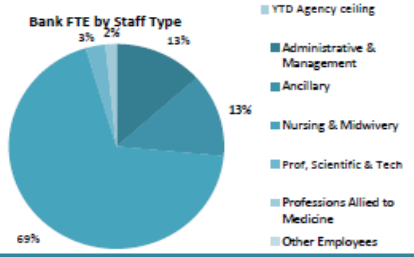
Medicine division have shown a significant overspend on pay, related to special observations on the wards and medical temporary staffing premiums.
The increase in non-elective activity above plan accounts for some of the higher costs, further work is being undertaken to understand the activity related staffing and non-pay costs.

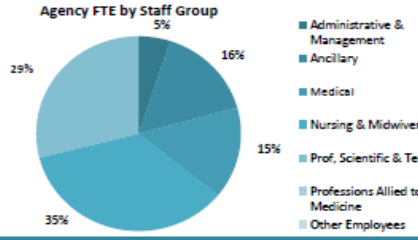
Temporary Workforce Summary - Month 3

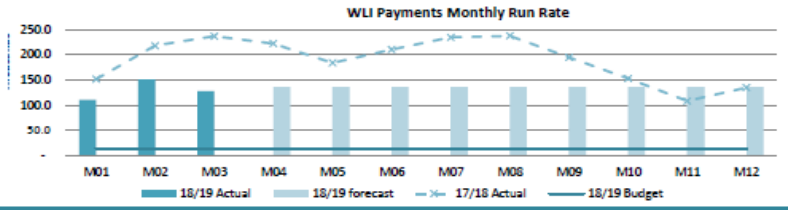
Cost Element	In Month								Year to Date				Forecast Outturn			
	17/18 WTE Actual	18/19 WTE Plan	18/19 WTE Actual	WTE Variance	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	Expenditure Variance (£k)	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	Expenditure Variance (£k)	18/19 Plan (£k)	18/19 FOT (£k)	Variance (£k)	
Agency																
Administrative & Management	7.94	0.00	5.90	(5.90)	99	81	(7)	88	249	243	314	(71)	872	872	0	
Ancillary	28.26	0.00	18.42	(18.42)	66	81	72	9	195	243	185	58	872	872	0	
Medical	55.94	10.71	17.89	(7.18)	812	324	269	55	2,441	1,014	1,028	(14)	3,580	3,580	0	
Nursing & Midwivery	54.06	0.00	41.35	(41.35)	227	217	176	41	748	623	610	13	1,582	1,582	0	
Prof, Scientific & Tech	37.86	2.68	34.08	(31.40)	269	252	187	65	807	756	650	106	2,399	2,399	0	
Professions Allied to Medicine	0.00	0.00	0.00	0.00	0	0	0	0	0	0	0	0	0	0	0	
Other Employees	0.00	0.00	0.00	0.00	0	0	0	0	0	0	0	0	0	0	0	
Total Agency	**184.06**	**13.39**	**117.64**	**(104.25)**	**1,473**	**955**	**697**	**258**	**4,440**	**2,879**	**2,787**	**92**	**9,305**	**9,305**	**0**	
Bank																
Administrative & Management	94.44	7.12	62.60	(55.48)	175	305	131	174	501	915	410	505	3,510	3,510	0	
Ancillary	80.95	21.75	61.62	(39.87)	155	0	126	(126)	482	0	402	(402)	0	0	0	
Nursing & Midwivery	336.67	121.11	322.88	(201.77)	930	1,100	887	213	2,831	3,289	2,976	313	11,763	11,763	0	
Prof, Scientific & Tech	9.61	0.00	13.97	(13.97)	28	58	40	18	84	174	123	51	696	696	0	
Professions Allied to Medicine	3.43	0.20	7.77	(7.57)	11	33	25	8	34	99	94	5	436	436	0	
Other Employees	0.00	0.00	0.00	0.00	0	0	0	0	0	0	0	0	0	0	0	
Total Bank	**525.10**	**150.18**	**468.84**	**(318.66)**	**1,299**	**1,496**	**1,210**	**286**	**3,932**	**4,477**	**4,003**	**474**	**16,405**	**16,405**	**0**	
Total Locum	**70.92**	**18.60**	**74.44**	**(55.84)**	**696**	**669**	**923**	**(254)**	**1,589**	**2,077**	**2,920**	**(843)**	**6,361**	**6,361**	**0**	
Total Waiting List Initiative	**16.16**	**0.00**	**7.23**	**(7.23)**	**237**	**14**	**128**	**(114)**	**606**	**41**	**389**	**(348)**	**0**	**0**	**0**	
TotalTemporary Workforce	**796.24**	**182.17**	**668.15**	**(485.98)**	**3,704**	**3,134**	**2,957**	**176**	**10,567**	**9,474**	**10,099**	**(625)**	**32,071**	**32,071**	**0**	











Summary & Next steps

Bank FTE utilisation has reduced due to an accounting adjustment.

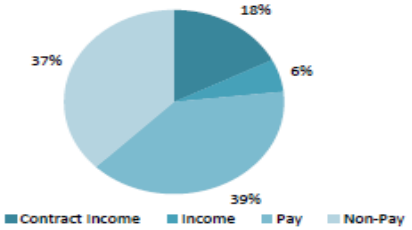
Waiting list initiative payments have reduced compared to the previous month with spend of £128k in M3, further approval controls are being put in place to improve grip and control. Agency costs are within the ceiling and are lower than planned for Q1.

Admin & Clerical agency usage will decrease from M4 as contracts finish and further work on grip and control is being undertaken to reduce temporary workforce costs across the Trust.

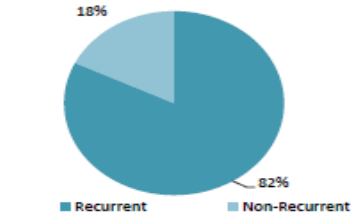
Cost Improvement Programme Summary - Month 3

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	96	188	91	289	323	34	1,271	1,331	60	153	170
Income	63	62	-1	151	146	-5	822	808	-13	128	18
Pay	743	422	-321	1,877	1,406	-471	8,596	7,700	-896	1,114	293
Non-Pay	427	402	-25	797	827	29	4,383	4,099	-284	827	0
Total 'Green' schemes	**1,330**	**1,074**	**-256**	**3,115**	**2,702**	**-413**	**15,072**	**13,939**	**-1,132**	**2,221**	**480**
Pipeline/Unidentified	0	0	0	0	0	0	4,194	5,327	1,132	82%	18%
Total	**1,330**	**1,074**	**-256**	**3,115**	**2,702**	**-413**	**19,266**	**19,266**	**0**		

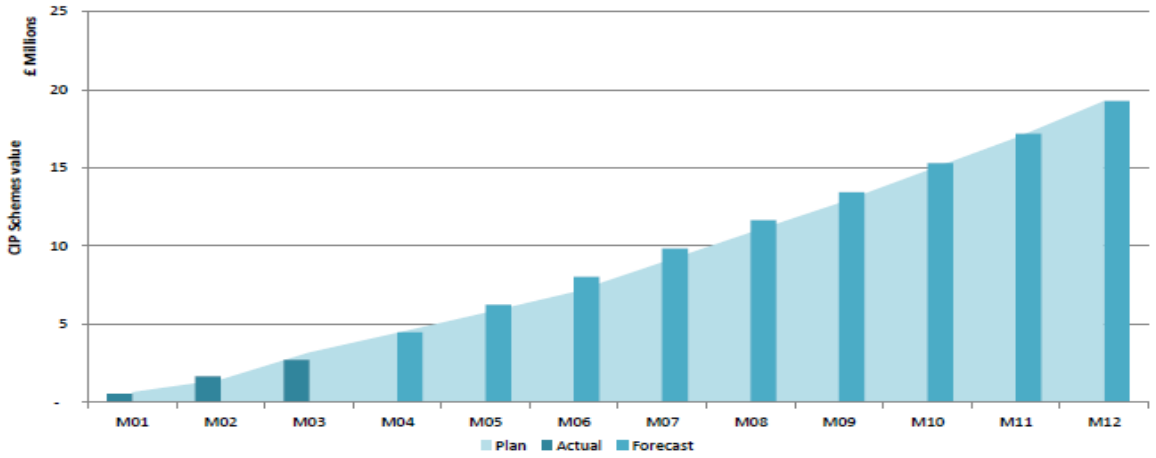
YTD CIP green schemes by category



YTD CIP green schemes recurrent/non-recurrent



CIP Performance



Summary & Next Steps

The Trust is behind plan for month 3. The variance on contract income is associated with audiology activity, this is mitigating a shortfall on a spend to save scheme. Staff have not been recruited and therefore costs have not been incurred.

Pay is underperforming and is largely associated with bed modelling, which has a later start date than was assumed in the financial plan.

Non-pay is showing a slight overperformance YTD. This is associated with pharmacy drugs savings. The impact of this is mitigating the delay on realising the savings on endoscopy scopes and bed modelling.

The £23.5m plan is based on the stretch required to meet the £19.2m as there may be in-year slippage.

Statement of Financial Position - Month 3

	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	215.7	214.9	(0.8)	215.7	215.7	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**	**219.0**	**218.1**	**(0.8)**	**219.0**	**219.0**	**0.0**	
Inventories	7.3	7.3	7.1	(0.2)	7.3	7.3	0.0	
Trade and Other Receivables	35.3	26.0	27.5	1.4	26.0	26.0	0.0	
Cash and Cash Equivalents	2.1	2.1	1.9	(0.2)	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**	**35.4**	**36.4**	**1.0**	**35.4**	**35.4**	**0.0**	
Trade and Other Payables	(37.7)	(28.6)	(31.1)	(2.5)	(28.6)	(28.6)	0.0	
Borrowings	(35.7)	(0.4)	(35.7)	(35.3)	(0.4)	(0.4)	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)	(0.0)	(0.6)	(0.6)	0.0	
Other Liabilities	(1.7)	(1.7)	(1.1)	0.7	(1.7)	(1.7)	0.0	
Current Liabilities	**(75.7)**	**(31.3)**	**(68.4)**	**(37.1)**	**(31.3)**	**(31.3)**	**0.0**	
Borrowings	(121.5)	(201.6)	(133.1)	68.5	(201.6)	(201.6)	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**	**19.2**	**50.8**	**(5.6)**	**19.2**	**19.2**	**0.0**	
Public Dividend Capital	156	156	156	0	156	156	0	
Income & Expenditure Reserve	(187)	(232)	(200)	32	(232)	(232)	0	
Revaluation Reserve	94	94	94	(0)	94	94	0	
Total Tax Payers Equity	**64.2**	**19.2**	**50.8**	**31.6**	**19.2**	**19.2**	**0.0**	

Summary & Next Steps

Month 3 borrowings in line with the original plan, cash below planned balance due to £14m payments to creditors in month.

Cashflow & Borrowing Summary - Month 3

Short Term (13 week) Cashflow Forecast

	Actual (£k)				Forecast (£k)								
Week Ending (Friday)	08-Jun	15-Jun	22-Jun	29-Jun	06-Jul	13-Jul	20-Jul	27-Jul	03-Aug	10-Aug	17-Aug	24-Aug	31-Aug
Balance Brought Forward	**3,135**	**2,908**	**31,136**	**5,906**	**4,587**	**11,048**	**32,730**	**21,772**	**5,567**	**3,290**	**2,207**	**30,797**	**3,774**
Receipts													
WGA Income	677	29,226	21	369	8,755	23,073	0	0	630	0	28,816	0	630
Other Income	1,948	750	1,317	116	1,059	1,646	550	470	673	1,325	1,431	552	409
External Financing	0	3,771	0	0	0	0	3,080	0	0	0	2,931	0	0
Total Receipts	**2,625**	**33,746**	**1,338**	**484**	**9,814**	**24,719**	**3,630**	**470**	**1,303**	**1,325**	**33,178**	**552**	**1,039**
Payments													
Pay	(332)	(304)	(22,139)	(225)	(274)	(271)	(9,879)	(13,585)	(270)	(270)	(270)	(25,985)	(270)
Non-Pay	(2,480)	(5,102)	(3,779)	(1,563)	(2,883)	(2,766)	(4,170)	(3,090)	(3,310)	(2,138)	(3,674)	(1,590)	(1,590)
Capital Expenditure	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend	0	0	0	0	0	0	0	0	0	0	0	0	0
Other payments	(40)	(111)	(651)	(15)	(196)	(0)	(539)	0	0	0	(644)	0	0
Total Payments	**(2,852)**	**(5,518)**	**(26,569)**	**(1,803)**	**(3,353)**	**(3,037)**	**(14,588)**	**(16,675)**	**(3,580)**	**(2,408)**	**(4,588)**	**(27,575)**	**(1,860)**
Net Cash Movement	**(227)**	**28,229**	**(25,231)**	**(1,319)**	**6,461**	**21,682**	**(10,958)**	**(16,205)**	**(2,277)**	**(1,083)**	**28,590**	**(27,023)**	**(821)**
Balance Carried Forward	**2,908**	**31,136**	**5,906**	**4,587**	**11,048**	**32,730**	**21,772**	**5,567**	**3,290**	**2,207**	**30,797**	**3,774**	**2,953**

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 Ce	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	Jan 00	5	3.50%	31,300	1,096
Interim Loan Agreement	35,218	Jan 00	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 April-July 2017	13,755	Apr-Jul	3	6.00%	13,785	827
Loan August - March 2018	50,393	Aug-Mar	3	3.50%	50,363	1,781
Prior Years Total	**160,979**				**157,212**	**5,703**
Current Year						
Loan Apr 2018	3,916	Apr 18	3	3.50%	3,916	69
Loan May 2018	3,917	May 18	3	3.50%	3,917	71
Loan June 2018	3,771	Jun 18	3	3.50%	3,771	69
Current Year Total	**11,604**				**11,604**	**209**
Total Loans	**172,583**				**168,816**	**5,912**

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.

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

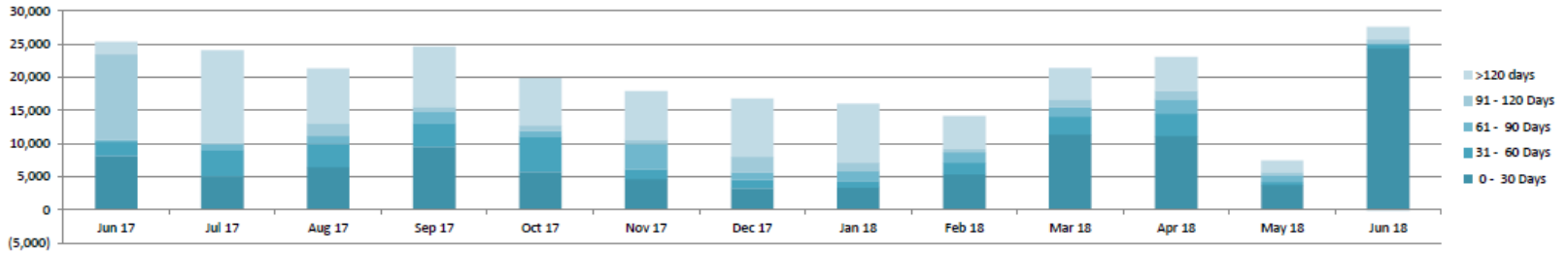
5. All existing loans listed in the table on the left.

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.

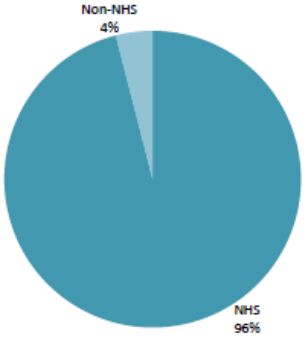
Receivables Summary - Month 3

Receivables Aging Run rate (£k)

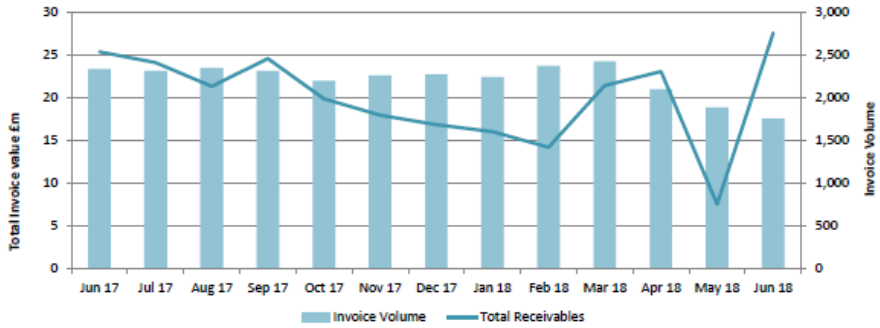
Aging Profile	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
0 - 30 Days	8,102	5,079	6,448	9,548	5,737	4,648	3,269	3,418	5,379	11,332	11,164	3,753	24,337
31 - 60 Days	2,153	3,871	3,461	3,411	5,217	1,450	1,286	960	1,745	2,686	3,335	448	696
61 - 90 Days	299	973	1,248	1,938	941	3,850	1,099	1,588	1,573	1,467	2,189	968	(44)
91 - 120 Days	12,894	242	1,920	643	782	583	2,331	1,133	470	1,214	1,316	518	618
>120 days	1,900	13,908	8,233	9,036	7,179	7,372	8,809	8,897	4,997	4,685	5,048	1,775	1,963
Total Receivables	**25,348**	**24,074**	**21,309**	**24,576**	**19,856**	**17,903**	**16,794**	**15,996**	**14,164**	**21,384**	**23,053**	**7,461**	**27,572**
Invoice Volume	**2,337**	**2,309**	**2,344**	**2,311**	**2,193**	**2,260**	**2,269**	**2,241**	**2,366**	**2,426**	**2,100**	**1,880**	**1,749**



Current Month % NHS vs Non-NHS by Value



Receivables Invoice Value vs Volume Run Rate



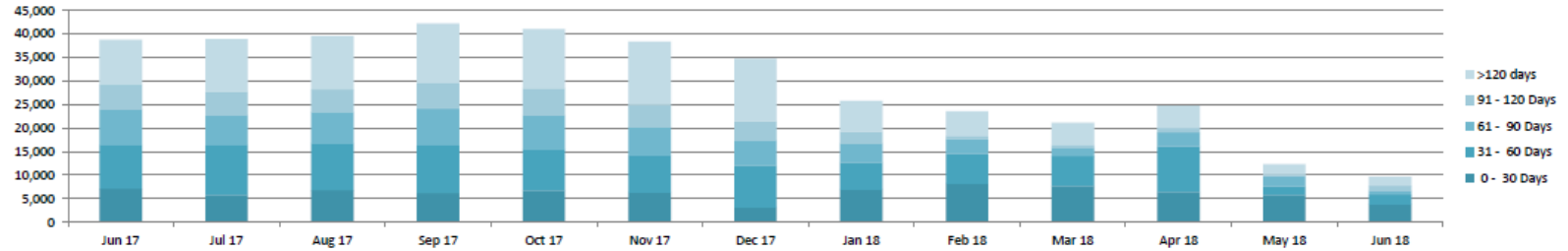
Summary & Next Steps

1. Internal plan to bring receivables down to £6m at month-end and to deliver Debtor Day KPI of 18 days by end of July.
2. Improving liquidity means that additional payments being made to NHS creditors - improving the likelihood of negotiating additional payments from NHS organisations to ESHT.
3. Receivables increased by £20m between May and June as a result of advance payment agreed with CCG's. Current debtor days is 27 days (37 days in April).

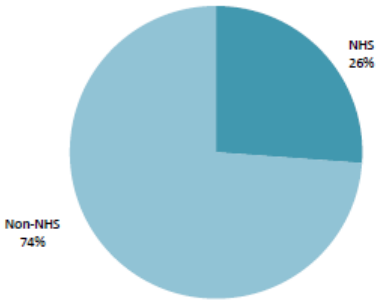
Payables Summary - Month 3

Payables Aging Run rate (£k)

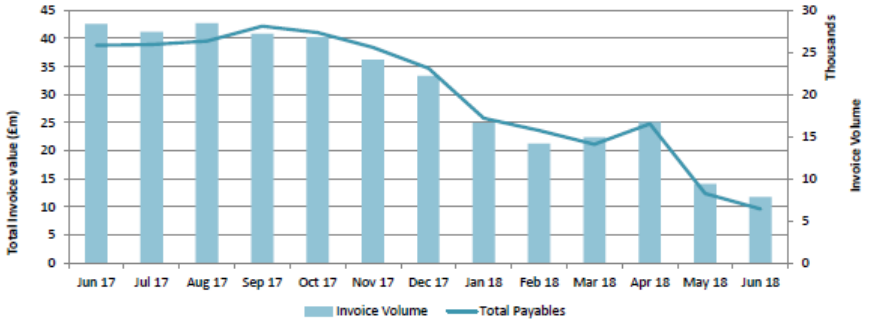
Aging Profile	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
0 - 30 Days	7,086	5,751	6,799	6,188	6,726	6,227	3,130	6,872	8,184	7,668	6,423	5,752	3,711
31 - 60 Days	9,244	10,518	9,861	10,094	8,620	7,924	8,902	5,760	6,341	6,360	9,679	1,843	2,117
61 - 90 Days	7,536	6,516	6,737	7,883	7,267	5,929	5,430	4,064	3,128	1,681	2,969	2,267	766
91 - 120 Days	5,328	4,980	4,792	5,402	5,851	4,875	4,025	2,521	729	655	932	367	1,148
>120 days	9,592	11,178	11,353	12,638	12,599	13,449	13,202	6,556	5,220	4,753	4,762	2,135	1,854
Total Payables	**38,786**	**38,943**	**39,542**	**42,204**	**41,063**	**38,405**	**34,688**	**25,773**	**23,602**	**21,118**	**24,765**	**12,363**	**9,596**
Invoice Volume	**28,386**	**27,428**	**28,488**	**27,245**	**26,840**	**24,162**	**22,223**	**16,609**	**14,182**	**14,954**	**16,715**	**9,382**	**7,829**



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 (September 2017).
2. Prioritisation of invoices not ready to pay (currently £6m).
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 (more efficient).

Capital Programme Summary - Month 3

YTD Capital Programme Performance	TOTAL PLAN ADJUSTED £000	CRG COMMITTED £000	ACTUAL EXPENDITURE £000	FORECAST EXPENDITURE £000	SYSTEM COMMITTED £000
Brought Forward	**500**	**686**	**1,259**	**1,259**	**1,301**
External Funding	3,709	250	4	250	22
New Business Case	2,570	100	22	1,720	0
Medical Equipment	2,200	294	52	293	200
Digital	1,872	837	28	1,839	185
Estates	11,005	9,576	560	14,204	1,516
Finance	2,000	1,593	375	1,593	1,593
Total Owned	**23,856**	**13,336**	**2,301**	**21,158**	**4,816**
Donated	0	0	168	0	0
Less donated Income	0	0	(168)	0	0
Total	**23,856**	**13,336**	**2,301**	**21,158**	**4,816**

Capital Resource Limit	Source	£k
Opening Capital Resource Limit		**12,838**
Closing Capital Resource Limit		**12,838**

Summary & Next steps

1. The Capital Resource Group has committed £13.3m of this year's Capital Resource Limit (CRL) of £12.8m.
2. Within the Capital Programme there are schemes where estimated costs amount to £3.7m and where external funding will be explored.
3. The Capital Programme will deliver the CRL target at year end.
4. The Trust is actively seeking significant external funding to bring the CRL closer to plan.

Sustainability and Strategy

SUSTAINABILITY

ESHT – Long-term

The draft long term strategic model and financial plan was discussed at the Trust Board seminar on the 3rd July. The paper described the work required to deliver safe and sustainable services, both clinically and financially, for our population.

The next stage is to build on the draft and develop a detailed model and plan together with a draft 3 year delivery plan to be discussed by the Trust Board on the 3rd September and submitted to NHSI by the 5th September for approval. The plan will be consistent with the 'system' recovery plan.


WHAT
MATTERS
TO YOU
MATTERS
TO US
ALL

ESHT 2020 – Our Ambition to be Outstanding by 2020

Meeting information:			
Date of Meeting:	7th August 2018	Agenda Item:	10
Meeting:	Trust Board	Reporting Officer:	Catherine Ashton, Director of Strategy, Innovation and Planning

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?	

Summary:

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

ESHT 2020 sets out the Trust's ambition to be an outstanding organisation by the year 2020 and provides the framework for how this will be achieved. The framework describes the Trust's vision and values, alongside the overarching strategic objectives that will enable delivery of this vision and be recognised as an 'Outstanding' organisation by 2020.

It is the reference document for personal objectives, internal communications, and external communication with partner organisations and other stakeholders. The values and objectives have been embedded across the organisation and translated into the individual work programmes in clinical units, corporate services, and cross-organisation initiatives.

ESHT 2020 is revisited, refreshed and recommitted to annually as part of the Trust's business planning cycle and the attached document provides the updated framework.

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

June Executive Directors

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

To note the updated ESHT 2020 framework including the strategic objectives for 2018/19.

East Sussex Healthcare NHS Trust

ESHT 2020

Our ambition to be outstanding by 2020

June 2018

WHAT **MATTERS** TO YOU
MATTERS TO US ALL

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Background

ESHT 2020 sets out our ambition to be an outstanding organisation by the year 2020 and provides the framework for how we will achieve this.

The framework describes the Trust's vision and values, alongside our overarching strategic objectives that will enable us to deliver this vision and be recognised as an 'Outstanding' organisation by 2020.

ESHT 2020 is the reference document for personal objectives, internal communications, and external communication with partner organisations and other stakeholders. The values and objectives have been embedded across the organisation and translated into the individual work programmes in clinical units, corporate services, and cross-organisation initiatives.

ESHT 2020 is revisited, refreshed and recommitted to annually as part of the Trust's business planning cycle.

2017/2018 progress

With ESHT 2020 as its core, the Trust has implemented many changes and improvements during 2017/18 and there is a growing confidence within the organisation in our ability to achieve important national standards and our ambition to be an outstanding Trust by 2020.

We are transforming the way we provide urgent and emergency care, and have made great progress in delivering the target of assessing and treating or referring 95% of patients within four hours in our emergency departments. We are embedding quality management systems, better identifying and supporting those patients at the end of their life, reducing patient falls and pressure ulcers and effectively detecting and managing infections.

Throughout the year, our patients have continued to rate their experiences of our care very highly. Our patient experience scores have improved and our two hospitals have four and four and a half star ratings on NHS Choices. We are also seeing more plaudits about the care we offer and fewer complaints.

During 2017/18 we reduced our vacancy rate, recruiting to a number of nationally ‘hard to recruit to’ posts. In the 2017 NHS Staff Survey, we maintained the significant improvements that we saw in the 2016 survey and saw further improvements in many important areas. This improvement was borne out in improved results from the Medical Engagement Scale and the GMC junior doctor survey.

We continue to value innovation and research as a way to provide high quality patient care. Over the last year, the Trust has worked with patients, universities, industry and others to take the best new ideas and use them to care for our patients in the most effective way. ESHT members of staff have supported many advances over the years, including pioneering treatments and technology that are now routinely used in hospitals throughout the UK.

These improvements are set within the context of our work as a partner with Eastbourne Hailsham and Seaford CCG, Hastings and Rother CCG and East Sussex County Council in East Sussex Better Together (ESBT). This is a transformation programme to fully integrate health and social care to deliver high quality and sustainable services to our local population. Our shared vision is to ensure that people receive proactive, joined up care, supporting them to live as independently as possible and achieve the best possible outcomes. Together we are building a new model of care that integrates our whole system: primary prevention, primary and community care, social care, mental health, acute and specialist care so that we can demonstrably make the best use of the £850m that is spent each year to meet the health and care needs of the people of East Sussex.

Towards the end of 2017/18 the Trust was inspected by the Care Quality Commission (CQC). The CQC inspected Medicine and Urgent Care on both sites, Surgery and Maternity at Conquest Hospital and Outpatients at Eastbourne District General Hospital. We were pleased that the continued improvements that the Trust has made were recognised. The CQC rated the Trust as ‘Good’ or ‘Outstanding’ in almost all of the services they inspected.

For the first time, ‘Outstanding’ ratings were given in three categories. The CQC noted the Trust had made a marked improvement in the quality of its care and concluded that the trust no longer needed to be in special measures for quality.

Although no longer in special measures for quality, we remain in special measures for finance. This year the Trust’s finances remained challenging and we ended the financial year with an operational deficit of £57.4m. This figure is far larger than we wanted and more than the ambitious target we set ourselves at the start of this year. While we slightly improved our underlying financial position and made £22.3m in financial savings, we did not do enough to reach our financial targets. Across the organisation, we are all working hard to identify ways to further reduce our costs in 2018/19 and beyond, through building effective and efficient services while maintaining safe and high quality care for our patients. The ‘Model Hospital’ and the ‘Getting it Right First Time’ programmes, both of which are supported nationally, but are locally implemented through our clinicians and operational teams, are the key tools we are using to deliver these changes.

Our aim is to be an organisation that provides excellent healthcare for the people of East Sussex and one in which people are happy and proud to work. We are working hard to achieve “Outstanding” status in 2020.

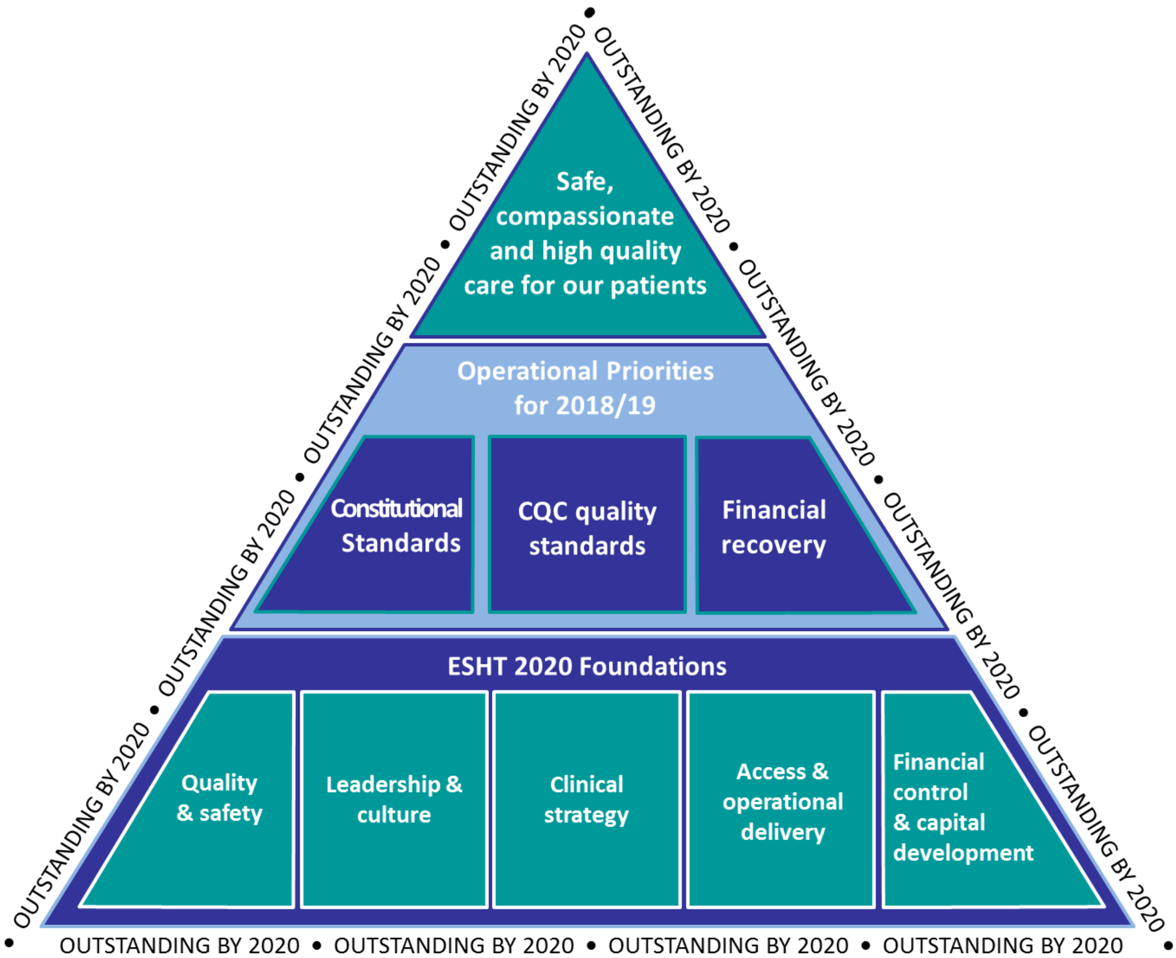
ESHT 2020: vision, values & objectives

Our vision at East Sussex Healthcare Trust is to combine community and hospital services to provide safe, compassionate and high quality care to improve the health and wellbeing of the people of East Sussex.

Our values are fundamental to how we undertake our everyday work. They shape our beliefs and behaviours and were developed by our staff.

Our objectives encompass our commitment to provide clinical services that achieve and demonstrate the best clinical outcomes and provide an excellence experience for patients. These are:

- **Safe patient care is our highest priority**
  We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.
- **All our employees will be valued and respected**
  They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.
- **We will work closely with commissioners, local authority and other partners…**
  …to plan and deliver services that meet the needs of our local population, in conjunction with other care services.
- **We will operate efficiently and effectively…**
  …diagnosing and treating patients in timely fashion and expediting their return to health.
- **We will use our resources efficiently and effectively for the benefit of our patients and their care**…
  …to ensure our services are clinically, operationally, and financially sustainable.

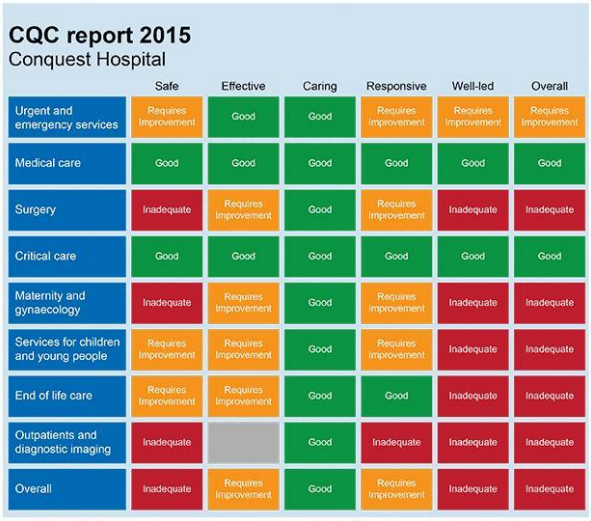


2020 foundation our core operational priorities for 2018/19 are driven by our vision to provide the highest quality care for our patients. These are built upon our 2020 foundations:

- Quality and safety
- Leadership and culture
- Clinical Strategy
- Access and operational delivery
- Financial control and capital development

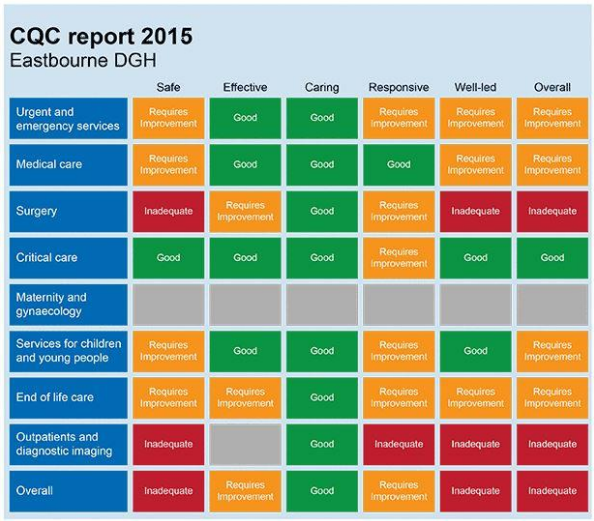
CQC inspection ratings: 2015 - 2018

CQC inspection 2015



CQC report 2015
Conquest Hospital

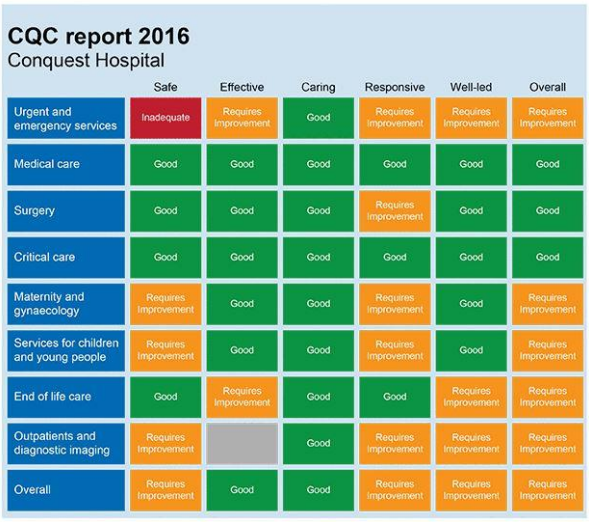
	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Services for children and young people	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
End of life care	Requires Improvement	Requires Improvement	Good	Good	Inadequate	Inadequate
Outpatients and diagnostic imaging	Inadequate		Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate



CQC report 2015
Eastbourne DGH

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Medical care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Surgery	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Critical care	Good	Good	Good	Requires Improvement	Good	Good
Maternity and gynaecology						
Services for children and young people	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
End of life care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Outpatients and diagnostic imaging	Inadequate		Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate

CQC inspection 2016



CQC report 2016
Conquest Hospital

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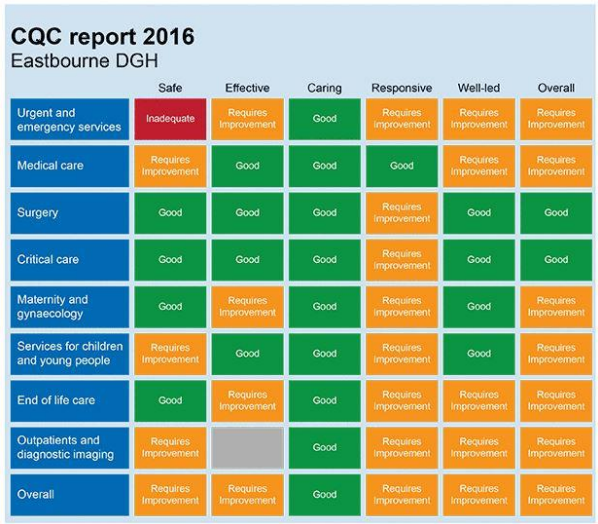
Services for children and young people	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
End of life care	Good	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Outpatients and diagnostic imaging	Requires Improvement		Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement



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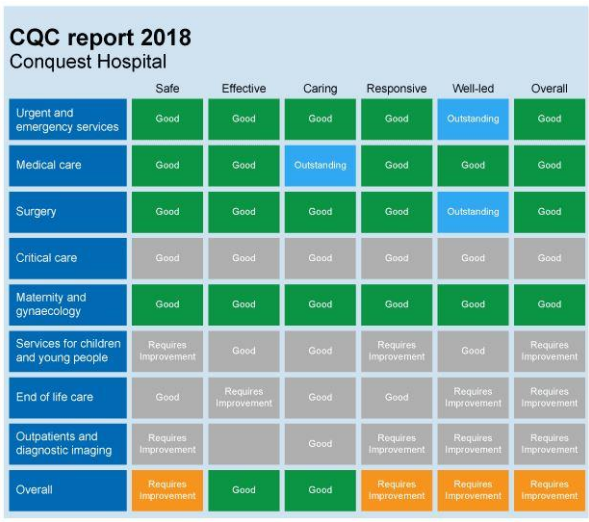
End of life care	Good	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Outpatients and diagnostic imaging	Requires Improvement		Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

CQC inspection 2018



CQC report 2018
Conquest Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Outstanding	Good
Medical care	Good	Good	Outstanding	Good	Good	Good
Surgery	Good	Good	Good	Good	Outstanding	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
End of life care	Good	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Outpatients and diagnostic imaging	Requires Improvement		Good	Requires Improvement	Requires Improvement	Requires Improvement
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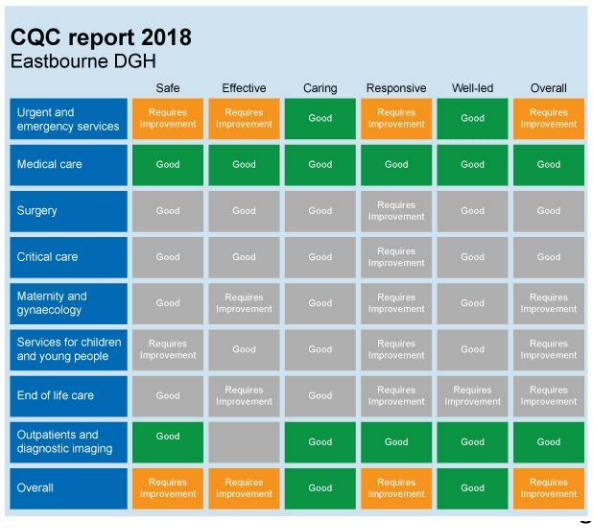

CQC report 2018
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Surgery	Good	Good	Good	Requires Improvement	Good	Good
Critical care	Good	Good	Good	Requires Improvement	Good	Good
Maternity and gynaecology	Good	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement
Services for children and young people	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
End of life care	Good	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Outpatients and diagnostic imaging	Good		Good	Good	Good	Good
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement

CQC inspection: 2018

The CQC acknowledged that on the basis of their most recent inspection in March 2018, the Trust's rating would be 'Good', however the Trust's overall rating remains as 'Requires Improvement' because not all services were inspected.

This is explained in the CQC report: "Whilst the aggregated rating for the core services inspected at this inspection visit would have brought the Trust to good overall, the impact of the cores services we did not re-inspect leaves it as Requires Improvement overall."

By 2020 we will have achieved the following:

Quality and safety

What we will have achieved	What it will feel like	Our next steps

Quality & Safety: We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.	• Across the organisation we are committed to safe care as our first priority
	• We monitor and publish our clinical outcomes which benchmark well with peer organisations
	• We fully comply with evidence based national standards of care and prevention
	• Patients regularly choose our services and recommend us to family and friends
	• We listen to patients and carers; we continually learn to improve
	• Patients and the public have full confidence in our services
	• The environment is clean, uncluttered and welcoming
	• Patient dignity and privacy is protected
	• Patients are cared for with minimum handovers and transfers of care. In hospital they are cared for on the correct ward from admission
		• We will implement a comprehensive safety strategy under which:
		  • we continually learn from past events
		  • we fully adopt evidenced standards and policies of safe practice
		  • we ensure operational resilience for the future
		• We will establish clear governance structures and business intelligence support to ensure safety
		• Senior medical staff will fully observe standards of safe practice through multi disciplinary ward rounds and early review of patients; standards of practice for hospital at night and 7 day working will be established.
		• Mortality and morbidity reviews will be regularly undertaken and clinical pathways adjusted according to lessons learned
		• We will ensure that we are staffed to full complement and reduce short notice staff transfers and short term agency working
		• End of life care standards will be defined & adopted
		• The use of wards and theatres will be reviewed to ensure sufficient capacity to ensure the treatment of all patients in the correct environment from the start of their treatment

Clinical strategy

What we will have achieved	What it will feel like	Our next steps
Clinical Strategy: We will work closely with commissioners, local authority, and other partners to plan and deliver services that meet the needs of our local population in conjunction with other care services	We will have a clear strategy for the organisation to fulfil its role as the lead provider of hospital and community healthcare services in East Sussex. The strategy will be fully aligned with the joint strategy for the local health and care economy 'East Sussex Better Together'. It will also take full account of the commissioning strategy for Lewes Havens & High Weald. Each clinical service will have a clear and settled view of its planned development over the next five years.	• We will develop and implement a long term strategic plan that will enable us to right size our resources and deliver safe and sustainable services to our population. • We have participated in the development of the Sustainability and Transformation Plan (STP) for Sussex and East Surrey, and continue to contribute to the review of acute services. • Each of our clinical units and clinical specialities will be supported to develop clinical strategies and transformation plans in the context of the STP and ESBT. • Clinical leaders will develop and own these clinical strategies • We will engage and support system wide strategic planning with primary care, local CCGs, and social services. • Our clinical and care strategies will encompass end to end patient care pathways focusing on maintaining health, preventing deterioration, and providing rapid acute response when required

Leadership and culture

What we will have achieved	What it will feel like	Our next steps
Leadership and Culture: All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfill their roles	• People across the organisation feel pride and satisfaction in their work and recommend the Trust as a place for care and a place to work • There is a fully developed multidisciplinary workforce which continues to explore and develop new roles and opportunities for people to develop their clinical and professional potential. • The Leadership teams at all levels actively shape the culture through engagement with staff and people who use our services. • All leaders are clear of their expectations as leaders within ESHT • There is a healthy, open culture in which people feel able to raise their concerns and are confident that they will be heard and addressed as appropriate • Our values are reflected in our behaviours in all parts of the organisation • All staff feel they are able to access development and talent opportunities • Our leaders are prepared for working across systems. • People across the organisation feel they are cared for and that the Trust is enhancing and promoting their positive wellbeing	• Recruitment is the highest priority for the workforce, a range of recruitment initiatives will be used to attract and recruit staff • Strategies and actions will be developed and implemented that focus on retaining skilled staff • A workforce strategy and 5 year plan will be developed that is aligned with the clinical strategy, is financially sustainable and includes the development of new and enhanced roles to meet patient needs and development of our staff. • Robust annual divisional plans in place and monitored • Regularly update staff about ESHT's vision, mission and values. Everyone understands how they fit into the goals of the Trust. • The Behavioural framework is embedded irrespective of the seniority or professional group of staff • A programme outlining our expectations for leaders will be ongoing and a new management induction will be launched for all new staff. • The appraisal process will be further developed so that values and behaviours inform the discussion with leaders and managers • The Trust will act on what staff tell us as part of the staff survey and refresh local action plans annually • The Trust will refresh approaches to staff feedback • The leadership development pathway will be continued and monitored in conjunction with our partners in health and social care • Support to develop and maintain high performing teams • Talent management implemented within the organisation • Develop and implement a Health and Wellbeing strategy • Review all HR interventions to ensure that they are inclusive and reflect the needs of the diversity of the workforce.

Access and delivery

What we will have achieved	What it will feel like	Our next steps
Access and Delivery: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion and expediting their return to health	• Clinical areas are calm and well controlled. • The hospital is meeting all access targets. • Elective care is protected from non-elective demand. • Patients are transferred directly to the right wards and are looked after in the most appropriate settings. • Discharge planning start at admission, including community based services, and is implemented efficiently. • Community services are fully aligned with primary and social care services • Hospital and community based services are fully linked and providing seamless care and integrated pathways. • Only in patients who need Consultant-led care will be in an acute bed. • We will meet the National 7 day working Standards	• Productivity programmes for theatres, out-patients and diagnostics, which deliver upper quartile performance as a minimum, evidenced through KPIs. • Right size the ward base to ensure reduced moves for patients and that they are cared for on the appropriate ward • Diagnostic services will have the capacity and resources that enable them to meet demand. We will also ensure that diagnostics are only undertaken when clinically appropriate. • We will develop and deliver an integrated discharged approach to support patient discharges into community services and social care. • Implement an integrated Urgent and Emergency Care Service, enhanced by primary care clinicians at the front of our DGHs • Re-base our community adult and paediatric services to contract values. • Implement a standardised medical model across EDGH and Conquest, including a “right-sized” acute medical service with appropriate capacity and clinical resource for ambulatory care; medical assessment; short stay facility. • Implement ring fenced dedicated day care service. • Frailty Services will be developed in the community and acute hospitals to reduce the number of patients admitted, or where acute care is required will have shorter stays. • Have in place an electronic bed management system • Ensure clear plan in place to delivery 7 day standards with progress towards this within year. • We will develop joint cross-organisation plans for the efficient and appropriate discharge of medically fit patients

Finance and capital

What we will have achieved	What it will feel like	Our next steps
Finance and Capital: 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	• Revenues and costs are managed to ensure financial balance while providing safe and effective services. • Contracts will have the appropriate balance of risk and opportunity • There is a culture of continuous efficiency improvement and achievement of low reference costs • Priorities will be clarified in annual plans; spending will be accurately budgeted and fully controlled by departments and clinical units. • Contract and CQUIN targets will be achieved consistently and well • There will be a systematic forward looking capital programme driven by clinical strategies with clear identification of equipment, estates and IM&T priorities • There is a robust procurement strategy and well managed comprehensive procurement programme ensuring optimum cost efficiency with appropriate governance	• Clear five year financial plan that reflects clinical priorities/strategies, our workforce plans, and brings the Trust to financial balance within three years • Operational and financial accountability of clinical units will be strengthened with enhanced information and reporting to support the achievement of plans, coupled with a rigorous and supportive Financial Performance Framework. • We will continue to develop an improved system of budgetary control and reporting that enables 'grip and control' by budget-holders • Recommendations from the Carter review will be prioritised and implemented, alongside the national Operational Productivity/Model Hospital programme. Participate in the 'Getting it Right First Time' programme. • Increase bank working and reduce dependency on agency staff. Approach will be extended to medical and AHP staff. Agency cap will be delivered • Procurement functions will be streamlined. Product lines will be rationalised. • Cost improvement programme will be delivered as planned based on meaningful dialogue with staff and stakeholders across the organisation • Annual contracts with commissioners and others will be clear, agreed in advance. Contract delivery requirements and CQUINs will be tracked and met • The coding team will use their expertise to ensure comprehensive and timely coding of activity, ensuring clinical pathways are recorded accurately • Capital programme will be prioritised according to clinical need. Bids for additional capital funding through loans and PDC will be made successfully to secure improvements in infrastructure and technology. Alternative sources of capital will be secured. • The budgeted workforce plan will be developed commensurate with operational plans, and the funding available • Activity levels will be tracked against plan on a weekly basis – building on clear and reliable plans made before the start of the financial year. Our production planning process will ensure visibility of delivery and will support using the capacity available within the Trust to meet demand.

Measuring our progress

The following tables provide the high level metrics that will be used to assess our progress. They are not intended to be comprehensive. The performance of the organisation will be tracked in more detail by a pyramid of metrics below each of these.

Quality and safety

Measure	16/17	17/18	18/19 target	2020 target
Reduction in number of reportable HCAIs	MRSA: 0 CDIFF: 43 MSSA: 11	MRSA: 3 CDIFF: 34 MSSA: 9	MRSA: 0 CDIFF: 40 E. coli blood stream infections: halved	Meet national standards
Improvement in Standardised Hospital Mortality Indicator (SHMI)	1.11	1.07	1.06	1.05
Reduction in number of falls (per 100 bed days)	6.2 falls per 1000 bed days	5.7 falls per 1000 bed days	5 falls per 1000 bed days	<5 falls per 1000 bed days
Reduction in number of falls (total)	1837	1613	Reduction	Reduction
Reduce number of acquired grade 3 and 4 pressure ulcers			<1.2 Acute and Community Grade 2 per 1000 bed days 0 Avoidable Grade 3 and 4	<1 Acute and Community Grade 2 per 1000 bed days 0 Avoidable Grade 3 and 4
All complaints investigated & responded to within target time	63 complaints overdue	1 complaint overdue	0 complaints overdue	0 complaints overdue
Reduction in number of complaints	55 per month (average)	47 per month (average)	44 per month (average)	35% Reduction overall (<40 per month average)
First consultant review of new admissions > 14 hours			80%	90%
Compliance with best care bundles for Sepsis			Screening: 90% Antibiotics within 1 hr of diagnosis: 90%	Screening: 95% Antibiotics within 1 hr of diagnosis: 95%

Improve identification and management of deteriorating patients			90% observations completed on time	>95% observations completed on time
Continue to create open culture for incident reporting and Duty of Candour • Duty of Candour compliance for all 3 components • Incident reporting figures		90% compliance across all areas	90% for all elements	> 95 % for all elements Year on year increase in reporting figures
Reduction in percentage against all reported incidents that resulted in harm	0.1%	0.2%	0.1%	0.05%
Increase Friends and Family Response rates for all areas	20% inpatient 8% A&E 32% Maternity	40% inpatient 8% A&E 28% Maternity	45% inpatient 15% A&E 45% Maternity	50% inpatient 22% A&E 50% Maternity

Leadership and culture

Metric	16/17	17/18	18/19 target	2020 Target
Our fill rate of substantive staff will be 95%. We will have a workforce plan in place for each division identifying the recruitment plan and the development of new roles and will have a range of new roles in place with staff fully utilising their skills and expertise	88.3%	92.2%	92%	95%
Our staff survey response rate will be at least 52% and show improvement in all key findings	46%	49%	52%	60%
key findings will be above average compared to comparator Trusts			70% of key findings	>70% of key findings
All divisions will have an action plan in place to address the results of the staff survey, produced in conjunction with staff			all	all
There will be an increase in appraisal rates for staff	79.3%	79.6%	90%	95%
There will be an increase in training rates for staff			90%	95%
Percentage of staff who will have had a talent management conversation as part of their appraisal.				75%
Annual sickness will have reduced to 4.2% with monthly ranges between 4.2-4.6%	4.2%	4.5%	4.20%	4.20%
Staff turnover rates will not be above 11.3%	11%	11%	11.3%	11.3%
The top 100 leaders in the Trust will be actively participating in the leading excellence programme			100	100
All new managers will attend the managers orientation programme			100%	100%

Access and delivery

Metric	16/17	17/18	18/19 target	2020 Target
Achieve 2ww	97.30%	96.10%	>93%	>93%
Achieve 31 day cancer target	98.70%	97.30%	>96%	>96%
Achieve 62 day cancer target (Urgent Referral)	76.40%	75.70%	85%	85%
Achieve all RTT Incomplete standard	88.20%	91.20%	80%	80%
Achieve Diagnostic Standard	1.90%	2.40%	<1%	<1%
Achieve A&E 4 hour standard	80.30%	87.50%	95%	95%
Achieve all waiting time targets for community services				
• Podiatry 13 weeks	100%	100%	100%	100%
• Dietetics 13 weeks	99%	99%	100%	100%
• Speech and Language Therapy 13 weeks	100%	100%	100%	100%
• Women and Men's Therapy 13 weeks	100%	97.5%	100%	100%
• Neurological Physiotherapy 13 weeks	100%	85.9%	100%	100%
• MSK Hastings and Rother 13 weeks	90%	86.6%	100%	100%
Reduce number of stranded patients (over 7 days)	540	400	320	200
Reduce number of medically fit for discharge patients from 200 to 80	--	--	100	80
Reduced length of stay to upper quartile (Acute - Days)	5.9	5.1	Upper quartile	Upper quartile
Improve productivity across: • Out-patients, reducing DNAs and new to follow up rates • Theatres, to meet agreed cases per list as per benchmarking analysis • Increased rate of ambulatory care.			Reduction	Reduction
Increased rate of ambulatory care			Reduction	Reduction

Finance and capital

Metric	16/17	17/18	18/19 target	2020 target
Deliver annual financial plan			Deliver planned deficit	Deliver planned deficit
Secure ESHT cash position			BPPC performance >85%	BPPC performance >95%
Establish and achieve 5 year financial trajectory			Trajectory agreed with NHSI and ESBT	Trust on trajectory for breakeven
Achieve reference costs of 100 by end March 2020			Reference costs<105	Reference costs=100
Achieve financial balance as a local health economy by end March 2021			System deficit<2017/18 deficit (£94m)	System Financial balance
Establish and deliver 5 year capital programme IT/Maintenance/Equipment/Estates			Capital Programme agreed	Trust on track for delivery of 5 year programme
Complete improvement of contracting and business intelligence by end March 2019			New approach to contracting and business intelligence	System contract in place, covering all key issues

Strategic enablers

Delivery of ESHT 2020 will be supported by a number of strategic enablers, primarily focused on our estate and our digital transformation programmes.

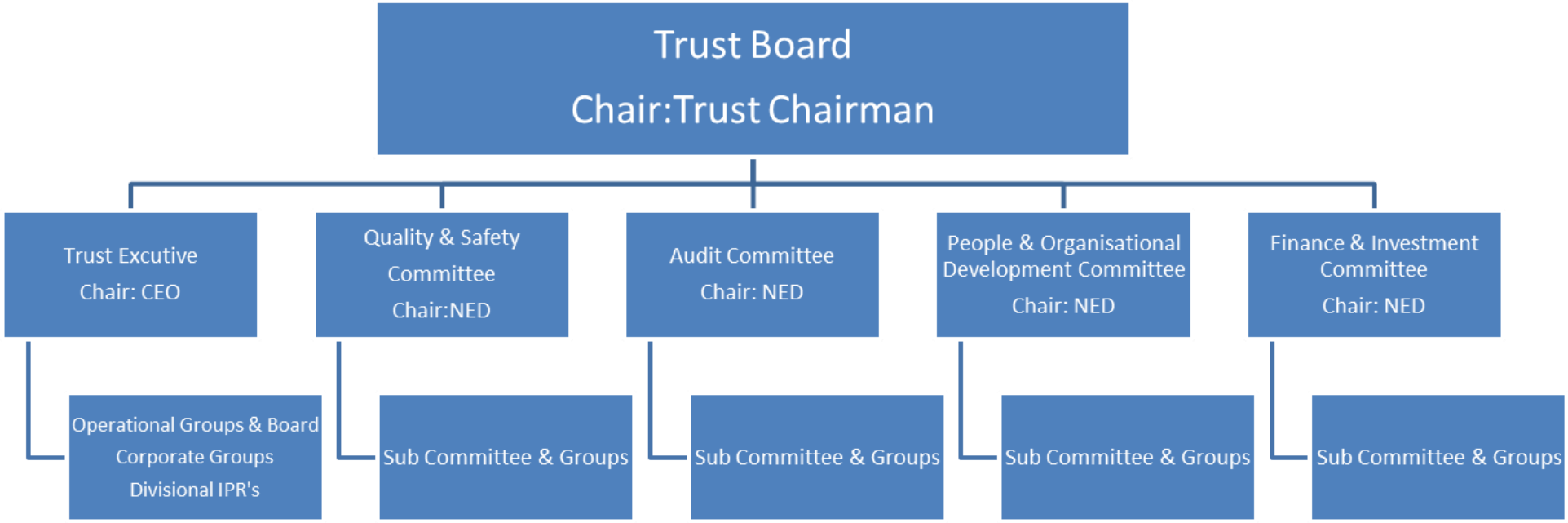
Estates and facilities

Priorities for 2018/19
Ambitious capital program
• Development of front entrances at Eastbourne and Conquest
• New twin MRI facility at Conquest
• New dual CT scanner facility at Eastbourne
• New Urology Investigation Unit at Eastbourne
• New way finding signage at Conquest and Eastbourne
• Continuing investment in backlog maintenance across all sites
• Various clinical areas and ward refurbishment works
Car parking initiatives at Conquest and Eastbourne
Masterplans for Conquest, Eastbourne and Bexhill following clinical strategy review

Digital

Priorities for 2018/19
EDM eForm Development
ePMA Electronic Pharmacy Medicine Administration
Skype Desktop Video Conference and Instant Messaging
VoIP Telephone System – New telephone system across ESHT
ePHR Electronic Personal Health Record
Windows 10 Rollout
Digital Care Record – Sharing information across care providers

Governance structures



East Sussex Better Together Alliance Agreement

Meeting information:			
Date of Meeting:	7th August 2018	Agenda Item:	11
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:	Commissioners/ESCC		
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

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

2017/18 has been the first transitional 'test-bed' year of collectively managing and operating an integrated (accountable) care system with our ESBT Alliance partners. This has been underpinned by our ESBT Alliance Agreement that has been signed by Eastbourne Hailsham and Seaford Clinical Commissioning Group, Hastings and Rother Clinical Commissioning Group, East Sussex County Council (ESCC) and East Sussex Healthcare Trust as full members, with Sussex Partnership NHS Foundation Trust joining as an associate member

The arrangement is underpinned by an Alliance Agreement and the initial term runs until 31/03/2019. At its meeting in November, the ESBT Alliance Governing Board collectively recommended that the Agreement should be extended for a further year until 31/03/2020, in line with the parameters set out in the Agreement. This paper proposes that some minor revisions are made to this document and the Trust Board agrees the extension

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

No internal committees. The paper will be reviewed in the appropriate governance forum for the CCGs and ESCC.

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

The Board is asked to review the attached document and agree to:

- Amend the ESBT Alliance Agreement for 2018/19 as set out in para 2.1 of the report, and delegate authority to the Chief Executive to finalise and agree these amendments and agree the terms of and enter into a data sharing agreement with the other partners.

- Delegate authority to the Chief Executive to make any other amendments to the Alliance Agreement they consider appropriate arising from the Governance review or from a review of learning from the first year. Including;

- Extend the ESBT Alliance Agreement for a further year until March 2020

East Sussex Better Together Alliance Agreement

1. Background

1.1 East Sussex Better Together is our whole system health and care transformation programme. Our shared vision is that by 2020/21, there will be an integrated, sustainable health and care economy in East Sussex that ensures people receive proactive, joined up care, supporting them to live as well and as independently as possible. Since we started in August 2014, the partnership has enabled us to deliver significant improvements in the accessibility, quality and safety of our services, as well as helping more people to live well in their home setting.

1.2 2017/18 has been the first transitional 'test-bed' year of collectively managing and operating an integrated (accountable) care system with our ESBT Alliance partners. This has been underpinned by our ESBT Alliance Agreement that has been signed by Eastbourne Hailsham and Seaford Clinical Commissioning Group (EHS CCG); Hastings and Rother Clinical Commissioning Group (HR CCG); East Sussex County Council (ESCC) and East Sussex Healthcare Trust (ESHT) as full members, with Sussex Partnership NHS Foundation Trust (SPFT) joining as an associate member. The Alliance Agreement has the following overall purpose:

- enable commissioners and providers to work together as a single integrated system to deliver services under a framework that seeks to align investment decisions with the ESBT programme's aims and objectives.

- create a collaborative environment of cooperation between Alliance providers and commissioners so we act in a way that is best for the whole system rather than individual organisations, without the need for a new organisational form in the test bed phase, by ensuring all parties are working to the same outcomes and are committed to the same success measures within an agreed governance framework.

1.3 The Agreement provides the framework to operate as an ESBT Alliance, in order for us to act 'as an integrated care system, by bringing together the following elements:

- An integrated alliance governance structure;
- Single system leadership with the ability to deploy resources against a common platform for delivery;
- An alignment of our budgets to test an integrated care system operating model;
- A potential mechanism for opportunity and risk share;
- A potential to test appropriate levels of delegation;
- A shared approach to the management of conflicts of interest;
- Arrangements for citizen integration into the governance framework; and
- A framework for the Alliance arrangement itself, detailing which organisations are involved and in what capacity, and how it will relate to the other parts of our health and care system.

1.4 The initial term of the ESBT Alliance Agreement runs until 31/03/2019 and, at its meeting in November, the ESBT Alliance Governing Board collectively recommended that the Agreement should be extended for a further year until 31/03/2020, in line with the parameters set out in the Agreement. This is with a view to providing stability and consistency of our place based Alliance arrangement in the context of our wider Sussex and East Surrey Sustainable Transformation Plan (the STP) footprint. The specific details of the extension period and any amendments we make to the Agreement to support this, will need to be agreed by individual ESBT member organisations through their sovereign governance processes by 31st December 2018.

2. Revisions to the Agreement

Updates to the ESBT Alliance Agreement in 2018/19

2.1 In order to strengthen our Alliance arrangement in 2018/9 the following minor updates to the Alliance Agreement are needed:

- As a result of the agreement to establish an ESBT Integrated Commissioning Fund (ICF) in 2018/19, and the new standalone Financial Framework Agreement (FFA) between the CCGs and Council to support this, there have been some minor updates made to the Aligned Funds section (i.e. the aligned commissioner and provider budgets of full Alliance members) in the Alliance Agreement to reflect these developments and the complementary nature of the FFA and the Alliance Agreement.

- A draft Staff Management Protocol is being finalised to support the ESBT Alliance Integrated Locality Teams to deliver integrated health and social care services. This will be adopted as part of the formal ESBT Alliance Agreement, and the intention is that the ESBT partners will use this as the basis of similar staff management protocols to support integrated commissioning and delivery in the future should the need arise.

Other potential changes to ESBT Alliance governance arrangements as a result of learning in 2017/18

2.2 There are also some other possible amendments and updates as a result of reviewing the learning from the first year, and the outcomes of other governance reviews and processes which are currently taking place. In summary these cover:

- Possible changes to ESBT Alliance governance arrangements in response to the current review of the role of the East Sussex Health and Wellbeing Board in our 'place', as well as the consideration of the wider Sussex and East Surrey STP governance;
- Possible changes as a result of the planned work to be undertaken by the ESBT Alliance Governing Board to re-establish ambition, vision and system shape over the next three to five years over the summer including partnership, implementation, timelines and delivery.
- There are currently a number of Data Sharing Agreements in existence to support ESBT to operate at the service level. As a consequence of the new GDPR regulations, and to support appropriate information governance more generally, we are in the process of exploring whether the Alliance Agreement itself needs a dedicated Data Sharing Agreement, to underpin staff management protocols and any other information sharing exercises as a result of implementing our Integrated Care System model.

3. Conclusion

3.1 Updates to the ESBT Alliance Agreement through a deed of variation are necessary to ensure the operating framework is fit for purpose for our ESBT Alliance in 2018/19. Further additional changes may also be necessary during 2018/19 as a result of wider system reviews and exploration of possibilities for different approaches to governance of our local place, based on our continued learning and the requirements of our integrated system working going forward. These will potentially have an impact of the details for the extension of the Alliance Agreement in 2019/20.

3.2 Agreement is therefore sought to making the updates for 2018/19 set out above, and to delegate responsibility for finalising and agreeing the variations to the Alliance Agreement to the Chief Executive, as well as the extension arrangements for 2019/20.

Medical and Nursing & Midwifery Revalidation Annual Reports 2017 - 2018

Meeting information:			
Date of Meeting:	7 August 2018	Agenda Item:	12
Meeting:	Trust Board	Reporting Officer:	Medical Director and 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: GMC and NMC			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

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

Medical Revalidation:

1. ESHT has achieved 100% compliance for doctors who were expected to undergo a medical appraisal in 2017 – 2018

2. Although medical revalidation takes place over a five year cycle, revalidation was initially implemented by the GMC in 2012 in a phased approach over a three year period. In the first year of implementation (2012 – 2013), 20% of all doctors were put forward for a revalidation recommendation, followed by 40% for each of the following two years (2013 – 2015). This means that the medical revalidation workload will increase exponentially over the next few years as the full five year cycle is completed again. A plan is in place to accommodate the increased workload and ESHT but the success of revalidation compliance also depends on the number of medical appraisers required to assist with offering high quality appraisals.

Nursing & Midwifery Revalidation:

1. ESHT has achieved a 100% compliance with completed nursing revalidation submissions in its second year 2017 – 2018.

2. The system and processes for nursing and midwifery revalidation is now well embedded within the organisation and the nursing staff has engaged with enthusiasm.

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

- Medical Revalidation – Medical Revalidation Advisory Panel 9.5.18; People and Organisational Development Committee 9.5.18 (after which some additional sections have been included)

- Nursing Revalidation – Trust Professional Advisory Group 17.4.18; People and Organisational Development Committee 9.5.18

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

1. The Trust Board is asked to approve both annual reports
2. The Chair is asked to sign the Statement of Compliance for medical revalidation

NHS England

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Version 4, April 2014

THE NHS CONSTITUTION
the NHS belongs to us all

NHS England INFORMATION READER BOX

Directorate		
Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference:	**01142**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, **Annex E - Statement of Compliance**
Author	NHS England, Medical Revalidation Programme
Publication Date	4 April 2014
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS England Regional Directors, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Area Directors, NHS Trust Board Chairs, Directors of HR, NHS Trust CEs, All NHS England Employees
Description	The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	Replaces the Revalidation Support Team (RST) Organisational Readiness Self-Assessment (ORSA) process
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers (ROCR approval applied for).
Timings / Deadline	**From April 2014**
Contact Details for further information	england.revalidation-pmo@nhs.net http:// www.england.nhs.net/revalidation/

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet

Designated Body Statement of Compliance 2017 – 2018

The Trust Board of East Sussex Healthcare NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   YES. The Medical Director acts as the Responsible Officer. An Assistant Medical Director has been appointed as the Deputy Responsible Officer.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   YES. The revalidation team maintains an accurate record of all licensed medical practitioners with a prescribed connection to ESHT.

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   YES. There are also new appraisers being recruited and trained so that we retain sufficient numbers of medical appraisers to cope with the increased number of appraisals and revalidation recommendations.

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   YES. Medical appraisers are required to participate in two update training sessions each year which offer an opportunity for professional calibration and review of performance.

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   YES. The 100% compliance rating for medical appraisal policy adherence in ESHT cannot be surpassed. Full records are maintained of all appraisals when missed or deferred and an effective non-engagement process is in place, supported by Trust Policy.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

YES. Clinical governance and monitoring of conduct and performance is undertaken in divisions with the support of senior management and medical leaders. Information on clinical outcomes data, significant events, complaints and feedback from patients and colleagues is provided for doctors to include in their supporting information for their appraisal.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

YES. The Trust has a formal process for responding to concerns and a ratified remediation policy is in place.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

YES. A formal system of transfer of information is in place and is overseen by the revalidation team working in collaboration with the medical staffing and recruitment teams.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

YES. The Trust Temporary Workforce Services team work closely with the recruitment and revalidation teams to ensure employment checks are performed on all new starters.

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

YES. The Medical Revalidation Advisory Team oversees the continued improvement of all areas of medical appraisal and medical revalidation.

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

[Chief Executive or Chair

Date: _ _ _ _ _ _ _ _ _ _

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Organ Donation Annual Report

Meeting information:			
Date of Meeting:	7th August 2018	Agenda Item:	13
Meeting:	Trust Board	Reporting Officer:	Dr Tuhin Goswami

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?	

Summary:

Organ donation is an integral part of End of Life Care. The organ donation committee (ODC) has put in a policy and pathways to improve donation and identify barriers to this occurring. The Potential Donor Audit is an ongoing audit which monitors our success as well as identifying areas for improvement.

Potential Donor Audit:

8 solid organ donors leading to 17 transplant recipients. Policy and pathways in place.

Room for improvement in referral, neurological testing and consent. (now referred to as missed opportunities)

Organ Donation Committee:

Lack of Specialist nurses for Organ donation (SNOD) regionally.

New chair for organ donation committee, Jackie Churchward-Cardiff in post.

We need a new Clinical Lead for Organ donation (CLOD) as present CLOD has been in post over 8 years. New appointed ICU consultant interested and will need to be interviewed. She will potentially take over between November 2018 and March 2019.

Publicity team need volunteer contracts with Trust

Finances:

ODC finances – need clear roles of how we can utilise our monies without having to go to various managers for sign off/ raise purchase orders/ etc. We need named individuals to streamline the process

Emergency Department:

No senior medical staff involved in ODC – need to encourage involvement

BENEFITS:	Improve End of Life Care.	SO 1, 4, and 5
	Facilitate wishes of Donor and Donor family	SO 1,3,4,and 5
	Improve Transplantation rates in UK	SO 3
	Allow ODC easy access to monies to facilitate the above roles.	SO 4 and 5.
	Include our publicity team into ESHT	SO 2 and 5.

RISK & IMPLICATIONS:

Missed referrals result in missing potential donors and therefore not respecting or fulfilling their wishes after death.

Reduction of organ donors leads to reduction of transplants.

Potential for poor End of Life Care

Waste of ODC monies / unable to budget or plan for year ahead

ACTION PLAN:

Review of all Missed opportunities in organ donation to identify reasons (CLOD and SNOD are doing):

a. CLOD conversation with Consultant / team involved
b. Present to ICU M&M
c. If no engagement from Consultant/team then Datix and review at M&M

Need to interview and integrate new Clinical Lead for Organ Donation (CLOD) over a period of 3-6 months

ODC needs ability to easily use its finances; we need this stream lined

Publicity team needs to be given volunteer contracts by Trust

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

End of Life Care – Angela Colosi

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

The Board is asked to note the Organ Donation Annual Report.

Actual and Potential Deceased Organ Donation 1 April 2017 - 31 March 2018

NHS Blood and Transplant

East Sussex Healthcare NHS Trust

Taking Organ Transplantation to 2020

In 2017/18, from 9 consented donors the Trust facilitated 8 actual solid organ donors resulting in 17 patients receiving a life-saving or life-changing transplant.

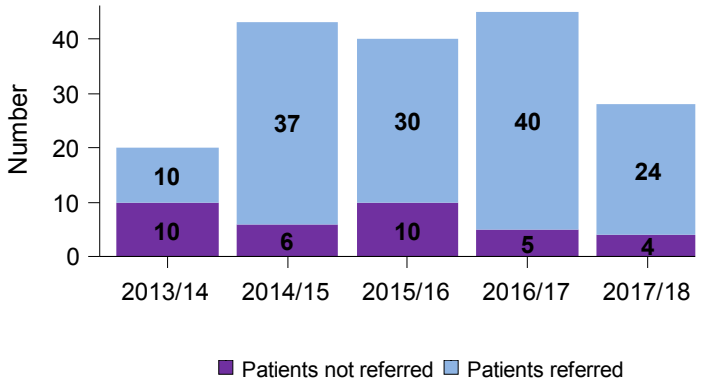
In addition to the 8 proceeding donors there was one additional consented donor that did not proceed.

Best quality of care in organ donation

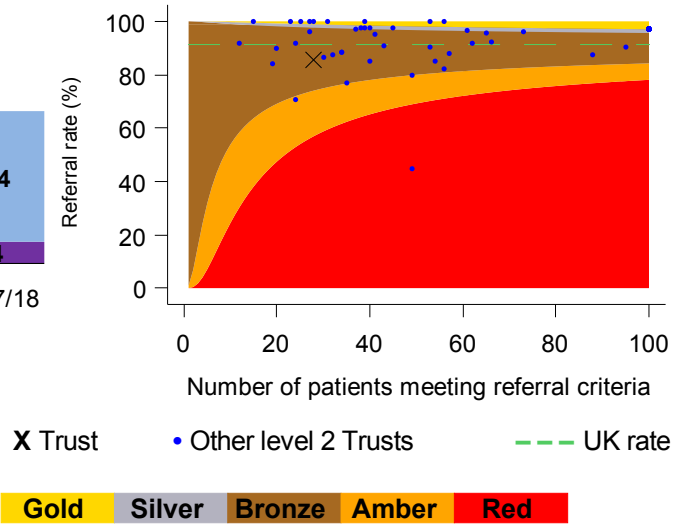
Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



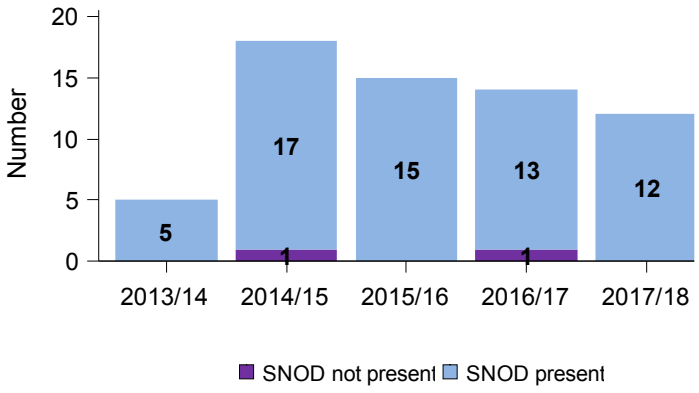
The Trust referred 24 potential organ donors during 2017/18. There were 4 occasions where potential organ donors were not referred.

When compared with UK performance, the Trust was average (bronze) for referral of potential organ donors to NHS Blood and Transplant.

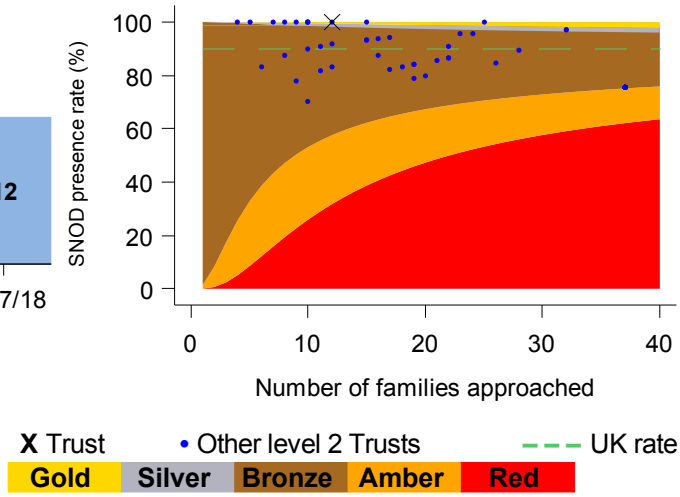
Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



A SNOD was present for 12 organ donation discussions with families during 2017/18. There were no occasions where a SNOD was not present.

When compared with UK performance, the Trust was exceptional (gold) for SNOD presence when approaching families to discuss organ donation.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South East Coast*	UK
1 April 2017 - 31 March 2018		
Deceased donors	86	1,574
Transplants from deceased donors	224	4,012
Deaths on the transplant list	14	426
As at 31 March 2018		
Active transplant list	334	6,045
Number of NHS ODR opt-in registrations (% registered)**	1,993,087 (43%)	24,941,804 (38%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 4.63 million, based on ONS 2011 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Trust are shown below, including a UK comparison.

Key numbers, rates and comparison with UK data, 1 April 2017 - 31 March 2018

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	5	1954	25	6281	28	7978
Referred to Organ Donation Service	5	1929	21	5615	24	7302
Referral rate %	G *100%*	*99%*	B *84%*	*89%*	B *86%*	*92%*
Neurological death tested	3	1676				
Testing rate %	B *60%*	*86%*				
Eligible donors[2]	3	1582	22	4456	25	6038
Family approached	3	1471	9	1858	12	3329
Family approached and SNOD present	3	1394	9	1591	12	2985
% of approaches where SNOD present	G *100%*	*95%*	G *100%*	*86%*	G *100%*	*90%*
Consent ascertained	3	1066	5	1115	8	2181
Consent rate %	G *100%*	*72%*	B *56%*	*60%*	B *67%*	*66%*
Actual donors (PDA data)	3	955	5	613	8	1568
% of consented donors that became actual donors	*100%*	*90%*	*100%*	*55%*	*100%*	*72%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

For further information, including definitions, see the latest Potential Donor Audit report at www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/

The Workforce Race Equality Standard (WRES)

Meeting information:			
Date of Meeting:	7th August 2018	Agenda Item:	13.2
Meeting:	Trust Board	Reporting Officer:	Kim Novis/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?	

Summary:

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

The WRES is a national initiative and a contractual requirement. It has 9 metrics which are used as a tool to help identify and close gaps between Black & Minority Ethnic (BME) and White British, White Irish and White Other (White) staff within the organisation.

The first four metrics of WRES analyse the Trust workforce data, the next four metrics are taken from the NHS Staff Survey. The final metric asks whether the Trust Board is representative of its workforce and the populations it serves

The BME Staff Network is Chaired by Dr Adrian Bull (CEO) and attended by the Equality Lead, Human Resource Managers, Leadership Managers, Staff Health & Wellbeing Leads and Staff Engagement Leads. The network reviews and monitors the WRES metrics bi-monthly through a rolling action log. The action log is updated annually following publication of WRES. The network has gone from strength to strength during 2017/18 with new members joining each month demonstrating good engagement amongst this group.

Using the WRES data, the BME Network has several aims which support achieving race equality at ESHT including to provide a safe place for BME staff to come and raise concerns and identify training and development opportunities for BME staff. Many local and national opportunities have been identified through this group and may have contributed towards the 5% increase in BME staff reporting believing they are provided with equal opportunities for career progression or promotion, when responding to the 2017 NHS staff survey.

Metric 2 looks at the relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts. BME applicants had a greater likelihood of being appointed than that of White applicants.

Metric 3 looks at the relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation over a 2 year rolling figure. 2016/17 was 1.46 times, 2017/18 was 1.58 times more likely. However it is

important to note when forming judgements on this metric that even using a 2 year rolling figure, the numbers are extremely small.

There are 2 identified risks:
Data suggests that junior doctors and career grade doctors have an aberrantly higher numbers of staff not declaring their ethnicity. This is currently being reviewed by HR and the EDHR Lead to identify whether this is an administrative issue when collecting and recording individual equalities data, or whether there is reluctance amongst these groups to declare their ethnicity when taking up their positions at ESHT.

15.92% of BME staff reported in the staff survey that they had experienced discrimination at work from their manager, team leader or other colleagues on the grounds of Ethnic background. This is a small increase (3.4%) compared to 2016 survey results. The survey results highlight no statistically significant changes in this response, however this has been considered in the development of the network's action plan.

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

ESHT BME Staff Network	9th July 2018
People & Organisational Development Committee	11th July 2018

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

The Trust Board is asked to note the assurance in achieving compliance with the WRES and continued commitment to advance race equality within the organisation.

Annual Report - Complaints & Patient Advice and Liaison Service (PALS) 2017/18

Meeting information:	
Date of Meeting: 7 August 2018	Agenda Item: 13.3
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?	No

Summary:

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

- The Trust received 567 complaints across all sites during 2017/18; this represents a reduction of 15.4% compared to the number of complaints received in 2016/17 (667).
- The Trust's internal response rate for non-complex complaints (30 working days) at the end of 2017/18 was 83%, whilst the internal response rate for complex complaints (45 working days) was 71%. These are significant improvements compared to 2016/17, where the internal response rates were 54% and 53% respectively.
- There was a very small decrease in PALS contacts for 2017/18; 7,139 contacts compared with 7,325 recorded in 2016/17, marking a reduction in activity of just 2.5%.

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

Patient Safety and Quality Group (May 2018)

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

The Trust Board is asked to note and comment on the content of this Annual Report, which is provided for information and assurance purposes.

Complaints and Patient Advice and Liaison Service (PALS) Annual Report 2017/18 Summary

This report details the activity of the Complaints and PALS team at East Sussex Healthcare NHS Trust for the year 2017/18, alongside activity in key areas for 2016/17 for comparative purposes.

- The Trust received 567 complaints across all sites during 2017/18; this represents a reduction of 15.4% compared to the number of complaints received in 2016/17 (667).
- The Trust acknowledged 100% of complaints within three working days.
- The Trust's internal response rate for non-complex complaints (30 working days) at the end of 2017/18 was 83%, whilst the internal response rate for complex complaints (45 working days) was 71%. These are significant improvements compared to 2016/17, where the internal response rates were 54% and 53% respectively.
- The top 3 complaint themes were, standard of care, communication and patient pathway.

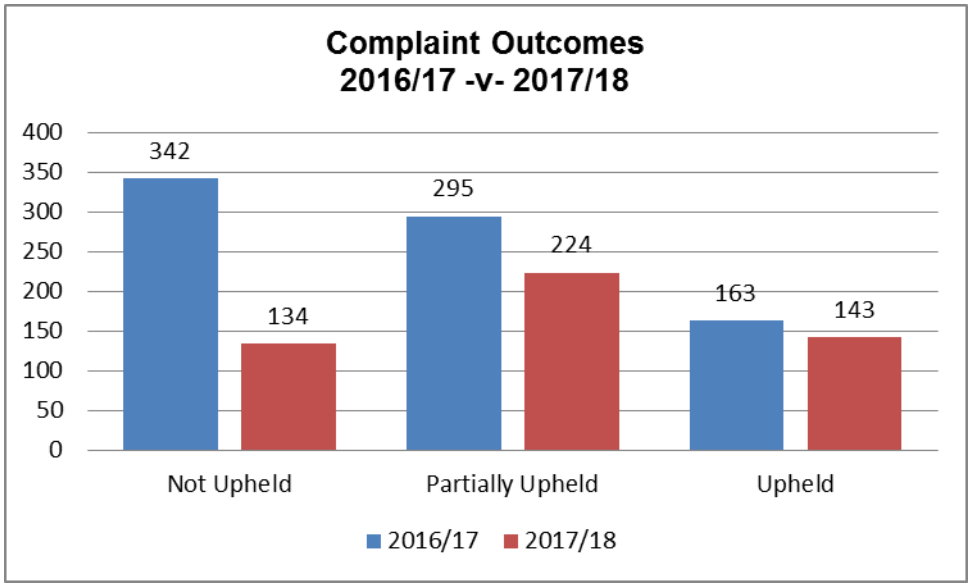
  Of this, the top five sub-subjects within this area were:

  Overall Care (67)
  Missed Diagnosis (29)
  Incorrect Diagnosis (20)
  Lack of Confidence in Delivery of Care (18)
  Problems/Complications Following Surgery/Procedure (15)

- Complaints received by division:

	2016/17	2017/18	Difference
Diagnostics, Anaesthetics and Surgery	221	181	↓ 40
Medicine	169	166	↓ 03
Out of Hospital	35	30	↓ 05
Urgent Care	143	72	↓ 71
Women, Children & Sexual Health	74	90	↑ 16

- There were 83 complaints re-opened in 2017/18; this represents a reduction of 23.8% compared to the number of complaints re-opened during 2016/17 (109).
- There were no complaints overdue at the end of 2017/18, compared to 14 complaints overdue at the end of 2016/17.
- The Complaints Team provided 69 Local Resolution Meetings during 2017/18.
- The following chart represents the outcome of complaints received in 2017/18, with comparative data for 2016/17. The figures for February and March 2018 are low as not all of the complaints received in these months have been closed at the time of this report.



In addition to the routine handling of complaints, the Trust is also committed to the implementation of learning arising from complaints to prevent recurrence of the situation. The following are examples of learning embedded during 2017/18;

Podiatry

The way patients were being discharged from the clinic. As a result of the complaint, the Podiatry Team now write to all patients they plan to discharge, and provide an explanation as to the reason for the discharge.

Intensive Therapy Unit (ITU) – Eastbourne DGH

Lack of communication between staff and relatives when a loved one was being settled on the unit (which could take up to two hours). As a result of the complaint, staff on the ITU have developed a pathway "tree" so that relatives can see at a glance how staff settle patients, what is involved and how long the process can take. They now also ensure relatives are met with and updated every 30 minutes.

Clinical Decisions Unit (CDU)

A complaint was raised with regards to the inability of patients to get to a telephone to call and speak to relatives and loved ones. As a result of the complaint, the CDU now has a portable telephone so that patients can make telephone calls from their bed.

Day Surgery Unit (DSU) – Litlington Ward

A complaint was raised with regards to the fact that patients were being asked to attend the SDU at 7.00am, but were often not seen until 1.00pm with no explanation as to what was happening. As a result of the complaint, the DSU now send a leaflet with the appointment letter to explain to patients there may be a wait between arrival and being seen, and staff deliver a speech to all patients about the process so they are aware of what is happening on the day.

Urgent Care

A complaint was raised with regards to the way in which staff treated a patient with learning disabilities. As a result of the complaint, Urgent Care staff have reviewed and updated their policy to ensure the pathway for patients with learning disabilities is clear, equitable and appropriate.

Post Complaint Survey-

In terms of the three questions scoring the highest positive feedback (by combining all responses scoring questions with Strongly Agree or Agree), these were:

I was able to communicate my concerns in the way I wanted	74%
It was easy to find out how to make a complaint	64%
I was able to understand the response as everything was clearly explained, including names and terminology	60%

Conversely, the three questions scoring the highest negative feedback (by combining all responses scoring questions with Disagree or Strongly Disagree) were:

I felt the response answered all of the concerns I had raised	58%
I felt assured that the Trust would learn from my experience	52%
I felt the Trust understood my concerns and what I wanted from raising a complaint	46%

- There was a very small decrease in PALS contacts for 2017/18; 7,139 contacts compared with 7,325 recorded in 2016/17, marking a reduction in activity of just 2.5%.
- The Trust received 13 contacts from the Parliamentary and Health Service Ombudsman (PHSO) during 2017/18. Of the contacts made in respect of investigations, four were to provide decisions/outcomes (one case upheld, two cases partially upheld and one case not upheld); there are six cases awaiting investigation decisions/outcomes. This represents a reduction in the rate of contacts by 18.75% compared to the number of contacts received from the PHSO in 2016/17 (16).

The objectives for 2018/19 are:

1. To sustain and further improve on the internal response rates for all complaints;
2. To audit a selection of actions identified from complaint investigations that have been reported as closed, to ensure the learning has been embedded and wherever possible prevented any further complaints of the same nature being raised;
3. To review, evaluate and report on trends and themes emerging from contact with PALS; and
4. To develop and deliver complaint management training for managers.

Guardian of Safe Working Hours Annual Report

Meeting information:	
Date of Meeting: 7/8/2018	Agenda Item: 13.4
Meeting: Trust Board	Reporting Officer: Nadia Muhi-Iddin/Waleed Yousef

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

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state			
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? No	

Summary:

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

- All junior doctors in training have transitioned to the New 2016 Contract TCS. With the new intake for 8/2018 is a total of 240 Trainee's.
- Areas showing vulnerability to exception reporting this year include (Gastroenterology and Geriatrics at EDGH and Respiratory medicine at the Conquest). Some areas that did show vulnerability earlier on have improved including ENT at EDGH and Endocrinology cross site.
- Doctors in training haven't agreed on how to spend the exception report fines. The Guardian team are increasing awareness of the issue amongst trainees and inviting more trainee representatives to the Guardian Junior Doctor Forums to encourage agreement on expenditure of £18,133.00.

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

People and Organizational Development Committee 9/5/2018

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

- The Board to support the Urgent review and provision of extra computer /IT access on certain wards. Patient care is increasingly dependent on IT access with the move to electronic records (Evolve) in all aspects of patient care. Teams are struggling to complete ward rounds in some areas due to insufficient computer access with several teams competing together causing delay in patient care and discharge.
- The foundation doctors raised this issue at the LAB meeting earlier on this year. It was brought to the attention of the educational leads and unit lead. The wards mentioned include: Gardner, Cookson, and Duchamp, AAU, Hailsham 3 cross site.
- The board to support ongoing provision by the Trust of (Rest rooms for junior doctors) after night shifts.

Guardian of Safe Working Hours – Report
May 2017 - July 2018

1.0 Purpose

The purpose of this report is to provide an update to the Board committee by the Guardians of Safe Working Hours on the impact of implementing the junior doctor contract 2016.

2.0 Background

The New Junior Doctors Contract came into effect on 3rd August 2016. Implementation guidance was published by NHS Employers Total number of trainees across site that can Exception Report is 238.

3.0 Exception Reporting

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

The remit of this report is to focus on Exception Reporting associated with safe working hours .

3.1 Exception Reporting Working Hours

If a trainee Exception Reports for working hours this is reviewed by their Clinical Supervisor who will either approve Time off in Lieu (TOIL) or will authorise payment for the additional hours worked if agreed. There is also requirement for the clinical supervisor to review and ideally discuss with the trainee or comment on the factors that had led to the exception report.

The following table indicates the number of Exception Reports and the payments made to Doctors as a result of Exception Reporting. The number of Exception Reports has a decreasing trend.

The main cause of breaches in working hours is predominately rota gaps and additional high patient workload. The cost in this reporting period (May 2017 to April 2018) equates to £25,551.34

Month	No of Drs eligible to submit an Exception Report	No of Drs Who Submitted an Exception Report	No of ER Processed for Payment By Month	Total Hours Paid at Basic Rate	Total Monetary Amount Paid at Basic Rate to Trainees		Total Hours Paid at Enhanced Rate	Total Paid at Enhanced Pay		Total Hours Paid Overall	Overall Cost of ER
May-17	117	8	37	63.25	**1610.13**		7.25	**237.74**		70.5	**1847.87**
Jun-17	117	9	53	155.5	**3644.48**		1.50	**48.00**		157	**3692.48**
Jul-17	144	11	63	103.75	**2470.64**		8.50	**287.15**		112.25	**2757.79**
Aug-17	238	19	100	124.75	**3368.96**		5.25	**173.67**		130.00	**3542.63**
Sep-17	238	17	74	128.75	**3399.22**		2.00	**74.10**		130.75	**3473.32**
Oct-17	238	14	67	117.00	**3513.53**		5.50	**266.74**		122.50	**3780.27**
Nov-17	238	20	45	54.75	**1490.70**		4.00	**145.76**		58.75	**1636.46**
Dec-17	238	13	27	22.75	**670.79**		7.00	**377.26**		29.75	**1048.05**
Jan-18	238	12	22	25.00	**624.17**		6.50	**314.91**		31.50	**939.08**
Feb-18	238	9	20	20.00	**536.89**		7.25	**402.88**		27.25	**939.77**
Mar-18	238	5	14	17.50	**522.76**		0.00	**0.00**		0.00	**522.76**
Apr-18	238	12	47	50.75	**1333.81**		1.00	**37.05**		51.75	**1370.86**
											£25,551.34

3.2 Working pattern reviews

Work pattern reviews were done in General Medicine Conquest for FY1, FY2 and SpR undertaken by a Consulting Company to minimize the clashes of zero days, reducing the number of doctors off at any one time in the same “team”. This was unrelated to Exception Reports or Guardian Fines.

Two patterns at CQ in the AAU were also undertaken to add in a twilight shift to finish at 2300 hrs to minimize evening workload.

3.2.1 Guardian Fines

Period	No of Drs Who Submitted an Exception Report	No of ER Processed for Payment By Period	Total Hours Paid at Basic Rate	Total Monetary Amount Paid at Basic Rate to Trainees	Total Hours Paid at Enhanced Rate	Total Paid at Enhanced Pay	Total Hours Paid Overall	Overall Cost of Guardian Fines
01.05.17 - 31.07.17	28	153	279.55	**8089.73**	0	**0**	279.55	**8089.73**
01.08.17 - 31.10.17	50	241	74.15	**2372.69**	2	**78.86**	76.15	**2451.55**
01.11.17 - 05.12.17	20	50	1.00	**27.69**	0	**0**	1.00	**27.69**
06.12.17 - 31.03.18	26	85	0.00	**0.00**	2.3	**65.86**	2.30	**151.48**
								£10720.45

3.3 Exception Reporting Education Provision

The Trust has received 52 Exception Reports during this period that were raised because of missed education opportunities these have been dealt with by the Director of Medical Education. Failure to deliver our contractual educational commitments could result in the deanery withdrawing trainees from the trust.

4.0 Action taken to address issues

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

- Areas showing vulnerability to exception reporting this year include (Gastroenterology and Geriatrics at EDGH and Respiratory medicine at the Conquest). Some areas that did show vulnerability earlier on have improved including ENT at EDGH and Endocrinology cross site. The GOSWH's have identified these trends and discussed areas of concern with Clinical Supervisors and Divisional Leads.

5.0 Health roster has been transitioned into most specialties to eradicate conflicts on zero days and enables Doctors to access their rotas.

6.0 Risks & Concerns

- The Guardians are pleased with the engagement of the trust management at the senior level. Some Clinical supervisors are slow to deal with the exception reports raised in their area. There is an escalation process in place to deal with this, so as not to disadvantage junior doctor from receiving additional monies or agreed TOIL.

- The Conquest GOWSH stood down from his role and a Dr N Muhi-Iddin was appointed to the post from the 1 February 2018.

- The ability to deliver the compliant rota patterns will be dependent on our allocation of DiT from HEE. Under the Code of Practice HEE advise Trusts 12 weeks prior the start date on the 9 May 2018. At the time of this report we only have 4 foundation vacancies from August which are currently under recruitment. This is much better than last year.

7.0 Conclusion/Summary

- All DiT have now transitioned to the new Contract, with there being a notable trend of reducing Exception Reports despite all doctors eligible to Exception Report. However, there is potentially an underreporting of breaches which would warrant exception reporting.

- All work patterns have undergone work pattern reviews to hours for DiT work about 45-46 hours average per week.

- We will continue to review work pattern reviews, be robust in filling vacancies; the introduction of Health roster and the continuation of the Doctors Assistant Programme will further underpin compliance with the Contract and improve DiT working conditions.

- IT and Space for IT Issues remain a concern on several wards.

- Exception reports trends noticed to increase at the beginning of rotations then reduce as trainees settle into their posts

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Thursday 24th May 2018 at 1000 in Seminar Room 3, EDGH

Present: Mr Mike Stevens, Non-Executive Director (Chair)

In attendance
Ms Vikki Carruth Director of Nursing
Mrs Joe Chadwick-Bell, Chief Operating Officer
Mr Jonathan Reid, Director of Finance
Dr David Walker, Medical Director
Mrs Lynette Wells, Director of Corporate Affairs
Mr Stephen Hoaen, Head of Financial Services

Ms Liulu Chen, Audit Executive, Grant Thornton
Mr Mike Townsend, TIAA
Mr Darren Wells, Engagement Lead, Grant Thornton

Mr Pete Palmer, Assistant Company Secretary (minutes)

Action

031/18 Welcome and Apologies for Absence
Mr Stevens opened the meeting. Apologies for absence had been received from:

Mrs Sue Bernhauser, Non-Executive Director
Mr Barry Nealon, Non-Executive Director
Dr Adrian Bull, Chief Executive
Dr James Wilkinson, Deputy Medical Director
Mr Adrian Mills, Audit Manager, TIAA
Mr Chris Lovegrove, Counterfraud Manager, TIAA

It was noted that the meeting would be made quorate once confirmation had been sought from the two Non-Executive members that they had reviewed the papers, had no issues and support the sign off and submission of the Annual accounts. [Note: this was received from both Mr Nealon and Mrs Bernhauser]

032/18 Minutes of the meeting held on 28th March 2018
The minutes of the meeting held on 28th March 2018 were reviewed and agreed as an accurate record.

033/18 Quality Account 2017/18 Update
Mrs Wells explained that the update provided assurance that the Trust had compiled the Quality Account in accordance with the Department of Health's (DoH) Quality Account toolkit 2010/11, subsequent DoH updated guidance and in conjunction with external assurance requirements outlined in the 2014/15 Auditor guidance.

She noted her disappointment about the limited assurance assessment given by auditors in relation to Venous Thromboembolism (VTE) data quality. Dr Walker noted that 116 records had been incorrectly attributed

as being inpatients rather than patients attending the Ambulatory Care Unit, in part due to a new ward clerk not fully understanding processes. He explained that the number of errors found within records during the audit was a concern and that work would be undertaken to continue to improve the quality of data collected by the Trust. Mr Reid agreed, explaining that the Trust had previously undertaken work on general data quality and had worked with auditors to realise improvements in a number of different areas. He noted that the audit provided evidence that improvements had not fully embedded throughout the Trust explaining that problematic areas would be revisited.

Ms Carruth explained that measurable quality account objectives had been developed in consultation with patients and members of staff. Mr Reid noted that he felt that the process for producing the Quality Account had improved compared to previous years.

034/18 Annual Accounts & Report 2017/18

i) Going Concern

Mr Reid explained that in previous years the DoH had issued a letter to the Trust confirming that it would remain a going concern. This was no longer the case and he presented a paper setting out the various metrics that provided assurance that the Trust would remain a going concern. Mr Stevens asked whether the Trust could reach a positon where it would cease to be a going concern, and Mr Reid explained that a number of measures could be taken. He noted that while material uncertainties remained about the Trust's position, there was no likelihood of the Trust merging with another Trust or of it closing within the next twelve months

He reported that the Trust's three year financial plan was due to be discussed at the following week's Finance and Investment (F&I)Committee before being considered by the Trust Board, and submitted to NHSI once approved.

Mr Reid agreed to make an amendment to clause 3.1 for clarity, and to clause 4.1 of the report to ensure consistency with the Annual Accounts.

ii) ISA260 Grant Thornton Annual Governance Report on the Annual Accounts 2017/18

Mr Wells reported that Grant Thornton's work on finalising financial statements for the Trust was almost complete. He thanked the finance team for their co-operation, noting the extremely prompt responses to queries that had been received and praising the quality of the accounts that had initially been presented to auditors. He explained that an adverse value for money conclusion about the Trust was being given due to the financial positon, but recognised the areas of improvement within the Trust.

Mr Stevens asked about the auditor's significant audit risk concerning revaluation of the Trust's estate and their concerns that space for administration was no longer included within the valuation. Mr Reid noted that the revaluation process that had been undertaken was well established, and that the F&I Committee had spent a lot of time reviewing the assumptions that lay behind the process. The process looked at the potential value of the Trust's estate if hospitals were merged and relocated and under this model proposed that additional capacity for admin support could be realised by leasing from the private sector when necessary.

Mr Stevens raised a concern that the change in valuation might impact capital allocated to the Trust in the future. Mr Reid noted that Dr Bull shared these concerns, explaining that they would be considered by the F&I Committee when any future valuations were undertaken.

Mr Stevens asked for additional information about the auditors' overall conclusion which had noted weaknesses in planning finances effectively. Mr Wells explained that narrative had been included to explain how this conclusion had been reached. He noted that the conclusion was consistent to that given to other Trusts with deficits of a similar size. Mr Reid and Mrs Chadwick-Bell agreed with the conclusion reached by auditors, noting that the Trust had not yet finalised its three year plan for reaching financial sustainability. It was anticipated that this would be finalised over the coming months.

A discussion took place about the wording of the going concern statement concerning the Trust's CIP target for 2018/19 and revised wording was agreed.

Mr Stevens asked whether the reference to 116 VTE patients included within the report on the Quality Account should remain, given Dr Walker's earlier statement that they had been wrongly allocated as inpatients. He noted that if auditors felt that it was appropriate for the information to remain then he would be happy to follow their recommendation. Mr Wells explained that the report was currently a work in progress, and that he would be happy to reflect on whether the figure should remain, and if additional context should be included.

035/18 Annual Report including Annual Governance Statement

Mrs Wells noted that the Annual Report being presented would be subject to a number of minor changes, including the correction of typos that had been noticed. No material changes would be made to the document following approval and Mr Wells confirmed that he was happy with this arrangement.

Mrs Wells explained that the Annual Report would be submitted to the Department of Health on 29th May, and would be formally received by the Board at the AGM in August.

036/18 Annual Accounts and associated certificates

Mr Reid noted that, subject to a final check of accounts, the letter of representation had been agreed. Mrs Wells noted a minor amendment concerning CIPs that needed to be made to the letter.

Mr Reid thanked Mr Hoaen and his team for their all their hard work on completing the accounts.

037/18 Internal Audit Annual Report and Head of Internal Audit Opinion for 2017/18

Mr Townsend reported that the overall Head of Internal Audit Opinion for 2017/18 for the Trust was of reasonable assurance. He highlighted the improved assurance rating and noted the positive relationship that auditors had with managers in the organisation, explaining that the number of audit recommendations issued during the previous year had fallen, but an increased number of operational effectiveness matters had been identified.

Mr Stevens praised Mr Hoaen and his team for maintaining excellent working relationships with auditors while managing busy workloads. Mr Reid thanked the internal audit team, and in particular Adrian Mills, for their commitment to the Trust.

038/18 ESHT Section 30 Referral Letter
This was noted by the Committee.

039/18 Internal Audit Annual Plan 2018/19 (verbal)
Mr Townsend confirmed that the Internal Audit Plan for 2018/19 had been shared with Trust Executives and would be presented to the Audit Committee for approval at the next meeting.

040/18 Audit Committee Annual Report 2017/18
Mr Stevens explained that he had been impressed by the Audit Committee's Annual Report, and approved its submission to the Trust Board.

041/18 Date of Next Meeting
The next meeting of the Audit Committee would be held on:
Wednesday, 25th July 2018 at 1300 in St Mary's Boardroom, EDGH

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE & ORGANISATIONAL DEVELOPMENT (POD) COMMITTEE

Minutes of the People & Organisational Development (POD) Committee meeting held on Wednesday 9th May 2018 15:00 – 17:00 Room 6 Education Centre, Conquest with vc to Sara Hampson Room, EDGH

Present:
Mrs Miranda Kavanagh, Non-Executive Director (MK) – Chair
Dr Adrian Bull, Chief Executive (AB)
Mrs Dawn Urquhart, Assistant Director HR, Education (DU)
Dr David Walker, Medical Director (DW)
Mr Jamal Zaidi, Associate Medical Director – Workforce (JZ)
Mrs Jackie Churchward-Cardiff, Non-Executive Director (JCC)
Mrs Kim Novis, Equality & Human Rights Lead (KN)
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)
Mrs Sharon Gardner-Blatch, Deputy Director of Nursing (SGB)
Ms Monica Green, Director of HR (MG)

In Attendance:
Dr Nadia Muhi-Iddin , Guardian of Safe Working (NMI)
Ms Liz Lipsham, Occupational Health Manager (LL)
Ms Kim Boorman, Health & Wellbeing Lead (KB)
Ms Jo Gahan, Head of Operational HR (JG)
Ms Janet Botting, Acting Medical Staffing Manager (JB)
Ms Debbie McGreevy, Assistant Director, Revalidation (DMc)
Ms Polly Moore-Weeks, Revalidation & Job Planning Team Leader (PMW)
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: Mr Jonathan Reid, Finance Director (JR) Mrs Jan Humber, Staff Side chair (JH) Mrs Lesley Houston, Deputy General Manager – Medicine (LH) Mrs Michele Elphick, General Manager – DAS Division (ME) Mrs Joe Chadwick-Bell, Chief Operating Officer (JCB) Ms Gail Reeves, Deputy Head of Nursing (GR) Mrs Lynette Wells, Director of Corporate Affairs (LW)	
2)	**2.1 Minutes of the last meeting held on 14th March 2018** The minutes were reviewed and agreed as an accurate reflection of the meeting. • A post note had been added to item 6) The Nursing Workforce: *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. **2.2 Review of Action Tracker:** The outstanding items on the Action Tracker were reviewed: WRES 2016-17 - BME MK reported that a discussion had taken place at the previous Board seminar regarding BME inclusion on the Board. It was agreed that this was not something that could be forced but there would be a look at different ways of advertising future posts. MG stated that the skills of the applicants were also important to compliment the current Board members. AB stated that representation from other protected groups could be on the board but not visible; if this was to be publicised then individuals would need to be comfortable to disclose this information. **Action: Closed** Medical Engagement Further update to be provided at July 2018 meeting. Response to the draft Health and Care Workforce Strategy MG reported that the response to the draft Health and Care Workforce Strategy had been submitted and would be added to the ESHT website. **Action: Closed** Nursing Workforce Report This item would be covered under Agenda Items 11 (Establishment Review) and item13, Nursing Report for information. **Action: Closed**	
3)	**Nursing Revalidation Annual Report & Medical Revalidation Annual Report 2017/18** DMc gave a verbal overview of the submitted annual reports. Medical Revalidation ESHT had achieved 100% appraisal compliance for all doctors who were expected to undergo a medical appraisal in 2017-2018. Key challenge - revalidation takes place over a 5 year cycle; validation initially implemented by the GMC in 2012. The medical revalidation workload to increase over the next few years as the full five year cycle needs to be completed again. MK asked what measures had been put in place regarding this challenge? DMc replied that extra medical appraisers would be recruited and also had discussed the potential for encouraging existing appraisers to take on a few more appraisals. The team were working on recommendations. MG asked how the Trust ensure/monitor consistency of appraisals. DMc replied that NHS England provided a quality assurance template which would be worked through with every new appraiser and an audit would be undertaken of the appraisal output against this template. A further template would be produced to help doctors that are not performing as well as others to support them in the future.	

	AB commended the department for the good achievement received year on year and asked to what extent the appraisals include reference to culture and values as part of the training. DMc replied that this would be taken up as part of the ongoing training within the team. AB stated that brief discussions had taken place regarding professions regulated by HCPC and the number of people who informally co-ordinate/update revalidation. It had been noted that the same support structure for HCPC was not in place as it was for nursing and medical staff. A training needs analysis would be required to ensure this is put in process. DU replied that the training needs analysis would commence next week; further clarity to be provided. **Action: DU to provide clarity regarding the training needs analysis.** MK highlighted the importance of leadership and culture as she had noticed when visiting clinical units' that the appreciation was variable. MK asked for the difference between the NHSE view and the Trust's view around prescribed connection. DMc stated that the prescribed connection was legislation: • Postponed appraisal - still undertaken within GMC appraisal cycle. • Deferred appraisal - staff on sick/maternity leave. <u>Nursing & Midwifery Revalidation</u> This was the third annual report for nursing and midwifery revalidation in ESHT. Revalidation was fully launched by the NMC in April 2016. ESHT had achieved 100% compliance with completed nursing revalidation submissions in 2017-2018. *DMc and PMW left the meeting*.	**DU**
4)	**Staff Wellbeing Report** LM gave a verbal overview of the submitted report. This report was to share the successes that the service had achieved to date, raise awareness of what the department had undertaken and the support around wellbeing of staff. LL highlighted the key points of the transformation of the occupational health services over the last couple of years: • Improvements – occupational health clearance, management referrals, governance. • Successes – staff wellbeing team, occupational health physio post, flu campaign. • Future plans – Relocation of premises at the Conquest, paperless system, electronic system upgrade. KB highlighted the wellbeing initiatives that had been set up: NHS health checks, health weight programme, roadshows, talks, exercise programmes, Schwartz rounds, emotional resilience workshops, stress less workshops, psychology and counselling through occupational health, wellbeing pop up events, coaching and stress listening conversations. KB highlighted the main successes: • NHS health checks. • Staff Survey. • Achieved full payment for CQUINS 2017/2018.	

	AB commended the good work undertaken by the department and highlighted that the staff survey had identified quite a lot of good feedback around health and wellbeing. JCC thanked the department for the work undertaken and stated that it would be helpful going forward to understand what had the biggest impact and measures in place. LM advised that a number of measures were being developed to address this, and would be part of the new Dashboard for the Board. A discussion took place regarding the workshops in place and the capacity of holding these as they could not always be fully staffed. The department were looking at the 3 x 2hour sessions that Healthy Minds were offering as a pilot. LM reported that this was linked with the Health & Wellbeing Plan and conversations would be taking place regarding an evaluation tool that would be feedback though the IPR meetings. It was noted that a Menopause support group would be set up in the near future. SGB highlighted that nursing and the staff engagement team had been jointly working as part of the NHSI recruitment and retention cohort, looking at organisational development to build in preventative resilience to prevent people having to attend occupational health department; focus groups to be set up. *LL and KB left the meeting*.	
5)	**Recruitment update** MT provided a verbal overview 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. JCC requested an analysis of benchmarking and queried whether any changes would be required. MG replied that the benchmarking detailed that the service provided an efficient service and within the opportunities, in some particular areas, time to recruit was an issue. The TRAC system details the stages of the applications; support on understanding the system to ease the workflow processes within their departments would be offered to managers. A discussion took place regarding the Vacancy Control Panel and AB highlighted that this procedure was in place to check on the recruiting position due to the financial position and had been modified to ensure as few delays as possible. MK asked if PA Consulting were looking at this process. MG stated that they had and would offer improvements for the service. JCC asked why the AHP turnover rate was still increasing. AB stated that a discussion had taken place with Out of Hospitals and it was highlighted that there was not enough progression through the bands, although this was not an obvious issue as a trend and exit interviews were being undertaken. JCC asked if there was a plan for the AHPs? MT suggested exploring leavers in terms of how many leave to go to Adult Social Care and our joint services, losing as an employer but not from the system. **Action: Abi Turner and Katy Lyne to provide a brief summary of views on the deteriorating retention of AHPs.**	**MK/NH**

	DU referred to working to retain talent and stated that the apprenticeship for Allied Healthcare Professionals (radiology), had talent but cannot develop as the apprenticeship standard was not ready. DU highlighted that staff were being supported for their educational development but the Trust policy about recovering fees if staff leave needs to be re-visited.	
6)	**HR Incident Report** JG provided a verbal overview of the submitted report. This 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. AB reported that there had been a lot of proactive work in this area, significant work on investigations and on individual teams. AB referred to Datix reports and stated that these were being looked at with a behavioural/cultural issue to it and ensuring that it would be dealt with. Ruth Agg would be producing a regular newsletter summarising lessons learnt from incidents. JCC asked how the Trust learns from losing a tribunal. JG replied that 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. MK highlighted that this had been a positive report. *JCC left the meeting*.	
7)	**Gender Pay Gap** MT provided a verbal overview 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 to 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. MK asked what were the consequences of this? MT replied that reporting is mandatory and an action plan would most likely to be requested in the future.	
8)	**New Roles update** DU provided a verbal update of the new roles, particularly in relation to the introduction of the Physician's Assistant role. DU stated that she had met with MT and the lead in primary care to set some focus and was reviewing the job description. DU stated that she had been in discussion with the Head of Workforce Informatics and Business Intelligence to work with divisions who had registered an interest in taking this role forward. AB referred to the physician assistant roles and stated that the medicine division had been very positive and focussed on this and 4 posts had been detailed in their business plan. **Action: DU to have a discussion with Sandra Field for further clarity.**	**DU**
9)	**Annual Report from the Guardian of Safe Working** NMI provided a verbal overview 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. SGB referred to the multi-disciplinary safety huddles and highlighted that doctors were most welcome to join these huddles at any point. These meetings were held on the ward as geographically this is where the patients are. AB stated that a communication from Vikki Carruth, Director of Nursing, encouraging the doctors to attend would be of value. To be followed up outside of this meeting. **Action: SGB to speak with VC re communication to doctors to join the multi-disciplinary safety huddles.** AB commended the report. AB referred to paragraph 6.1 Medical Staffing Capacity and Capability. A discussion took place regarding the group. To be followed up outside of this meeting. **Action: Follow up meeting with DW, NMI and AB to take place – are we reinforcing and giving full support to the group.**	**SGB** **AB/DW /NMI**
10)	**Apprenticeship update** DU provided a verbal update on the apprenticeship scheme. The total apprenticeship levy to spend was £1.37m. Digital apprenticeship service, national system where the levy is deposited; paper to presented in July 2018. **Action: DU to provide apprenticeship paper for July 2018 meeting.** Engagement had been undertaken with external agencies with very positive feedback. DU highlighted the key challenge 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 number of apprentices joining schemes. Solutions: • Revised the apprenticeship forum. • Training needs analysis to commence next week. • How we link back to workplace placements. • Better working relationships with workforce resourcing and transformation team. • Better monitoring of apprenticeship levy. • Develop excel spreadsheet to capture data for the provision of accurate spend against the levy.	**DU**
11)	**Establishment Review** Provided for information/assurance.	
12)	**Review of flexible working for nursing staff** SGB 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. MG 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. AB suggested a pilot of flexible working with the use of Healthroster to produce templates be undertaken, which would also allow for staff to work additional shifts.	

13)	**Items for information:** Nursing Report Item noted. Feedback from sub-groups: 13.1 – Engagement & OD Group Item noted. 13.2 Education Steering Group Item noted. 13.3 – Workforce Resourcing Group Item noted. 13.4 – HR Quality & Standards Group Item noted.	
14)	**Any other business** No other business.	
15)	**The next meeting of the Committee will take place on:** **Wednesday 11th July 2018** **15:00 – 17:00** **John Cook Room, Post Grad, EDGH**	

East Sussex Healthcare NHS
NHS Trust

Minutes of the Quality and Safety Committee Meeting

Wednesday 21 March 2018
Room 2 Ed Centre, CQ vc to John Cook Room, EDGH

Present:
Sue Bernhauser, Non-Executive Director - Chair
Adrian Bull, Chief Executive Officer
David Walker, Medical Director
Vikki Carruth, Director of Nursing
Joe Chadwick-Bell, Chief Operating Officer
James Wilkinson, Assistant Medical Director, Quality
Lynette Wells, Executive Director, Corporate Affairs
Monica Green, Director – Human Resources
Jonathan Reid, Director of Finance
Catherine Ashton, Director of Strategy, Innovation and Planning
Debbie Lennard, Assistant Director of Nursing, OOH
Claire Bishop, Head of Nursing, DAS

In attendance:
Hazel Tonge, Deputy Director of Nursing
Nicky Walker, General Manager, DAS Division
Gulzar Mufti, Inspection Team
Russell Brown, Inspection Team
Karen Salt, PA to Director of Nursing (notes)

1.0 Welcome and Apologies for Absence

Sue Bernhauser welcomed everyone to the Quality and Safety Committee meeting and introductions were made.

Apologies for absence were noted from:

Jackie Churchward-Cardiff, Non- Executive Director
Ashley Parrott, Associate Director of Governance
Amanda Isted
Korron Spence
Sarah Blanchard-Stow

Death of Janet Colvert – The Chair expressed gratitude for the significant contribution Janet had made to the work of the Committee, in particular in relation to access. The Chair would write to her two sons. Plans for a replacement would be discussed at the next meeting.

2.0 Patient Story

The Serious Incident reports circulated were taken as read. SI Report 2017 – 20811 related to the unwitnessed fall of a patient on Cuckmere Ward which had resulted in a hip fracture. The patient was discharged following surgery to repair but then readmitted with sepsis and subsequently died.

The RCA had focused on the fall and whether or not there were care issues. An action plan had been developed. The Medical Director and Director of Nursing had discussed the case and agreed to a review the 2nd admission.

David Walker said this was just such an example of a report that would go to an oversight group for a 2nd review – learning from a death. It had shown that all had been done that should have been done – the patient had been very unwell with various co-morbidities. But there were some overall care issues – the patient had been at risk of falling. The Morbidity Review Group and a structured review would take place. This would then be fed back to the consultant for the last admission.

With regard to assurance relating to the actions – the Falls Group was very active, Cuckmere had a no of actions and regular audits had down a significant improvement. A new falls risk assessment had been rolled out to 6 wards and Cuckmere would be an aread of focus. It was noted in her absence that Jackie Churchward-Cardiff had commented on the fact that the patient had been using a zimmer frame in her nursing home but that the Trust had not provided one. Were staff too busy ticking boxes rather than the patients. The patient had been mobile the day before and deemed to have capacity. There was a need to remind staff to look beyond the tool. It was also noted that she should have been flagged as high risk at the handover points from ED to MAU and then to Cuckmere. This was something that was being worked on.

Hazel Tonge arrived
Debbie Lennard arrived

Joe Chadwick-Bell commented that there was a 2nd part to this which was the sepsis. The focus of the report was on the first admission with a line added regarding the sepsis. More work needed to be done and mortality needed to take part one into account. Staff had focused on the bit of care that they had done.

Never Event SI 2017-23150 – this related to a component in a hip replacement. There had been identical incidents at Dartford and Gravesham NHS Trust and at Brighton. Feedback had been sent to NHSI that there would be some learning for cascading nationally.

It was noted that routinely the size of a prosthesis would not be determined until surgery was underway. Root cause and actions had been outlined and actions for sharing. An independent review of theatres had been commissioned and a report and recommendations issued. A number of actions were well under way and would be monitored through the Diagnostics, Anaesthetics and Surgery IPR.

David Walker confirmed that the never event was unrelated to the Surgical Site Infections issue that the Trust had experienced in mid-2017. Nick McNeillis had done a review of the papers which would be presented to a future meeting once it had been reviewed. The underlying cause had been found to be a run of patients with co-morbidities (diabetic, obese) with a level of risk that was high. It was noted that the action plan would go through the Division IPR and then the Quality and Safety Committee. Jon Buckley was the action plan owner.

3.1 Minutes of the Previous Meeting

The minutes of the 24 January 2018 meeting were approved.

3.2 Matters Arising

Action Log

QSC 90 - *Joe Chadwick-Bell to review the wording of the risks relating to the Divisions. Joe to be asked for wording suggestion*. Joe Chadwick-Bell confirmed the BAF had been updated and would be reviewed at the next meeting. Action closed.

QSC 97 - *Ashley Parrott to discuss assurance around the investigation of incidents (Action 2A) with Urgent Care.* Urgent Care Governance Review circulated to members. Action closed.

QSC 109 - *Ashley Parrott to investigate the reason for the higher rate of complaints against activity in the Women and Children Division and update to the next meeting.* Review of complaints relating to WCSH Division circulated to members. It was agreed that this action be closed and a new action opened relating to plans to address the complaints issues. Action closed.

Action – Women, Children and Sexual Health Division to present to the next IPR meeting an action plan aimed at addressing the rate of complaints.

QSC 110 - *Vikki Carruth to update on the validity of 'night move' data at the next meeting.* Vikki Carruth reported that she had met with the Ward Clerks, cover for leave and absence was a challenge and a risk had been added to the risk register. Moves were being tracked to monitor whether or not there were clinical reasons for night moves. Action closed.

Adrian Bull noted that night move data fed into patient flow and that ward clerk cover may not be the only issue. Joe Chadwick-Bell confirmed that some moves were appropriate. A new bed management system was being looked at. The specification allowed a speedy acceptance of patients onto wards. The aim was to have the new system in place by October 2018 following a procurement process and 12 week implementation period. This was being monitored through the Digital Steering Group. Jonathan Reid noted that cash flow constraints were a challenge but this was being tracked and monitored.

Action – New bed management system project update to be reported at the next meeting.

QSC 111 – *Justin Harris to be asked to provide data on the latest plain film backlog figures and improvement trajectory.* An update had been provided out of committee and it was agreed to close the action.

QSC 113 - *Action plan to be emailed out by Karen Salt when available*. Vikki Carruth reported that the survey had been to the Cancer Board and an action plan was being drafted. This would go back to the Divisions, be presented to the Patient Experience Group and then to the next meeting of the Quality and Safety Committee in May. Action remained open.

QSC 114 – *Justin Harris to present a position paper at a modified, extraordinary meeting of the Quality and Safety Committee in February.* Due to diary challenges the paper had been circulated to members electronically and considered as a Chair's Action. Vikki Carruth

reported that some immediate support had been offered to the team. The first reporting radiographer had started on 13 March and support would be in place for as long as it was needed. There had been progress with recruitment and a draft action plan was being developed and would be monitored through the Patient Safety and Quality Group and circulated at the next Quality & Safety Committee meeting in May 18. Sue Bernhauser expressed the appreciation of the Committee for the work that Justin Harris had put into resolving the issues. There was assurance in that the highest risk cases were being looked at first. Action closed.

Action – Draft Radiology action plan to be presented to the May 2018 meeting.

QSC 115 – *Vikki Carruth to formally escalate to Jonathan Reid, Director of Finance, concerns from the Committee regarding the impact of finance issues on quality in the organisation.* Action complete. It was noted that the recent receipt of NHS I special measures money had improved the position. Action closed.

QSC 116 - *Korron Spence to share Risk Assessment conducted at EDGH*. Joe Chadwick-Bell reported that the policies relating to the Full Capacity Protocol had been reviewed and were in place and embedded in practice. Action closed.

QSC 117 – *Korron Spence to arrange to update the risk register.* The risk was reviewed by the Chief Operating Officer on 5 Feb 18. Action complete.

QSC 118 – *Vikki Carruth to arrange for a discussion at the Executive Directors' meeting about how to manage/escalate troubled services*.

It was confirmed that management of such services was through the Executive Director meetings and an in depth review had been held into the ophthalmology service, covering quality, operations, complication rates etc. 10 action points had been identified and data would be tracked through the Divisional IPR. A similar review would be set up for the Urology service and the aim was to conduct reviews for every specialty.

It was reported that a business case relating to the consolidation of the ophthalmology service was due to be discussed on 20 April 2018.

Joe Chadwick-Bell confirmed that the waiting list and time to treatment was improving with the 18 week team picking up the outpatient element to release capacity.

Action - Ophthalmology Action Plan Deep Dive to be presented to the next meeting. To close the loop.

QSC 119 – *Sarah Blanchard-Stow to update the report to provide further information on actions and timescales for CTG monitoring.*

Nicky Mason reported that a multi-faceted approach had been taken to improving CTG interpretation and escalation of concerns. This involved training, competence and human factors. An interactive CTG training package had been made mandatory and compliance compliance testing would be conducted at the end of March 2018. A 'Return to the Labour Ward' package, run by a consultant obstetrician, had been developed for staff returning from maternity leave and for new starters/newly qualified.

Other actions involved:

- Weekly quality walks
- Staffing - shift co-ordinators were being introduced
- Foetal Wellbeing Midwife role was being progressed
- Obstetric lead for CTG monitoring was being identified
- Fresh Eyes – hourly assessment of CTG
- Risk assessments looking at skill mix and movement of staff
- Daily review at CTG huddles.
- Quarterly newsletter for lessons learned.

Adrian Bull confirmed that this had been on the agenda of the WCSH IPR and the Maternity Board and a lot of focus and work had gone into achieving improvement. Action closed.

QSC 120 – *Business case for additional consultants to be presented to Executive Directors' meeting as soon as possible and before the end of the financial year.* No update, action remained open.

QSC 121 - *Sharon Ball to advise Vikki Carruth and David Walker what support was needed following the meeting due to take place on the evening of 24 Jan 18.* No update, action remained open.

QSC 122 - *Ashley Parrott to meet with Sharon Ball to link the two risks.* Ashley Parrott had confirmed that a request to link the risks had been made. No further update. Action remained open.

Compliance and Risk

4.1 – Patient Safety and Quality – Board Assurance Framework

Lynette Wells presented the report noting the following recommendations to remove gaps in control:

2.1.2 – Emergency Department Reconfiguration – it was agreed to recommend to the Board that this was removed from the BAF.

2.1.3 – Patient Flow – Joe Chadwick-Bell reported that there would always remain an issue but processes were in place and Delayed Transfers of Care were down from 7.9 to 1.3. This could be monitored in other meetings.

2.2.1 – Mandatory training/appraisal compliance. Monica Green reported improvement and this was being monitored in more granular detail at the IPRs. It was agreed to remove this from the BAF.

2.2.2 – Developing and supporting clinical leadership. There had been a significant turnaround and monitoring would continue through the People and Organisational Development Committee.

It was agreed that Learning from Deaths should not be added to the BAF. The Trust had a robust process that was not being operated well but the Trust was not an outlier. There was

sight at Board level and the process was being managed and needed time to develop.

4.2 – Patient Safety and Quality – High Level Risk Register

The Committee had the following comments:

Risk 1502 – *Non-compliance with 4 hour Waiting Time Standard and delay in the provision of optimal care*. It was agreed that there were continuing breaches but the lengths of time had reduced which had lowered the impact. There was no evidence of detriment to patient care and the likelihood had reduced. It was agreed that the Division should provide a recommendation to the Board to reduce the score.
Risk 1458 – *Non-Compliance with NICE guidance NG19 (Diabetic Foot)* – It was agreed that this should be reviewed by Medicine.
Risk 1642 – *Management of the Trust when it is at Full Capacity* – SLF request to update commentary still to be completed. Score to be amended to 16.
Risk 1658 - *Interpretation and escalation of antenatal/intrapartum CTG* – this was being reviewed regularly. Score to remain at 20.
Risk 1459 – Diabetic eye screening IT performance issues. Score to remain at 20.
Risk 1289 - Long standing vacancies in histopathology – Score to remain at 20 but expected to reduce in due course.
Risk 1134 – Consultant and Middle Grade Vacancies in Emergency Medicine. Risk to be reviewed given recent recruitment.
Risk 1617 – Achievement of 2017/18 Financial Plan – risk at a reduced level. Due to be reviewed in the new financial year and likely to increase to 20.
Risk 1671 – Non-compliance of fire detection system in single room accommodation at EDGH. Update from Estates colleagues required.
Risk 1877 – Vacancies in the Infection Prevention and Control Team – The 4th microbiologist had agreed to take on the Director of Infection Prevention and Control role and interviews were scheduled for the substantive nursing post (Head of Infection Prevention and Control). Score likely to reduce from 16 to 12 once the above were confirmed.
Risk 1659 – *Non PTL follow up appointments not adequately recorded and monitored to ensure timely reappointment.* PTL system was being piloted in urology and would then be rolled out to ophthalmology.
Risk 1632 - Gaps in middle grade on call medical rota at EDGH – score to remain the same.
Risk 1577 – Temperature in pathology stores – Jonathan Reid reported that an investment of £14,000 had been approved to address this issue which was putting £20,000 of stock at risk. And order would be submitted in the next 10 days following which the risk score would reduce. Score to remain the same in the meantime.
Risk 1616 – *Consultant Vacancies in the Medicine Division* – risk to remain given recent resignation of a further consultant. Medicine Division to review and consider increase to score.
Risk 1621 - *Lack of UPS in critical areas* – no change, this was a permanent issue.
Risk 1538 – *Nursing Recruitment* – no change.
Risk 1410 – *Fire, Physical Environment* – score to remain the same until result of compartmentation business case known.
Risk 1425 – *Failure of Lifts (Conquest and EDGH)* – Likelihood felt to be too high but Estates Team keen for risk to remain at 16.

Action – Estates and Facilities IPR to be advised of the Committees views regarding

the too high score for likelihood of Risk 1425 - Failure of Lifts.

Risk 1255 – *Shortage of trained nurses in all areas of Medicine* – score to remain the same.
Risk 1261 - *Insufficient isolation capacity to meet demand consistently due to new and emerging risks* – Attempts to manage by cohorting (flu for example). Score to remain the same.

Action – Vikki Carruth to discuss Risk 1261 at the next Trust Infection Prevention and Control Group meeting.

Risk 1291 – *Risk to pathology accreditation with CPA and UKAS ISO15189* – it was confirmed that following a UKAS inspection all actions had been completed.

Action – Vikki Carruth to confirm status of Risk 1291 – Risk to Pathology Accreditation - at the next Trust Infection Protection and Control Group.

Risk 1187 – *Outstanding ophthalmology patient follow ups* – David Walker reported that this had got worse and was resulting in Serious Incidents with sight impacted. Risk to be reviewed with a view to increasing the likelihood.

Action – Risk 1187 – Outstanding Ophthalmology patient follow ups to be reviewed by DAS Division.

Risk 1540 – *Recruitment AHP/Professional/Technical/Estates/Corporate* – score to remain the same.
Risk 1494 – *2 and 18 week referral to treatment targets* - Sandra Field, ADO to review and consider adding 62 day RTT.

Action – Sandra Field, ADO Medicine to be asked to review risk 1494 (2 and 18 week RTT) and consider adding 62 day RTT.

Risk 1528 – *Liquidity* – NHS I Special Measures Money had reduced the risk for this financial year so likelihood reduced to 3. It was agreed to reduce the risk to 12. Noted that the risk would increase for the next financial year.

Action – Risk 1528 – Liquidity to be reduced to 12.

Risk 1535 – *Insufficient ward decamp facilities to support deep cleaning Estates work* - It was agreed that the likelihood should reduce to 3 resulting in a reduced score of 12.

Action – Vikki Carruth to ask Trust Infection Prevention and Control Group to review score and consider reducing likelihood to 3 with a resulting reduced score of 12.

Risk 1537 – *Medical Staff Recruitment* – score to remain the same.
Risk 1301 – *Delayed Discharge from Critical Care* – score to remain the same.
Risk 1360 – *Frequent Episodes of Cath Lab equipment breakdown* – It was noted that new equipment was on order but had not yet arrived. Compliance checks needed to be carried out by the Estates Team. A robust back up plan and mitigations/controls were in place – score to remain the same.
Risk 767 – *Workforce Plan and capacity* – score to remain the same.

Risk 779 – *Neuraxial Safety, non-compliant medical devices* – solution not yet found. Connectors reported to be available. Score to remain at 16 but may reduce if solution found.

Action – Vikki Carruth to obtain an update on the position regarding epidural connectors with Ashley Parrott.

Risk 1397 – *Clinical Environment Maintenance and Refurbishment* – Score to remain the same.
Risk 1398 – *External Cladding/Façade* – Score to remain at 15.
Risk 1660 - *Cyber attack* – Score to remain at 16.
Risk 588 - *Backlog in reporting of plain film x-ray examinations* – to be reviewed by the Committee at the next meeting.
Risk 1118 – *Failure Building Management System* – Score to remain the same.
Risk 1152 – *Unsupported Medical Devices in Daily Clinical Use* – Score to remain the same.
Risk 1406 - *Water Ingress Phase 2* – Score to remain the same.
Risk 1622 - *Working at height – Roof Access* – Score to remain the same.
Risk 1626 – *Inadequate environment in several areas for the safe management of medicines* – Score considered to be high.

Action – Vikki Carruth with Simon Badcott (Chief Pharmacist) to review the high score of Risk 1626.

Risk 1645 – *7 Day Services* – Failure to achieve all core standards – Score to remain the same.
Risk 1655 – *Containment Level 3 (CL3) Laboratories at DGH failed commissioning* – Update required.

Action – Vikki Carruth to ask DAS Division to update Risk 1655.

Risk 1246 – *Point of Care Testing* – Not reviewed.

Action – Vikki Carruth to ask Jacqueline Munro, Clinical Lead to review Risk 1246.

Risk 79 – *Organisational Risk Associated with the management and control of Asbestos* – Score to remain the same.

4.3 – CQC Progress Report – February 2018

Lynette Wells presented the report noting that feedback had been sent to the areas visited. The Committee noted the report.

4.4 – ESHT 2020 Improvement Programme – Governance Structure (Verbal)

Catherine Ashton presented a verbal update noting that it had been agreed at Executive Directors' meeting that ESHT 2020 would be reviewed and refreshed every year. The expectation would be to refresh the key priorities. A refreshed ESHT 2020 would be deferred to June 2018 to allow a full and robust set of data to be available for comparison.

4.5 – Improvement Group Exception Report

Catherine Ashton presented the report noting that work was progressing and that an Improvement Forum was planned for the Conquest site following the recent Improvement Forum event at EDGH.

In response to a suggestion from Jackie Churchward-Cardiff that an update on the 70 schemes would be helpful Catherine Ashton advised that the schemes were being consolidated into a matrix of 5 broad themes. The aim of this was to keep oversight on them and to pull into themes. Feedback on this would be available in due course as the matrix developed.

Safety and Quality

5.1 – Governance Quality Report (including PSQG Report)

Vikki Carruth presented the report noting that work on falls was gaining traction. Medication incidents had increased and a deep dive would be conducted to ascertain whether there were any themes.

Pressure Ulcers were showing consistent improvement. A quarterly snapshot audit of category 2 pressure ulcers would be conducted and feed into the Patient Experience Steering Group and the Patient Safety and Quality Group.
Themes from Serious Incidents were being picked up in the Falls Group
Discharge information was a recurring theme and there was a plan to monitor this through the Discharge Improvement Group and the Patient Experience Steering Group.

Jackie Churchward-Cardiff had sent a written comment noting that the high level of 6 month overdues in DAS and Medicine. 82 actions needed closing down. There was a discussion about ownership of governance in the Divisions. Attendance from the Divisions at meetings was not reliable due to conflicting priorities.

Action – Vikki Carruth and David Walker to meet with the Division ADNs to understand how to support them to get on top of actions and governance.

FFT in A & E remained a challenge – the Division was being supported to improve.

5.2 – Risk and Quality Delivery Strategy

Vikki Carruth presented the report and reported that she and Catherine Ashton would, over the next month, be working on trying to streamline the various strategies in the Trust.

Lynette Wells endorsed the very clear document which contained some minor revisions to a Strategy that had been approved by the Committee the previous year. It was noted that the name of the Strategy might change to reflect better it's aim.

In response to a written query from Jackie Churchward-Cardiff Adrian Bull confirmed that 'Well Led' was addressed in other documents.

5.3 – External Visits and Reviews

Lynette Wells presented the report and commended the Paediatric Audiology Accreditation,

one of the few for paediatrics, and the only one in the South.

JAG Accreditation had been received in February 2018 – the registration was conditional with a 3 month deferral but there had been good feedback received for a very large and complex piece of work.

5.4 – Independent Review of Theatres Operation – Action Plan

Nicky Walker presented the report and action plan. It was noted that white boards in Theatres would be picked up in the service plan and through Get It Right the First Time. The Action Plan would be reviewed and monitored through the DAS IPR.

5.5 – Non-Executive Director Quality Walks (Verbal)

In the absence of Jackie Churchward-Cardiff it was agreed to defer this item to the May meeting.

5.6 – Quality Section of the Integrated Performance Report Month 10

Vikki Carruth presented the IPR Month 10 noting a reduction in falls per 1000 bed days from last year's figures.
The aim in slower time was to stop using the Safety Thermometer but an alternative source of data was needed for monitoring some of the data.
Key highlights were as follows:

- Dip in VTE compliance.
- CDiff – The Trust was just under the threshold of 32 with 30 cases (no lapses in care)
- Pressure Ulcers would be monitored through the snapshot audit of category 2s as mentioned earlier on the agenda.
- Mixed Sex Accommodation – a change to monitoring and reporting had been introduced and the process was now real time. All breaches would have to be reported and there would be an increase. Validation of clinically justified breaches would take place. As the process was new there was no benchmark available but an expected increase had been seen. It was not felt to be a safety issue. Point prevalent monitoring would continue in the meantime to confirm that there were no increases.

5.7 – Maternity Strategy

Nicky Mason presented the draft Maternity Strategy noting that there had been criticism in 2015 for not having a strategy. There had been engagement with staff and service users to help develop the strategy which needed further development.

It was agreed that Catherine Ashton would support the completion of the strategy so that it described what the Trust would try to achieve, how it would be achieved and what it would feel like for patients.

5.8 – ESHT Staff Survey 2017 - Results

It was noted that a presentation relating to feedback from the Staff Survey was due to be

presented at the next Trust Board meeting. James Wilkinson commented that note needed to be taken of staff concerns relating to raising clinical concerns.

Action – Discussion around staff concerns relating to raising clinical concerns to be added to the agenda of the next meeting.

6.0 - Deep Dive

There was no Deep Dive presented for this meeting.

7.0 – Papers for noting

The Committee noted the Voices Survey with no further comments.

8.0 – Deep Dive for next meeting

It was agreed that the next Deep Dive would be the Ophthalmology - Action Plan.

9.0 – AOB

There were no matters raised under AOB.

East Sussex Healthcare NHS
NHS Trust

Minutes of the Quality and Safety Committee Meeting

Wednesday 16 May 2018
St Mary's Boardroom, EDGH vc to Chair's Office Conquest

Present:
Sue Bernhauser, Non-Executive Director - Chair
Jackie Churchward-Cardiff, Non- Executive Director
David Walker, Medical Director
Vikki Carruth, Director of Nursing
James Wilkinson, Assistant Medical Director, Quality
Lynette Wells, Executive Director, Corporate Affairs
Monica Green, Director – Human Resources
Jonathan Reid, Director of Finance
Catherine Ashton, Director of Strategy, Innovation and Planning
Ashley Parrott, Associate Director of Governance
Debbie Lennard, Assistant Director of Nursing, OOH
Jayne Cannon, Assistant Director of Nursing, DAS
Sarah Blanchard-Stow, Assistant Director of Nursing and Head of Midwifery
Sue Allen, Assistant Director of Nursing, Medicine

In attendance:
Hazel Tonge, Deputy Director of Nursing (for Item 5.6)
Sharon Gardner-Blatch, Deputy Director of Nursing (for Item 5.3)
Sharon Ball, Service Manager, Ophthalmology (for Item 6.0)
Karen Salt, PA to Director of Nursing (notes)

1.0 **Welcome and Apologies for Absence**

Sue Bernhauser welcomed everyone to the Quality and Safety Committee meeting and introductions were made.

Apologies for absence were noted from:

Adrian Bull, Chief Executive Officer

2.0 Patient Story

Vikki Carruth introduced a video interview with a former patient and his wife. The patient's experience had been the subject of an Amber investigation. The patient had been admitted post-stroke but the issues around his care centred around communication with his wife when he was suffering from a reaction to his medication. There had been a delay in diagnosis of a problem with his eyes which had led to longer term issues and had an impact on his day to day life. The patient and his wife wanted to relate the story so that learning could be taken from his case about the impact on him. He also wanted to highlight that he had had to make use of further NHS resources for something that had potentially been avoidable – the patient was due to undergo further treatment.

It was agreed that this was a clear example of the impact of not listening to patients or, if they were very unwell, their close family or carers. While the medication reaction was rare

it had not been addressed due to not being documented in the patient's notes and the delay in diagnosis had led to harm to the patient.

Ashley Parrott reported that the event had been some time ago and actions had been followed up by the Head of Nursing in Medicine Division.
Positive things to say – but we did something that caused further work – for the NHS

The video interview was the first of a series that were planned for sharing with wards and for training purposes.

3.1 Minutes of the Previous Meeting

The minutes of the 21 March 2018 meeting were approved subject to the deletion from Item 5.6 of the following:
Line 4 - 'was needed for'
Line 5 of bullet point 4 - 'mostly in Critical Care which used to be excluded from reporting'

3.2 Matters Arising

Action Log

The Chair noted concern about delays in responses to actions which hindered the Committee's ability to assure the Board. Action 113 was a case in point.

QSC 113 – *Cancer Survey Action Plan to be emailed out by Karen Salt when available*. Action plan had been due to be circulated in the week of 8 May but had not yet been received. Vikki Carruth would follow up with Dee Daly and arrange for it to be provided for circulation to Committee members for comment. Action remained open.

QSC 120 – *Business case for additional consultants to be presented to Executive Directors' meeting as soon as possible and before the end of the financial year.* There was no update - action remained open.

QSC 121 - *Sharon Ball to advise Vikki Carruth and David Walker what support was needed following the meeting due to take place on the evening of 24 Jan 18.* Event had taken place and further support not requested. It was agreed to close the action.

QSC 122 - *Ashley Parrott to meet with Sharon Ball to link the two risks.* Ashley Parrott confirmed that a link to the risks had been made. Action closed.

QSC 123 – *Women, Children and Sexual Health Division to present to the next IPR meeting an action plan aimed at addressing the rate of complaints.* Sarah Blanchard-Stow reported that a Deep Dive was being conducted by the Head of Nursing to ascertain any themes and trends and an action plan was being developed. It was agreed to present the action plan at the next meeting. Action closed.

Action – Sarah Blanchard-Stow to present Women, Children and Sexual Health Division complaints action plan to the next meeting of the Quality and Safety Committee.

QSC 124 – *New bed management system project update to be reported at the next meeting.* No update, action remained open.

QSC 125 – *Draft Radiology Action Plan to be presented to the May 2018 meeting*. Justin Harris provided an update as an item on the agenda. Action closed.

QSC 126 - *Ophthalmology Action Plan Deep Dive to be presented to the next meeting.* To close the loop. Item on the agenda. Action closed.

QSC 127 – *Estates and Facilities IPR to be advised of the Committees views regarding the too high score for likelihood of Risk 1425 - Failure of Lifts.* Lynette Wells confirmed this had been raised in Estates IPR. Action closed.

It was agreed that Assistant Directors of Nursing and Assistant Directors of Operations retained responsibility for ensuring that reviews of risks were done and updates recorded on the risk register. It was therefore agreed that Actions 128 to 137 would be closed and a reminder would be sent to the risk owners, copied to Divisional leads. Updates would feature in the High Level Risk Register report at the next meeting.

Action – Assistant Directors of Nursing to follow up their risks with risk owners and ensure risks were reviewed and the risk register updated prior to the next meeting.

QSC 128 – *Vikki Carruth to discuss Risk 1261 at the next Trust Infection Prevention and Control Group meeting.* See above – action closed.

QSC 129 – *Vikki Carruth to confirm status of Risk 1291 – Risk to Pathology Accreditation - at the next Trust Infection Protection and Control Group.* See above – action closed.

QSC 130 – *Risk 1187 – Outstanding Ophthalmology patient follow ups to be reviewed by DAS Division.* See above – action closed.

QSC 131 – *Sandra Field, ADO Medicine to be asked to review risk 1494 (2 and 18 week RTT) and consider adding 62 day RTT.* See above – action closed.

QSC 132 – *Risk 1528 – Liquidity to be reduced to 12.* See above – action closed.

QSC 133 – *Vikki Carruth to ask Trust Infection Prevention and Control Group to review score and consider reducing likelihood to 3 with a resulting reduced score of 12.* See above – action closed.

QSC 134 – *Vikki Carruth to obtain an update on the position regarding epidural connectors with Ashley Parrott.* See above – action closed.

QSC 135 – *Vikki Carruth with Simon Badcott (Chief Pharmacist) to review the high score of Risk 1626.* See above – action closed.

QSC 136 – *Vikki Carruth to ask DAS Division to update Risk 1655.* See above – action closed.

QSC 137 – *Vikki Carruth to ask Jacqueline Munro, Clinical Lead to review Risk 1246.* See above – action closed.

QSC 138 – *Vikki Carruth and David Walker to meet with the Division ADNs to understand how to support them to get on top of actions and governance.* There was no update. Action remained open.

QSC 139 - *Discussion around staff concerns relating to raising clinical concerns to be added to the agenda of the next meeting.* On the agenda. Action closed.

Compliance and Risk

4.1 – Patient Safety and Quality – Board Assurance Framework

Lynette Wells presented the Board Assurance Framework noting that gaps in control for had been removed for some risks enabling them to be taken off the Framework.

Risk 2.1.2 *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.* While controls were said to be in place Jackie Churchward-Cardiff asked for evidence to be presented to the next meeting before consideration was given to removing the risk.

It was noted that the major proportion of the risk was on the Sussex Partnership Foundation Trust risk register.

Action – Sarah Blanchard-Stow (WCSH Division) to obtain numbers from Amy Collis (Urgent Care) conduct an audit and identify if there are commissioning gaps to be addressed and update the gaps in control for this risk. If commissioning gaps identified, David Walker and Vikki Carruth to raise with the CCG and report back to the Quality and Safety Committee.

Risk 5.1.1 - *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*. Medical vacancies had reduced but it was noted that where gaps existed the impact was great. It was agreed to leave the risk at Amber.

4.2 – Patient Safety and Quality – High Level Risk Register

Ashley Parrott presented the High Level Risk Register noting that some risks still needed updates following comments at the last meeting. The Risk Register had been reviewed thoroughly following the last Senior Leaders' Forum meeting in April.

It was agreed that going forward, ADNs would talk to their risks on the Risk Register.

Risk 1246 – Point of Care Testing – It was noted that there was assurance around staff training and quality tests on the machines already in the Trust but assurance around ongoing compliance with testing was still needed. It was agreed to leave the score at 16.

4.3 – CQC Progress Report – April 2018 (verbal)

Lynette Wells presented a verbal update noting that the report was embargoed. It was noted that previous scores be carried forward for areas not inspected. The plan was to publish the report in early June and the Trust had asked for a Quality Summit.

Safety and Quality

5.1 – Governance Quality Report

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

- Falls roll out plan had been agreed with the Divisions.
- Amber report completion had been a challenge but Divisions were working hard to resolve.
- Diagnostics SIs – a review of 13 had revealed no themes or trends.
- FFT – A & E was still a concern and the new Allocate system implementation was likely to affect the data negatively for May.
- Closing the Loop from Never Events – of 24 actions 16 had full assurance of actions embedded.

It was agreed that a report of the last six months' worth of Serious Incidents/learning should be presented to each meeting of the Quality & Safety Committee.

Action – Ashley Parrott to add a report outlining the previous six months' worth of Serious Incidents and resulting learning to the Governance Quality Report for each meeting.

There followed a discussion about assurance reporting from sub-groups of the Patient Safety and Quality Group. It was agreed that the Quality and Safety Committee should have high level assurance/escalation and that sub-group reports should continue to be presented to the Patient Safety and Quality Group.

It was **agreed** that Ashley Parrott would include escalation issues and actions being taken in the Governance Quality Report and only Annual Reports for the sub-groups of the Patient Safety and Quality Group would be presented to the Quality and Safety Committee and Trust Board.

Lynette Wells noted that an Annual Review of Effectiveness of the Quality and Safety Committee had been submitted to the last Trust Board meeting.

Catherine Ashton and Jonathan Reid left the meeting.

There was a discussion about slips, trips and falls and it was agreed that Ashley Parrott would review times of day and potential handover issues and include in the Governance Quality Report for the next meeting. Jackie Churchward-Cardiff commended the reduction in falls on Egerton Ward following the introduction of the new falls risk assessment.

Action - Snapshot Grade 2 Pressure Ulcer Audit to be presented as a Deep Dive at the next meeting.

It was agreed that the incidents of incorrect administration of drugs should be reviewed.

Action – Simon Badcott to present to the next meeting a Deep Dive into the incidents of incorrect administration of drugs.

Sharon Gardner-Blatch joined the meeting.

5.2 – Quality Account/Improvement Priorities – Chairs Action

Chairs action on Quality Account/Improvement priorities reported and noted.

5.3 – Quarterly Safeguarding Report

Sharon Gardner-Blatch presented the report noting the following 3 key points:

- Reviewed safeguarding governance
- Variation in training being addressed and level 3 adult safeguarding training being developed for go live during 2018/19
- Improvement to tracking of the implementation and embedding of learning

There was a discussion about the proportionate release of information during safeguarding investigations as this had been raised at a recent Caldicott Guardian conference. It was noted that the minimum information necessary was provided to Adult Social Care colleagues but noted that this had not, to date, been audited but was being added to the workplan for 2018/19.

Action – Sharon Gardner-Blatch to ask the Safeguarding Team to conduct an audit on the release of information during safeguarding investigations for review, and to update David Walker (Caldicott Guardian).

5.4 – Quarterly Infection Prevention and Control Report

Vikki Carruth presented the update noting the following:

- Pressure on the team due to gaps – the 4th microbiologist role was again out to advert.
- Lisa Redmond had been substantively appointed to the Head of Infection Prevention and Control role.

The year-end position had been positive for CDI and MRSA. The flu season had been difficult but it had been managed well with teams working hard to keep staff and patients safe.

Hand hygiene had shown a good from 87% to 99%.

It was noted that even with building works underway the ED had scored 100% for cleaning and Sue Bernhauser reported great enthusiasm shown by staff during a night walk at the Conquest site.

5.5 – Children and Young People's Survey

Sarah Blanchard-Stow presented the report noting that the needs of teenagers had not,

hitherto, been met. This had been added to the Trust Quality Improvement Programme.

5.6 – PLACE – Dementia and Catering – Action Plan Update (Verbal)

Hazel Tonge presented a verbal update noting that there was no update to the previous year's action plan as the team were now focusing on the more recent PLACE inspection had taken place in April and May 2018. The report was embargoed until September 2018 when an executive summary would be presented. Actions not completed from the last inspection would be rolled into the new action plan.

5.7 – Staff Survey – including staff concerns relating to raising clinical concerns

Jeanette Williams presented the report which, due to time constraints, had not been considered at the last meeting but had been presented to Trust Board subsequently.

It was noted that further work with the divisions and staff groups was needed to understand how feedback after an error or a near miss could be improved, and further understanding was needed as to why some staff would not feel secure raising concerns about unsafe clinical issues. There was a discussion about the reasons for this.

There was a suggestion that this information be triangulated with the CQC Report, once available, to see if the picture had changed in the intervening months.

Vikki Carruth reported that a member of the public had raised concerns in the margins of the last Trust Board meeting around the radiology and the staff survey. It was noted that the Trust leads were aware of the issues and support was being provided.

5.8 – Radiology Update

Justin Harris provided a verbal update noting the following key points:

- 2012/13 over 800 CT reports that could not be found on the old or new PACS (Picture Archiving and Communication System) due to a communication issue between the systems. 90% of the missing reports had been found on Sunquest ICE, reviewed and cleared. Caveats had been added to reports to advise that they could be found on Sunquest ICE.

- 75% of 2012 reports and all of 2013 had been reviewed and no issues found. The focus was now on duplicate requests on PACS. 650 A & E unreported films had been reviewed and cleared by InHealth.

- The main concern now was the 30,000 to 40,000 films for 2014 which had not been signed off due to an agreement at the time. The aim was to clear everything outside 2014 and to agree what to do going forward.

- Dedicated session was planned to look at what was left from the database.
- Ultimate aim was to get 10 reporting radiographers into the Trust (possibly by training up ESHT staff) to support the consultants in this work.

- KPIs would be set up to trigger outsourcing where needed so that reporting, going

forward, was done in a timely way. A fortnightly check would be kept on the figures to make sure issues of non-reporting did not arise.

Action – Verbal update to the next meeting to confirm that all radiology reports have been reviewed back to 2013 (4.75 years instead of 5 years).

It was acknowledged that this had been a very difficult task and the Committee commended Justin Harris and the team for the efforts to resolve. It was now important to ensure that this did not arise again. There had been one CT issue identified so far from 15 to 20 non-reported CTs. The patient involved had a very slow growing adenocarcinoma. This would be put on Datix and a Serious Incident investigation was being raised.

It was noted that the Executive Directors would risk assess and make a decision around whether to stop looking further back. Multiple reports from 2012/13 had disappeared and appeared to relate to data lost for some patients.

Action – Ashley Parrott to help Justin Harris review/write the risk relating to inpatient and Out Patient Department plain films that have not been reviewed by radiology staff.

5.9 – Non-Executive Director Quality Walks

Sue Bernhauser reported that the Non-Executive Directors had tried to revisit areas following Quality Walks to see whether improvements had been made and to try to improve the feedback 'loop'.

6.0 - Deep Dive – Opthalmology

Sharon Ball presented a verbal update noting that while things had moved on since January 2018 there was work still to do. The following key highlights were reported:
- A Deep Dive had taken place in February 2018
- Get It Right the First Time (GIRFT) session in March had resulted in an action plan

There was a long term strategy to write a business case for moving from 3 sites to 2 and this would be presented to the DAS IPR in August 2018. This would inform what staffing levels were needed.

There was a discussion about the increase in the follow up backlog. The '18 weeks' company had been engaged to assist from December 2017 to March 2018 – 2300 patients had been processed – half of which were new patients and half of which were follow up patients. The wait was now down to 14 weeks.

Follow up appointments remained a concern with around 1200 at EDGH. The team had considered re-engaging the '18 weeks' company but it was agreed that the following should help to address the backlog:

- weekend working;
- additional weekday clinics;
- increased virtual clinics – the Trust was working on this with ESBT;
- and an increase in non-medical practitioners and optometrists;
- reductions in DNAs.

An action plan was in place and it was hoped that the service would meet Referral to Treatment Time targets in April 2018.

It was noted that recruitment efforts continued with panels in June, October and November.

Action – Ophthalmology Action Plan (with dates) to be shared with members of the Committee

7.0 – Papers for noting

8.0 – Deep Dive for next meeting

Medicines Administration Incidents.

Pressure Ulcers – Snapshot Audit of Category 2.

9.0 – AOB

Next meeting 18 July 2018 – St Mary's Boardroom.

Use of Trust Seal

Meeting information:			
Date of Meeting:	7th August 2018	Agenda Item:	15
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?	

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.

28th June 2018 – Three year agreement between East Sussex Healthcare NHS Trust and HC-One for the provision of non-weight bearing beds.

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.

East Sussex Healthcare NHS
NHS Trust

MEDICAL REVALIDATION ANNUAL REPORT 2017-2018

1. Executive Summary

This report provides information about the medical appraisal and revalidation system and processes over the year 2017-2018, highlighting key issues and actions being taken to respond to them.

On 31st March 2018 there were 384 doctors in the Trust claiming a prescribed connection to the Responsible Officer, the Medical Director. The Trust has, for the fifth year running, achieved a very high medical appraisal compliance status; in 2017-2018, 100% of all Trust doctors, who were expected to have their medical appraisal within the required timescales, have done so. Of the 384 doctors with a prescribed connection at 31/3/18, 75 were not due to undertake an appraisal at ESHT until 2018-19 as they had either undertaken an appraisal before joining ESHT OR have an authorised deferral until the next year's appraisal cycle as they have been in the Trust for less than six months or have been on long-term sickness/maternity leave.

It should be noted that, because doctors join and leave during the year, the actual number of appraisals undertaken by our appraisers differs from the revalidation data relating to the 384 doctors discussed in this report and totals 344, including doctors who work for the local hospices. Some doctors have joined the Trust as Locum Appointed for Service (LAS) or engaged via the Trust Bank, of whom some have not required an appraisal within the Trust during this reporting period as they will have had their annual appraisal elsewhere or are not yet due to have an appraisal.

ESHT's Responsible Officer offers all doctors who are employed at either St.Wilfrid's Hospice or St.Michael's Hospice a prescribed connection to ESHT as a Designated Body in support of their revalidation and appraisal. A formal Service Level Agreement is in place. Both hospices have achieved 100% compliance for the year 2017 – 2018 and a Higher Level Responsible Officer Quality Review (HLROQR) visit was made on 31st January 2018. For the purpose of this report, however, the data refers exclusively to the medical staff in ESHT.

2. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that the Trust Board of ESHT will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can

[1] 'The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

inform the appraisal and revalidation process for their doctors; and

- ensuring that appropriate pre-employment background checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

3. Trust values

Every medical appraiser is expected to abide by a professional code of conduct which is explicitly included within the medical revalidation policy. This code of conduct reinforces the Trust's set of values and behaviours of: respect & compassion; engagement & involvement; improvement & development; and working together.

Every doctor being appraised is also invited to provide feedback on their appraisal and the Trust values can be evaluated as part of this process. Doctors are provided with an annual appraisal governance report, which includes information on any complaints or incidents in which they may have been involved, and this helps them to reflect on their behaviours and learning from these.

At least once per revalidation cycle doctors are required to undergo colleague and patient feedback which reports, for example, how effectively they work with colleagues, how polite they are to patients and colleagues and how they have involved patients in decisions about their treatment. Each doctor is also expected to provide information on how they learn from this feedback to improve and enhance their clinical practice. Another facet of the medical appraisal is the requirement to demonstrate involvement in quality improvement initiatives to promote the quality of patient care.

4. Governance and Quality Assurance

NHS England provides a Framework of Quality Assurance for Responsible Officers (FQA) and this has been published by the Department of Health. The framework details the combined approaches to achieving quality assurance so that the Responsible Officer has confidence that the doctors working in ESHT are up to date and fit to practise. It comprises of the following elements:

Monthly and Quarterly information:

There is a quarterly report sent from the ESHT Responsible Officer to the 2nd Tier (higher level) Responsible Officer, to whom they are linked, which informs NHS England of ESHT's appraisal compliance data. A monthly performance report/dashboard with narrative is also provided by the revalidation team to the Trust Board so that assurance is given that the medical appraisal compliance status is steadily increasing during the year.

NHS England has advised us that the quarterly reporting mechanisms may be amended in the forthcoming year.

Annual Organisational Audit (AOA):

The AOA is a mandatory audit that all Responsible Officers are required to complete. This is a standardised return to the higher level Responsible Officer and ultimately to Ministers and the public on the status of the implementation of revalidation across England. This information forms the benchmark across the NHS region. ESHT has consistently improved its medical appraisal rates, achieving the highest compliance in the region for an acute hospital trust over the previous four years.

In the 2017–2018 Annual Organisational Audit (AOA), submitted in April 2018, it is reported that 384 doctors held a prescribed connection to the Responsible Officer in ESHT at 31st March 2018, of whom 318 had completed the entire medical appraisal process within the last year and a further 60 of the doctors to be appraised were new starters in the Trust and received authorisation to defer their appraisals to the 2018-19 cycle. The

remaining 6 doctors had received authorised deferrals to the following year (i.e. 2018–2019) as they had mitigating circumstances.

There are no doctors, with a prescribed connection to the Responsible Officer in the Trust, who should have had their appraisal and did not, or deferred their appraisal, without formal authorisation in 2017 – 2018. This means that 100% of all Trust doctors with a prescribed connection to the Trust's Responsible Officer are compliant with the Trust's Medical Revalidation Policy.

Trust Board Annual Report:

Trust Boards are responsible for monitoring the organisation's progress in implementing the Responsible Officer regulations. The Trust Board annual report is one method of informing the Board of the achievements, challenges and compliance status in ESHT with regard to medical appraisals and medical revalidation

Statement of Compliance:

The Responsible Officer Regulations include the requirement of Designated Bodies such as ESHT to provide adequate support to the Responsible Officer. The Chair of the Trust Board or the Chief Executive is asked to sign a statement of the organisation's compliance with the RO Regulations. This is submitted to the higher level Responsible Officer. The statement of compliance accompanies this Trust Board annual report for signed approval and submission to the Secretary of State for Health.

Independent Verification:

All Designated Bodies undergo a process to validate their systems and processes at least once in each five year revalidation cycle. The last independent verification visit to ESHT was held in December 2014 and was reported upon in the Trust Board Annual Report 2015 – 2016. These visits are now called 'Higher Level Responsible Officer Quality Reviews (HLROQR).

A HLROQR visit was made to both the local hospices, St Wilfrid's Hospice and St Michael's Hospice on 31 January 2018. The Trust has a Service Level Agreement with both the hospices to provide the services of a Responsible Officer for medical appraisals and revalidation recommendations. The outcome of the visit was very positive and several areas of good practice were identified. These included:

a. the ESHT Medical Revalidation Advisory Panel which provides oversight on the implementation of the RO regulations for all three designated bodies. It includes lay representation and is supported by the Appraisal Lead and revalidation team.

b. the Hospice Medical Directors and senior management teams have good working relationships with the ESHT revalidation team and feel they can contact them for support and advice.

c. lunchtime sessions on appraisal and revalidation in ESHT are open to all doctors including those from the hospices; these are well attended by doctors new to the organisations.

d. the ESHT policy section on data security assesses the specific risks around appraisal and set out sensible guidelines for appraisers and clinicians to abide by.

e. The template for Performance and Development Review for hospice clinicians was shared and was viewed as concise and relevant. The use of this by the Hospice Medical Director with doctors is timed to feed into the medical appraisal discussion of personal development plans and quality improvement and so the relationship between the two is both formalised and clear.

Actions were also identified as an outcome of the HLROQR visit and an action plan was developed in response to this by all three designated bodies. All actions are either in the final stages of being completed or are now completed. The key action for ESHT included making some minor revisions to the ESHT Medical Revalidation & Appraisal Policy such as making a change to the sections on prescribed connection and conflict of interest. This revised policy is in the process of ratification.

Consistency of the quality of medical appraisals

The quality and consistency of appraisal is supported by regular medical appraiser training which is mandated at least twice per year and contributes to the medical appraiser's own Professional Development Plan. Medical appraisers are encouraged to undertake professional calibration of their medical appraisal judgements during this training.

ESHT has a process of undertaking regular quality assurance checks for the first three appraisal outputs of new appraisers with constructive feedback provided. Regular quality assurance audits of medical appraisal outputs are undertaken using a template provided by NHS England called the Appraisal Summary and Personal Development Plan Audit Tool (ASPAT). Feedback is then provided to the individual medical appraiser and further training and support provided if the need is identified.

All medical appraisals are anonymously evaluated by the doctors being appraised after their appraisal; reports on the evaluations for each medical appraiser are provided to them on an annual basis.

5. The 'Pearson' report

4.1 Pearson Report recommendations for acute Trusts

In January 2017 and at the GMC's request, 'Taking Revalidation Forward: improving the process of relicensing for doctors', a report by Sir Keith Pearson, was published. The report reviewed the progress of medical revalidation over the first five years of revalidation and made some recommendations.

a) These recommendations were included within last year's annual report for 2016 – 2017 and identified actions that have either since been addressed or where progress is being made. One of two areas to bring to the Trust Board's attention is the recommendation: Work with patient groups to publicise and promote processes for ensuring that doctors are up to date and fit to practise.

It is with great sadness and regret that we report that our Trust has lost its highly valued lay representative for medical revalidation, Janet Colvert, as she passed away earlier this year. Her valuable and constructive contributions to the quality assurance of medical appraisals, and the recruitment and training of medical appraisers, was very much appreciated. Janet will be very sadly missed.

We have been fortunate in gaining a new lay representative, the Chair of the Board of Trustees, who further strengthens the bond between the Trust and St Wilfrid's Hospice and who joins the Medical Revalidation Advisory Panel in May 2018. An integral element of this role will be to work with the Trust to progress the work on promoting medical revalidation and appraisals to the public.

b) Strengthening assurance around locum doctors

The second area to bring to the attention of the Trust Board refers to sections 213 – 222 of the Pearson report; it suggests that locum doctors are generally perceived to be a greater risk to patient safety and the reputation of an organisation for a variety of reasons, many of which are often systemic rather than related to the individual practitioner. One key reason

for this risk is the difficulty experienced by ROs in accessing all the information they need when they are required to provide a prescribed connection.

In ESHT we mainly divide locum doctors into two types: a) those engaged via an agency (with whom there is a contract framework that stipulates the requirement of the agency's provision of an RO and support for appraisal and revalidation) and b) those whom are directly engaged via our bank as a temporary workforce doctor on a non-substantive contract. In ESHT, our dilemma has been how to support the potentially many bank doctors who belong to the latter group and whom we might only employ for days or weeks but who could legitimately claim a prescribed connection to our RO.

NHS England has advised all Trusts that a prescribed connection is not the choice of the RO or the individual doctor but it is enshrined in The Medical Profession (Responsible Officers) Regulations 2010 and The Medical Profession (Responsible Officers) (Amendment) Regulations 2013.

NHS England has also reiterated that certain information should be obtained before a doctor begins working in an organisation in addition to the RO Transfer of Information form content that follows post-employment. The pre-employment check now adopted includes details of the locum doctor's previous appraisal summaries and outputs; revalidation history i.e. any deferrals, non-engagement recommendations, periods with no prescribed connection to a Responsible Officer; and a declaration that there have been no concerns raised about their practice which would lead to a probity investigation if later found to be incorrect.

This new formal revalidation employment check form has been introduced this year by the revalidation and recruitment teams who have worked closely together on this. This means that doctors now are obliged to provide information about their appraisal and revalidation status when they join the Trust. This is beneficial as it means that the doctor gains appraisal and revalidation support more quickly and this contributes to patient safety.

5. Policy and Guidance

The current Medical Revalidation & Medical Appraisal Policy has been revised to reflect all recent changes. The policy is waiting formal ratification.

6. Medical Revalidation and Medical Appraisals

6.1 Appraisal and Revalidation Performance Data

The GMC provides web based access to ESHT revalidation data via GMC Connect. The revalidation status of all doctors who claim a prescribed connection to the Responsible Officer and ESHT as their Designated Body features on this site. The list of doctors with a prescribed connection is cross checked each month against a list provided by the Medical Recruitment team and when doctors leave or join the Trust.

ESHT uses Datixweb to provide information in the form of an Appraisal Governance Report which includes anonymised information on incidents and complaints for each doctor. The revalidation team automatically sends a confidential report to the doctor being appraised around two weeks ahead of their appraisal which can be included within their appraisal as part of the reflective discussion. In excess of 370 Appraisal Governance Reports were generated in the year 2017-These reports are also generated immediately prior to the

medical revalidation recommendation to the GMC so that the Responsible Officer is able to make an informed recommendation of the doctor's fitness to practise.

Doctors being appraised are additionally provided, where relevant, with their mortality data over the previous year prior to the appraisal.

Additionally, there is a robust process in place for the provision of multisource feedback from patients and colleagues, with doctors being offered this feedback report at least twice per revalidation cycle and on request if it is indicated as part of a Professional Development Plan by a line manager or medical appraiser.

6.2 Revalidation Recommendations in ESHT between 1 April 2017 – 31 March 2018

Table 1. Revalidation Recommendations in ESHT 1 April 2017 – 31 March 2018

Positive recommendations	14
Non engagement notifications	0
Recommendations completed on time	19
Recommendations completed not on time	1*
Deferrals requests	6
Reasons for all missed or late recommendations *The GMC contacted ESHT to advise of a doctor recommendation date on the day of the recommendation deadline. It was the doctor's responsibility to change their prescribed connection from their previous RO before their revalidation recommendation date but did not do so. On the GMC's advice, our RO made a deferral recommendation the following day.	

The Responsible Officer is proud to report that ESHT has never missed any of the deadlines for recommendation for revalidation.

Table 2. Reasons for medical revalidation deferrals 1 April 2017 – 31 March 2018

Reason for a deferral recommendation	**Number of doctors**
Time allowed for completion of a '360' multi-source feedback report	1
New starters - to provide them with sufficient time to have their appraisals and to prepare supporting information for their medical revalidation recommendation	5

Medical Appraisals

Table 3. Medical Appraisals in ESHT between 1 April 2017 – 31 March 2018

Mar-18	Total	Green	%	Amber	%	Red	%
Consultants	218	218	100.0%	0	0.0%	0	0.0%
SAS/Trust Grade	85	85	100.0%	0	0.0%	0	0.0%
LAS	66	66	100.0%	0	0.0%	0	0.0%
Bank	15	15	100.0%	0	0.0%	0	0.0%
Totals	384	384	100.0%	0	0.0%	0	0.0%

KEY:

Total (n) Doctor Appraisal status	Total (%) Doctor Appraisal status	
384	100.0%	Doctors who HAVE forwarded evidence of an appraisal since April this year OR have an authorised deferral until the next year's appraisal cycle as they have either been in the Trust for less than six months OR have been on long-term sickness/maternity leave
0	0.0%	Doctors who have NOT had an appraisal since 1st April this appraisal year but are expected to have an appraisal before the end of the appraisal cycle in March if still with the Trust at that date
0	0.0%	Doctors who do NOT have an authorised postponement and have missed their appraisal
384	**100%**	

On 31st March 2018 there were 384 in the Trust claiming a prescribed connection to the Responsible Officer, the Medical Director.

The Trust can again report an excellent medical appraisal compliance status for 2017 – 2018 with 100% (384) of all doctors with a prescribed connection abiding by the Trust's medical appraisal compliance criteria.

6.4 Methods of reporting appraisal compliance

There are two methods of reporting appraisal compliance and these are outlined below.

6.4.1 NHS England/GMC method of reporting:

The method of reporting medical appraisal compliance is prescribed by NHS England/GMC as follows:

1a is a completed annual medical appraisal whereby the appraisal meeting has taken place within the three months preceding the appraisal due date, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March.

1b is a completed annual medical appraisal whereby the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply:

- a period of time of greater than 12 months from the last appraisal has elapsed;
- the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting.
- The entire process did not occur between 1st April and 31 March

However, in the judgement of the Responsible Officer, the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.

Where the organisational systems of the designated body do not permit the parameters of a '*Category 1a* completed annual medical appraisal' to be confirmed with confidence, the appraisal should be counted as a '*Category 1b'.* For example, new starters in the Trust have been confirmed by NHS England as belonging to Category 1b.

6.4.2 ESHT method of reporting:

In ESHT, the medical appraisal cycle runs from April to December each year. If it is agreed by the Responsible Officer that, due to exceptional circumstances, an appraisal may take place between January and March, an additional appraisal must be undertaken by the end of December in the same year. Every doctor should have an appraisal in the anniversary month, or before, of their previous appraisal. Doctors who conform to this and/or have their appraisal within 365 days of their last appraisal are reported as being compliant.

ESHT's medical revalidation team contacts all doctors joining the Trust and provides them with supporting information including the expected month of appraisal; this is particularly significant in situations where their previous appraisal took place between January and March or if they have not had an appraisal within the twelve months before joining ESHT. Training sessions are conducted at regular intervals to support doctors in developing their understanding of the expectations placed upon them for medical appraisals and medical revalidation. Help and support is also offered by the revalidation team on an ad hoc basis.

The objectives of the training sessions are for doctors to understand: the purpose of appraisal and revalidation and how the process works at ESHT; how to complete the Medical Appraisal Guide (MAG) form; the supporting information they need to gather; and the importance of reflecting upon their supporting information and their practice. This enables their experienced appraiser to help them develop a personal development plan for the following year.

If doctors have had a medical appraisal within the last 12 months, and it was not conducted between January and March, the doctor will be expected to inform the Revalidation team, who will then make every effort to provide a medical appraisal no later than their annual appraisal anniversary month. Therefore, doctors are currently reported as being compliant until they have been in the Trust for six months. After this time, if the doctor has not had an appraisal, they are reported as being non-compliant.

6.5 Appraisals completed between 1 April 2017 and 31 March 2018 by Division & Specialty

Table 4. Appraisals completed between 1 April 2017 and 31 March 2018 by Division & Specialty

Division	Total Number of doctors (excluding hospice)	Number of completed appraisals (excluding hospice)	Number of doctors who missed their 2017-18 appraisal	Number of doctors with an authorised deferred appraisal	Number of new starters not due an appraisal until next cycle*(excluding hospice)
Diagnostics, Anaesthetics & Surgery	187	169	0	3	15
Medicine	101	74	0	0	27
Urgent Care	37	25	0	2	10
Women & Children	59	50	0	1	8
Totals	384	318	0	6	60

6.6 Audit of appraisals undertaken outside the 12 month appraisal annniversary

It is felt that one of the contributing factors in the high medical appraisal compliance status in ESHT is that doctors are reminded of their annual appraisal on at least two occasions. However, some doctors do miss their appraisals and an audit is conducted for all missed appraisals, whether approved or otherwise, and the reasons for these are provided here in Table 5.

A 'postponed' appraisal is defined as one that does not take place within the anniversary month but is authorised by the RO to take place in a later month and it does take place within the same Trust/GMC appraisal year.

A 'deferred' appraisal is defined as one that does not take place within the Trust/GMC appraisal year but it is authorised by the RO.

A 'missed' appraisal is defined as one that has not taken place within twelve months from the date of the last appraisal or one where the appraisal outputs are not signed off within 28 days from the date of the appraisal and has not been approved by the Responsible Officer.

Table 5. Reasons for postponed, deferred or missed appraisals 1st April 2017 – 31th March 2018

Doctor factors (total)	**Number**
Maternity leave during the majority of the 'appraisal due window' (authorised)	2
Sickness absence during the majority of the 'appraisal due window' (authorised)	12
New starter not due to have appraisal in current year but due within six months of joining (authorised)	67
Postponed due to incomplete portfolio/insufficient supporting information (authorised)	5
Lack of time of doctor	6
Lack of engagement of doctor (Unauthorised) • Both doctors subsequently completed their appraisal	2
Compassionate	6
Other doctor factors (describe) • An appraisal was due shortly for each of four doctors joined the Trust. Postponements were authorised to allow them time to gather relevant supporting information	4
Appraiser factors	
Unplanned absence of appraiser	2
Lack of time of appraiser	3
Organisational factors	
Other organisational factors An appraisal had to be halted due to emergency bleep calling the doctor to treat a patient	1
Difficulty in arranging a mutually convenient time due to opposing timetable/clinical commitments/annual leave	16

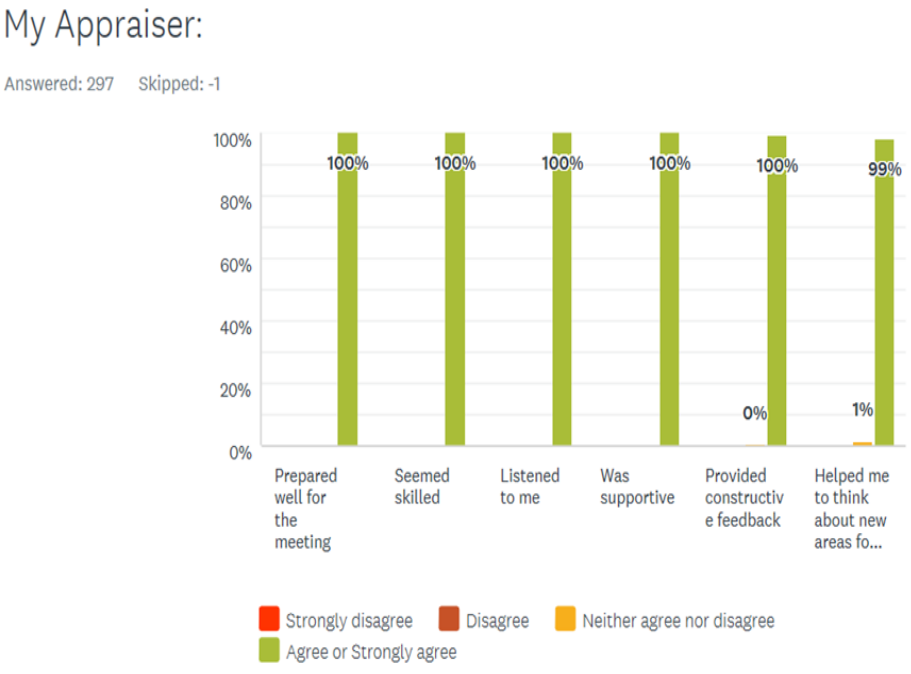
6.7 Medical Appraisers

NHS England requires that the Responsible Officer ensures that the Designated Body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection. Doctors from a variety of backgrounds should be considered for the role of appraiser. This includes associate specialist doctors in secondary care settings. An appropriate specialty mix is important and it is not actively encouraged for doctors to have an appraiser from the same specialty. The recommendation for the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. ESHT attempts to have approximately 40 trained medical appraisers available each year so that each appraiser has an average of 8 – 10 appraisals to conduct in that time scale. This offers a ratio of approximately 1:9 appraisers to doctors in ESHT, taking into account locum doctors and doctors who leave and join the organisation each year.

ESHT currently has 36 appointed medical appraisers. Recruitment of new appraisers has taken place in early 2018 and we expect to have sufficient appraisers to be able to manage the increased number of expected appraisals that will take place during 2018 – 2019.

Two training sessions were conducted during the medical appraisal year 2017 – 2018. The update sessions provide an opportunity to discuss any challenges that are posed by being a medical appraiser and these are addressed in an open forum when possible so that all appraisers can share their experiences and work together. The revalidation team offers advice and support to medical appraisers and both the team and medical appraisers receive very positive feedback.

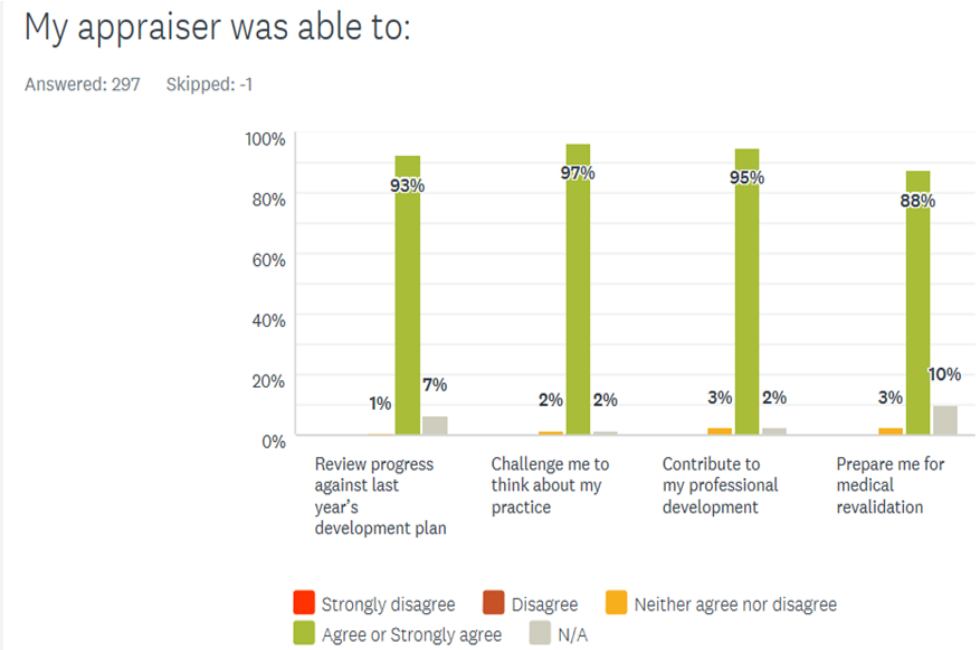
Table 6. Feedback on medical appraiser performance by 297 ESHT doctors 2017-18



"It was evident my appraiser had prepared well for our meeting & had reviewed my MAG form and evidence. He was extremely supportive & thorough and skilled at providing feedback."

"This was my first appraisal and my appraiser was extremely patient in addressing my concerns. He was very supportive and highlighted my strong and weak points and helps me to identify my areas needing scope for improvement. He was very approachable, frank and helpful throughout the appraisal meeting."

Table 7. Feedback on medical appraiser performance by 297 ESHT doctors 2017-18

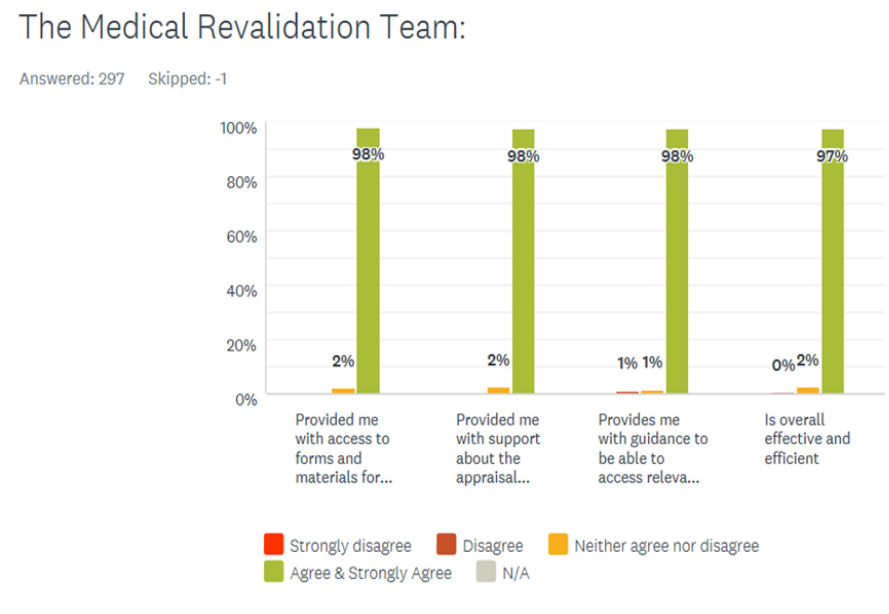


Medical appraisers receive regular training on their appraisal skills but also of any GMC updates and ESHT processes. This leads appraisers to become excellent sources of knowledge and champions for medical appraisals, one of the many reasons that the appraisal compliance in ESHT is so high, particularly compared with other Trusts. Our medical appraisers are highly valued.

"Helped me to work towards achievable goals for my next appraisal I would highly recommend my appraiser for others & would like to thank the revalidation team for this opportunity."

"My appraiser was very supportive, knowledgeable and well prepared. He went through all aspects of my appraisal carefully and kindly and advised to make necessary changes. He gave me more ideas and advised for my career progression and on the minor incidents I was involved with. I felt relaxed and very well supported during the process."

Table 8. Feedback on medical revalidation team performance by doctors



"Well supported. Following my 2016-17 appraisal, personal family events significantly delayed my completion of the appraisal process. Revalidation team supportive and constructive in giving advice to manage return to appraisal process"

"We all are better thanks to the great leadership and organisation within the team. Working in a busy department it is imperative that the revalidation team takes care of reminders and important notifications in such an effective way."

9.0 Challenges

Increased revalidation recommendation trajectory

Although medical revalidation takes place over a five year cycle, revalidation was initially implemented by the GMC in 2012 in a phased approach over a three year period. In the first year of implementation (2012 – 2013), 20% of all doctors were put forward for a revalidation recommendation, followed by 40% for each of the following two years (2013 – 2015).

The revalidation process does not just focus on appraisal and revalidation compliance but also on the quality of medical appraisals; ESHT strives for continuous improvement and excellence which additionally increases the workload of our Responsible Officer, the Medical Revalidation Advisory Panel, the Appraisal Lead, our medical appraisers and the revalidation team.

This means that the medical revalidation workload will increase exponentially over the next few years as the full five year revalidation cycle is completed again. Each revalidation recommendation is now accompanied by the need to review all five years' supporting evidence and the number of doctors in the Trust with a prescribed connection has recently increased. The higher number of locum doctors and doctors engaged via the Trust bank also means that greater support from the revalidation team is needed; these doctors are frequently unfamiliar with either or both the Trust appraisal and revalidation process or revalidation in general. This represents a risk to the Trust unless these doctors are adequately supported.

This increase in the number of revalidation recommendations has been addressed by the restructure of the revalidation team so that the team can provide sufficient support to the Responsible Officer and our medical colleagues alongside focusing on recruiting, retaining, training, quality assuring and supporting our medical appraisers.

Table 9. Current trajectory for revalidation recommendations until 2023

Month	Year					
Row Labels	**18/2019**	**19/2020**	**20/2021**	**21/2022**	**22/2023**	**Grand Total**
Apr	3	9	5	2	3	22
May	7	12	17	3	2	41
Jun	2	2	11	3	5	23
Jul	12	16	3	6	13	50
Aug	1	2	19	10	8	40
Sep	1	13	15	2	2	33
Oct	11	14	11	1	2	39
Nov	6	4	12	6	6	34
Dec	14	8	9	4	4	39
Jan	12	9	11	2	4	38
Feb	6	2	3	1	2	14
Mar	14	10	2	4	3	33
Grand Total	**89**	**101**	**118**	**44**	**54**	**406**

10.0 Recommendations

1. The Trust Board is asked to approve this annual report, noting it will be shared, along with the annual organisational audit, with the higher level Responsible Officer at NHS England.
2. The Trust Board is also asked to approve the 'statement of compliance' confirming that the organisation, as a designated body, is compliant with the regulations. The CEO and/or Chair of the Trust Board are asked to sign the statement.

Dr David Walker
Medical Director & Responsible Officer 16.5.18

East Sussex Healthcare NHS
NHS Trust

NURSING & MIDWIFERY REVALIDATION ANNUAL REPORT 2017 - 2018

1. Executive summary

1.1 This is the third annual report for Nursing and Midwifery revalidation in ESHT. Revalidation was fully launched by the NMC in April 2016, and this report details the progress made so far in the first of the three year revalidation cycle.

1.2 This report additionally provides information about the number of nurses in the Trust and the number of completed revalidation submissions within the year 1st April 2017 and 31st March 2018. It also highlights challenges experienced by the organisation and our responses to them. For ease of reading, the report will mainly refer to nurses but the report also includes midwives within this category.

2. Background to revalidation

2.1 Nursing & Midwifery Revalidation was launched by the Nursing & Midwifery Council (NMC) on 1st April 2016 following the publication on 29 January 2015 of The Code which contains the professional standards that registered nurses and midwives must uphold. Although they do not align exactly, the Trust values also feed into the process of adhering to the Code.

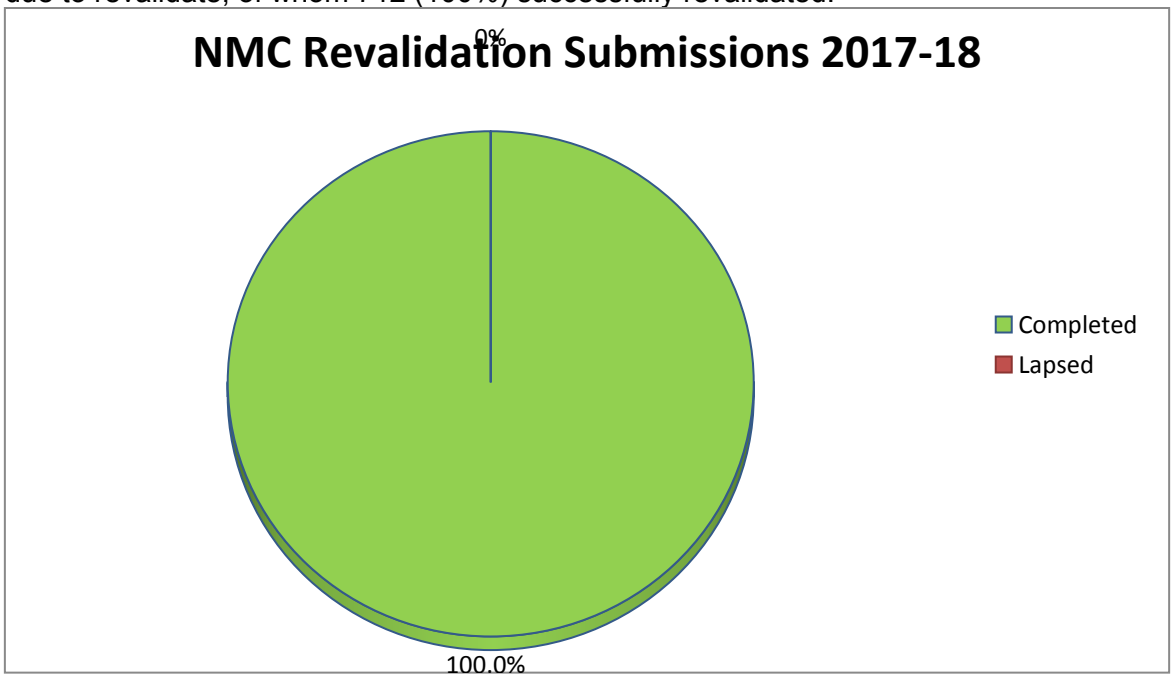
2.2. Nursing revalidation is the process that allows a nurse and/or midwife to maintain their registration with the NMC by building upon existing renewal requirements. Nurses and midwives must demonstrate their continued ability to practise safely and effectively. Revalidation is a continuous process that all nurses and midwives need to engage with throughout the year and they must meet certain requirements in order to complete their revalidation and renewal of registration every three years with the NMC.

2.3 All nurses and midwives must develop a portfolio that provides supporting information such as: a record of sufficient practice hours; continuing professional development; practice related feedback; written reflective accounts; evidence that a reflective discussion has taken place with another NMC registrant; and they must make declarations to the NMC in regard to health, character, and professional indemnity arrangements. The supporting information must be confirmed by an appropriate colleague, normally a line manager, before the revalidation submission is made to the NMC.

2.4 However, it should be noted that, unlike medical revalidation, nursing and midwifery revalidation is not an assessment of a nurse or midwife's fitness to practise. It is also not a new way of raising fitness to practise concerns as there are existing governance processes and systems to monitor the conduct and performance of nurses and midwives in ESHT and disciplinary policies and procedures are in place.

2.5 The responsibility for participating in the revalidation process lies with the nurse and midwife who are obliged to revalidate to maintain their registration. Failure to revalidate by the appointed date provided by the NMC has the consequence of being removed from the Register, meaning that it is illegal to continue to work as a Registered Nurse or Registered Midwife. It also puts the nurse or midwife at risk of being suspended from their role and of Trust disciplinary action. Nurses and midwives who have genuine reasons for delaying their revalidation submission are asked to contact the NMC directly and complete an exceptional circumstances form. The NMC considers each case on its merits. However, the NMC does not provide employers with details of these applications, and it is the responsibility of the registrant to keep the employer up to date on any decisions or outcomes from these applications.

2.6 Between the 1st April 2017 and 31st March 2018, 712 ESHT nurses and midwives were due to revalidate, of whom 712 (100%) successfully revalidated.



3. Governance & Quality Assurance

3.1 The Nursing & Midwifery Council provides their own system of quality assurance by contacting one per cent at random of those who have confirmed a nurse's portfolio. The NMC does not make the Trust aware of how it assesses or benchmarks the portfolio.

The NMC has the right to request further information from the nurse about their portfolio such as their evidence of practice hours and Continuing Professional Development. In these circumstances an email is also automatically sent to the nurse's confirmer and/or reflective partner.

The additional information needs to be returned within six weeks of the NMC requesting it, and the verification process will be completed within three months of the nurse's or midwife's renewal date. The registration will not be affected during this process, and it will be renewed once the verification process has been successfully completed.

Once the revalidation application has been submitted, the reflective partner and confirmer, as entered onto the nurse's or midwives revalidation application form, will be sent an email by the NMC to verify those requirements took place.

The revalidation team is not automatically made aware of the NMC's audit. However, it is possible to make an assumption that this is being carried out as, when the team checks the monthly registrations, if the expiry date of registration has not been updated – but the nurse is still classed as registered – it is evident that there is either an audit taking place or that the nurse has made an application for exceptional circumstances to be taken into account. In 2017 – 2018, less than one per cent (n=3) of those who were required to revalidate were asked to provide additional information by the NMC.

The revalidation team quality assures the process of support provided to nurses and midwives and this is addressed in the section on feedback that follows later in this report.

4. Training & Guidance

4.1 ESHT Nursing and Midwifery Revalidation Policy

The revised ESHT Nursing and Midwifery Revalidation Policy has been ratified and now reflects the findings and processes which were further developed over the first year of revalidation. The ESHT Nursing and Midwifery Revalidation Policy links to 'ESHT Appraisal Policy' which provides a method of discussing progress towards revalidation and raising any concerns a nurse or midwife may have in completing the requirements.

4.2 Support for ESHT nurses and midwives and those engaged via the Temporary Workforce Service

There were 2073 nurses and midwives in the Trust at 31 March 2018 excluding those who were engaged via the Trust's Temporary Workforce Service (TWS) (n=104).

The revalidation team has been providing monthly revalidation sessions at both the Conquest and EDGH sites. The following sessions have been held up to 31st March 2018:

- 27 workshop and team sessions have been provided. The sessions have been attended by 112 attendees that included registrants, confirmers, East Sussex County Council managers, East Sussex Better Together and TWS members and those not working within a clinical role, but still maintaining their registration.

4.3 Workshops

Workshop sessions have been developed to provide guidance for all areas of nursing and midwifery revalidation:

The NMC Revalidation Workshops provides:

a) a general overview of revalidation and how to meet the NMC requirements.

b) advice on the role of the confirmer' which specifically targets those who are providing confirmation.

All attendees receive a workbook, which provides thorough guidance on how to make progress towards their revalidation. A follow up email is also sent after the session, providing each attendee with a recap of the session, in addition to all the documents referenced during the workshop.

4.4 Team Sessions

On request the revalidation team provides sessions to groups of nurses within their areas, during a team meeting or study day. This proves popular with Practice Educators and Matrons.

4.5 Individual Sessions

Individual 1:1 sessions are provided on request, and have supported nurses who have had exceptional circumstances to complete their revalidation submissions on time.

4.6 Reflective Writing Session delivered by the Trust's Library Service.

In partnership with the revalidation team, the library service has been providing a reflective writing session at both the Health Sciences library and Rosewell library on a monthly basis. The content of the session is to aid with the 'written reflective account' requirement of the revalidation process, and how a reflective model, such as the Gibbs' Reflective Cycle could be used to fit into the mandatory form set by the NMC. The session also encourages nurses to use the services on offer from the library and how this could support their Continuing Professional Development. In the past year 2017- 2018, 62 have benefitted from this and the library service has received extremely positive feedback about these sessions.

4.7 Resource Materials

All the sessions offered on revalidation have been developed to provide all the required information and guidance needed to approach the NMC's revalidation requirements, and to help alleviate the anxiety surrounding revalidation. During the sessions, examples are given of how to complete some of the requirements and advice provided about their scope of practice. Resource materials have been developed to assist with the sessions including presentations, guidance sheets, workbooks, and completed examples. The revalidation team has been requesting feedback from the sessions and responding to comments and suggestions, some of the feedback is detailed further on in the report. All resource materials are available on the Trust's revalidation extranet page.

4.8 Extranet site

An extranet site has been developed and is kept updated, so that nurses can view details of any training and support sessions, roadshows, workshops, library sessions (such as training on reflective writing), templates for revalidation portfolios and the most up to date guidance. Comments made via our feedback form have suggested our extranet page could be made to become more user friendly. This feedback, and suggested content, has been referred to our colleagues in the Communications team and we look forward to the development of the updated extranet site

4.9 Renewal Dates and Reminder Emails

As part of our work in supporting the confirmer and line managers, the revalidation team has been providing team-specific lists of revalidation dates. This has proved popular, and assists line managers to plan ahead, and book the confirmation meetings in advance. It also highlights when confirmations will need to be delegated to other supervising staff. This is an ongoing service, as the teams are ever evolving.

The revalidation team has been sending out reminder emails to all nurses and midwives who are due to revalidate. Where an email address is not located, correspondence has been sent to either the Matron or line manager. The reminders are sent to them approximately 10-12 weeks prior to their revalidation date.

The reminder emails provide an opportunity for the nurse or midwife to contact the revalidation team if they have any concerns about revalidation, as well advertising the revalidation team support sessions.

Recent improvements within the ESR system have meant an automated reminder email is sent to named supervisors within ESR for those registrants who are due to revalidate in the next 6 months.

4.10 Text Messaging

As part of our engagement work with TWS, the revalidation team has started to use the text messaging facility to send revalidation reminders. This has proved very useful when requesting information from members.

4.11 Feedback on the organisational support provided by the revalidation team

During our support sessions a feedback form is provided. Tables 1 and 2 show the feedback about the information and support provided by the revalidation team; 100 feedback forms were returned by nurses and midwives during 2017 – 2018.

Table 1. Feedback on information provided by the revalidation team

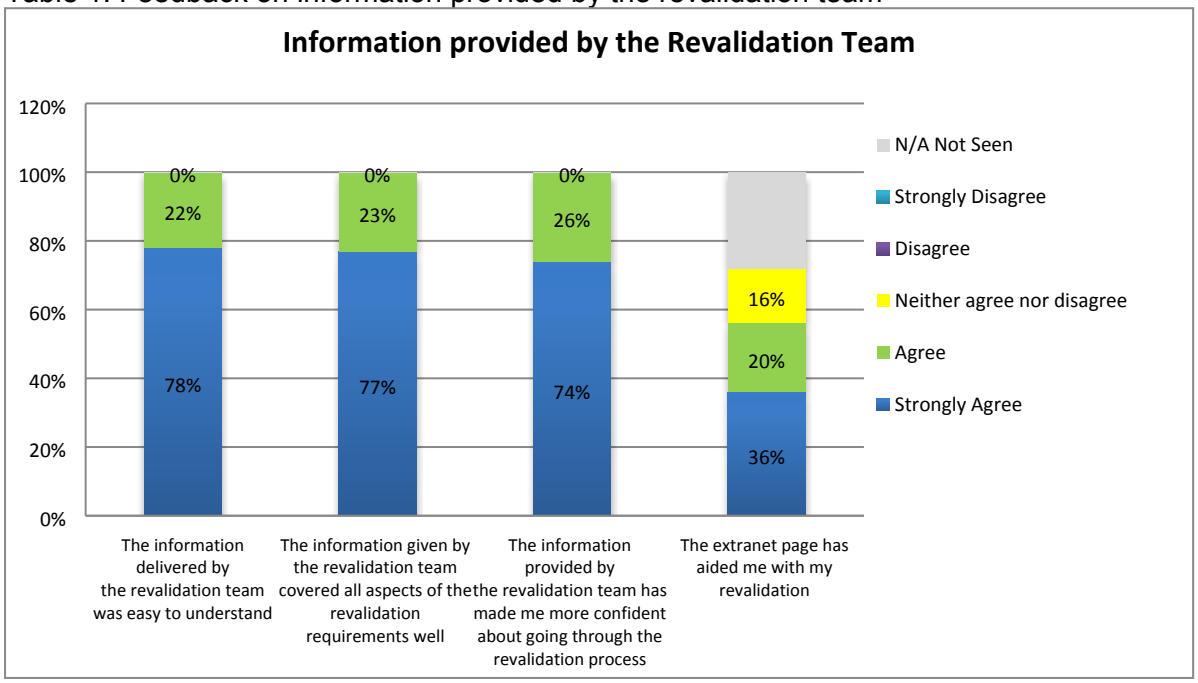
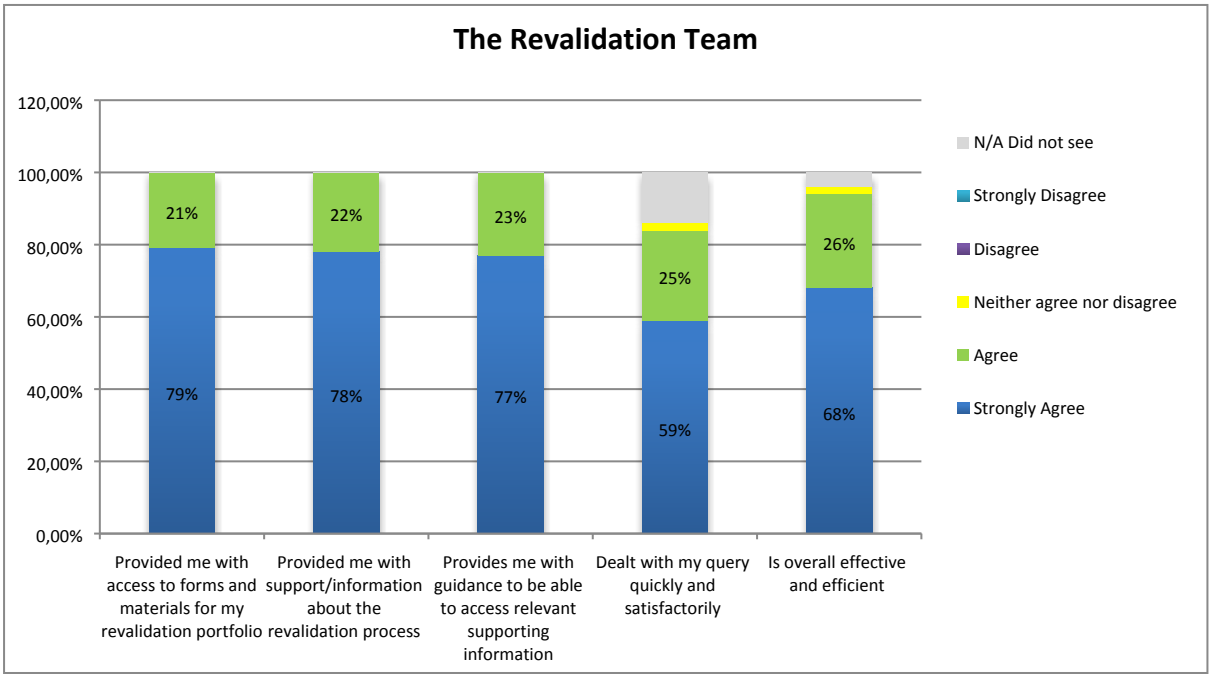


Table 2: Feedback on the support provided by the revalidation team



Comments received from attendees:

- *'A quick and useful overview of revalidation. this has been very helpful and made me feel confident'*
- *'I felt confident with the process and this session reinforced the process and gave me a link for whom to speak to if I had any issues.'*
- *'Well designed session, Information delivered with professionalism.'*
- *'The whole process, documentation & submission. it all feels much clearer now many thanks'*
- *'The revalidation workshop today helped me see that revalidation is a straightforward process'*

5. Challenges and Next Steps

6.1 Improved extranet information on revalidation and appraisal for nurses and midwives

Feedback from nurses and midwives tells us that they would like to be able to access information more easily from the Trust extranet site. We have referred this to our colleagues in the Communications team and hope that a revised version of the extranet site can be developed in the near future.

6. Recommendation

The Trust Board is asked to approve this annual report.

Vikki Carruth, Director of Nursing 9.5.18

NHS
Blood and Transplant

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2017 - 31 March 2018

East Sussex Healthcare NHS Trust

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Further Information

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report is available at http://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record. Issued May 2018 based on data meeting PDA criteria reported at 9 May 2018.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2017 and 31 March 2018, East Sussex Healthcare NHS Trust had 8 deceased solid organ donors, resulting in 17 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2016/17. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2017 - 31 March 2018 (1 April 2016 - 31 March 2017 for comparison)

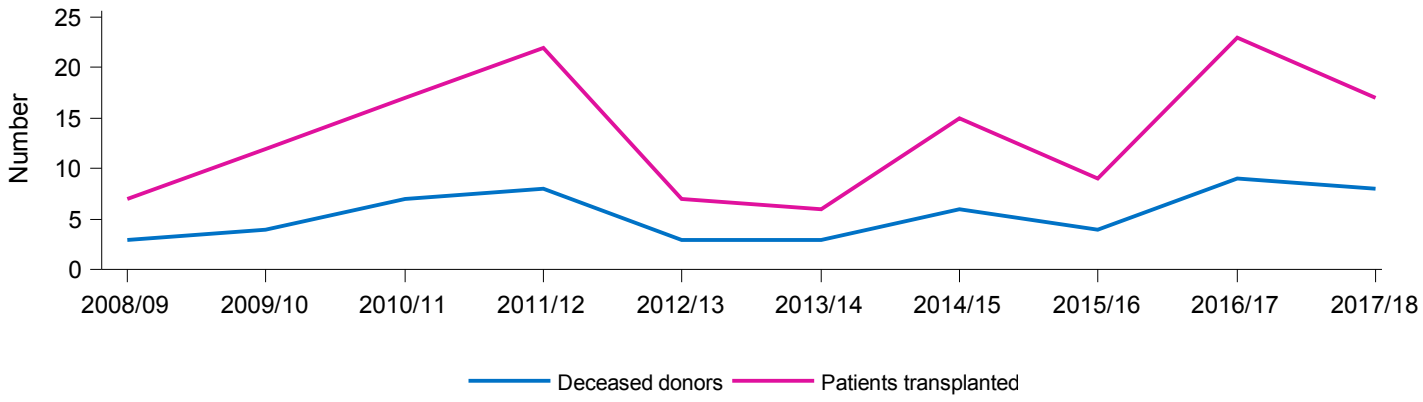
Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor: Trust		Average number of organs donated per donor: UK	
DBD	3	(5)	7	(18)	2.7	(4.2)	3.7	(3.7)
DCD	5	(4)	10	(5)	2.2	(2.3)	2.8	(2.7)
DBD and DCD	8	(9)	17	(23)	2.4	(3.3)	3.3	(3.3)

In addition to the 8 proceeding donors there was one additional consented donor that did not proceed, where DCD organ donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2017 - 31 March 2018 (1 April 2016 - 31 March 2017 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	4	(10)	1	(1)	3	(5)	0	(3)	0	(0)	0	(0)
DCD	10	(6)	0	(0)	1	(0)	0	(0)	0	(0)	0	(0)
DBD and DCD	14	(16)	1	(1)	4	(5)	0	(3)	0	(0)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2008 - 31 March 2018



2. Key Rates in Potential for Organ Donation

A summary of the key rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section presents specific percentage measures of potential donation activity for East Sussex Healthcare NHS Trust.

Performance in your Trust has been compared with UK performance in both Figure 2.1 and Table 2.1 using funnel plot boundaries and the Gold, Silver, Bronze, Amber, and Red (GoSBAR) colour scheme. When compared with UK performance, gold represents exceptional, silver represents good, bronze represents average, amber represents below average, and red represents poor performance. See Appendix A.3 for funnel plot ranges used.

It is acknowledged that the PDA does not capture all activity. In total there were 7 patients referred in 2017/18 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA. None of these are included in Section 1 because they did not become a solid organ donor.

Note that caution should be applied when interpreting percentages based on small numbers.

Goal: The agreed 2017/18 national targets for DBD and DCD consent rates are 73% and 67%, respectively.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2017 - 31 March 2018

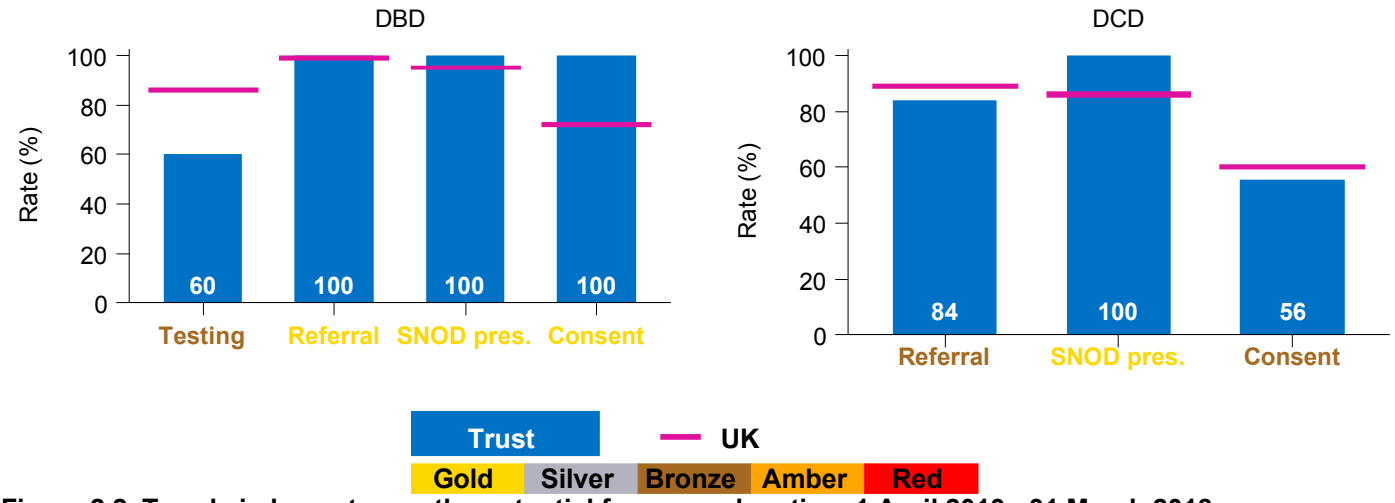


Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2013 - 31 March 2018

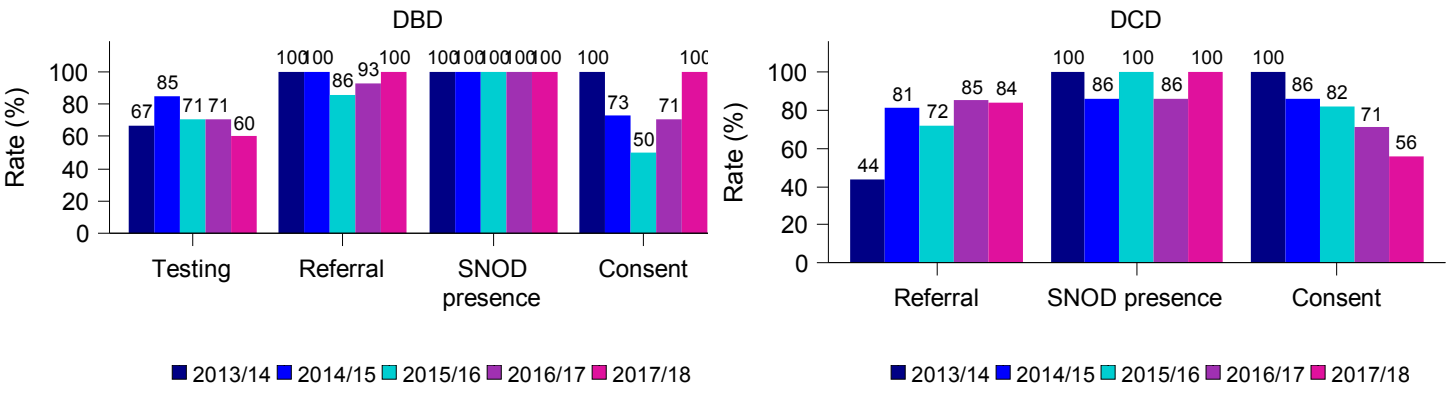


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2017 - 31 March 2018

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	5	1954	25	6281	28	7978
Referred to Organ Donation Service	5	1929	21	5615	24	7302
Referral rate %	G *100%*	*99%*	B *84%*	*89%*	B *86%*	*92%*
Neurological death tested	3	1676				
Testing rate %	B *60%*	*86%*				
Eligible donors[2]	3	1582	22	4456	25	6038
Family approached	3	1471	9	1858	12	3329
Family approached and SNOD present	3	1394	9	1591	12	2985
% of approaches where SNOD present	G *100%*	*95%*	G *100%*	*86%*	G *100%*	*90%*
Consent ascertained	3	1066	5	1115	8	2181
Consent rate %	G *100%*	*72%*	B *56%*	*60%*	B *67%*	*66%*
Actual donors (PDA data)	3	955	5	613	8	1568
% of consented donors that became actual donors	*100%*	*90%*	*100%*	*55%*	*100%*	*72%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

Note that from 1 April 2017 to 31 March 2018 there was one eligible DCD donor for whom consent for donation was ascertained who is not included in this section because they were either over 80 years of age or did not die in a unit participating in the PDA.

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Trust at the key stages of organ donation. The ambition is that your Trust misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2013 - 31 March 2018

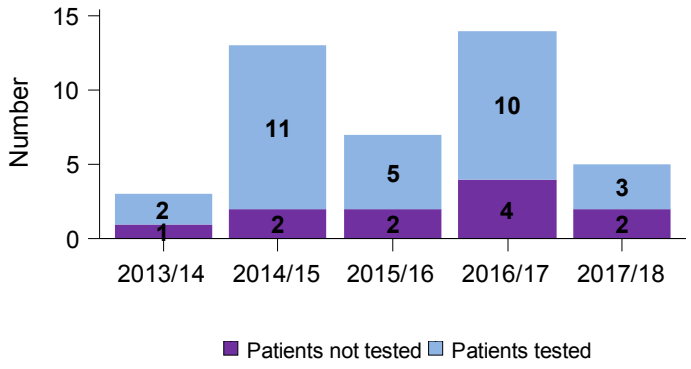


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2017 - 31 March 2018

	Trust	UK
Biochemical/endocrine abnormality	-	26
Clinical reason/Clinicians decision	-	64
Continuing effects of sedatives	-	17
Family declined donation	1	18
Family pressure not to test	-	21
Hypothermia	-	1
Inability to test all reflexes	-	12
Medical contraindication to donation	-	6
Other	-	18
Patient had previously expressed a wish not to donate	-	2
Patient haemodynamically unstable	-	69
Pressure on ICU beds	-	3
SN-OD advised that donor not suitable	1	9
Treatment withdrawn	-	9
Unknown	-	3
Total	**2**	**278**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2013 - 31 March 2018

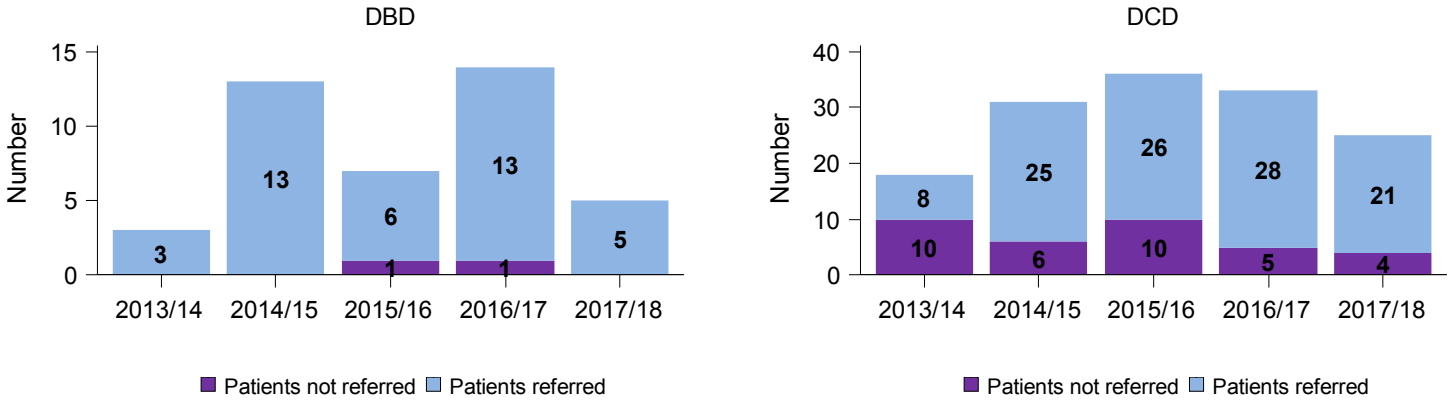


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2017 - 31 March 2018

	DBD		DCD	
	Trust	UK	Trust	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	7
Coroner/Procurator Fiscal Reason	-	1	-	3
Family declined donation after neurological testing	-	2	-	-
Family declined donation following decision to withdraw treatment	-	-	-	24
Family declined donation prior to neurological testing	-	2	-	3
Medical contraindications	-	1	-	110
Neurological death not confirmed	-	1	-	-
Not identified as a potential donor/organ donation not considered	-	10	3	320
Other	-	5	-	76
Patient had previously expressed a wish not to donate	-	-	-	2
Pressure on ICU beds	-	-	-	7
Reluctance to approach family	-	2	-	8
Thought to be medically unsuitable	-	1	1	106
Total	**-**	**25**	**4**	**666**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

Table 3.3 shows the primary absolute medical contraindications to solid organ donation, if applicable, for potential DBD donors confirmed dead by neurological death tests and potential DCD donors in your Trust.

Table 3.3 Primary absolute medical contraindications to solid organ donation, 1 April 2017 - 31 March 2018

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Active (not in remission) haematological malignancy (myeloma, lymphoma, leukaemia)	-	15	-	212
All secondary intracerebral tumours	-	-	-	2
Any active cancer with evidence of spread outside affected organ within 3 years of donation	1	41	3	605
Choriocarcinoma	-	-	-	1
Definite, probable or possible case of human TSE, including CJD and vCJD	-	-	-	2
HIV disease (but not HIV infection)	-	2	-	14
Human TSE, CJD or vCJD; blood relatives with CJD; other infectious neurodegenerative diseases	-	-	-	6
Melanoma (except completely excised Stage 1 cancers)	-	4	-	9
No transplantable organ in accordance with organ specific contraindications	-	19	-	306
Other neurodegenerative diseases associated with infectious agents	-	-	-	1
Primary intra-cerebral lymphoma	-	-	-	3
TB: active and untreated	-	3	-	17
Total	**1**	**84**	**3**	**1178**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.4 SNOD presence

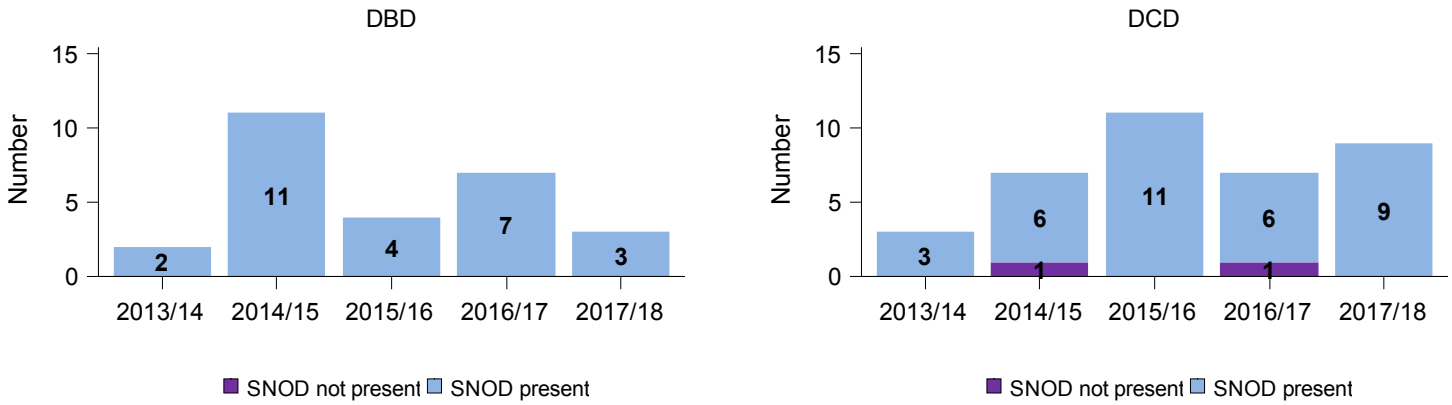
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2017/18, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 36% and 18%, respectively, compared with DBD and DCD consent/authorisation rates of 74% and 67%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known wishes of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2013 - 31 March 2018



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 9 May 2018]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 9 May 2018]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 9 May 2018]

3.5 Consent

Goal: The agreed 2017/18 national targets for DBD and DCD consent/authorisation rates are 73% and 67%, respectively.

In 2017/18 less than 10 families of eligible donors were approached to discuss organ donation in your Trust therefore consent rates are not presented.

Figure 3.4 Number of families approached, 1 April 2013 - 31 March 2018

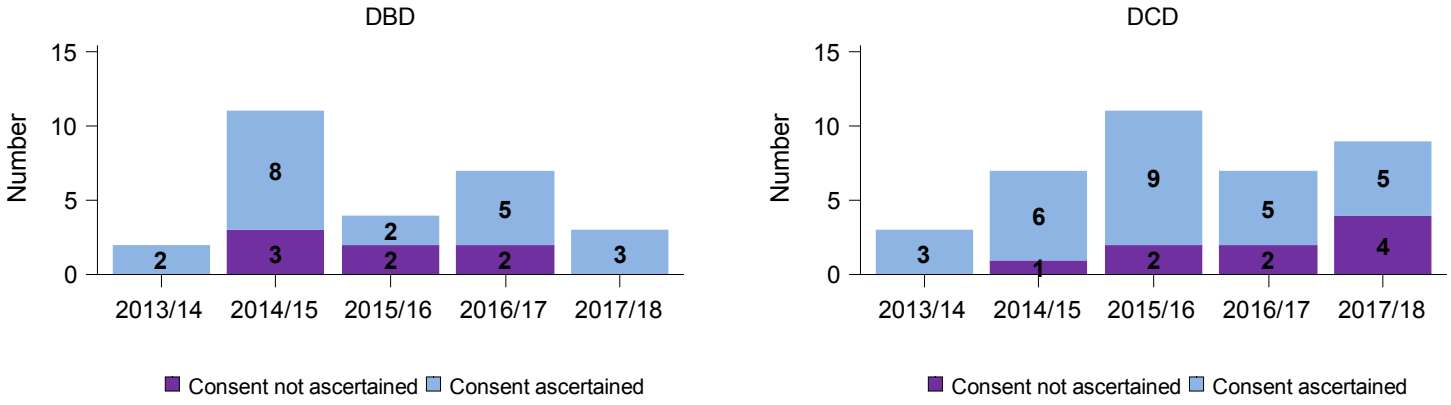


Table 3.4 Reasons given why consent was not ascertained, 1 April 2017 - 31 March 2018

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Families concerned about organ allocation	-	-	-	1
Family concerned donation may delay the funeral	-	2	-	1
Family concerned that organs may not be transplanted	-	2	-	11
Family did not believe in donation	-	13	-	29
Family did not want surgery to the body	-	52	-	72
Family felt it was against their religious/cultural beliefs	-	44	-	25
Family felt the body needs to be buried whole (unrelated to religious or cultural reasons)	-	39	-	24
Family felt the length of time for donation process was too long	-	23	1	128
Family felt the patient had suffered enough	-	15	-	57
Family had difficulty understanding/accepting neurological testing	-	3	-	-
Family wanted to stay with the patient after death	-	-	-	9
Family were divided over the decision	-	21	2	26
Family were not sure whether the patient would have agreed to donation	-	65	1	103
Other	-	24	-	79
Patient previously expressed a wish not to donate	-	91	-	162
Strong refusal - probing not appropriate	-	11	-	16
Total	**-**	**405**	**4**	**743**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted. The strategy for achieving this, including steps to minimising warm ischaemic injury in proceeding DCD donors, is set out in NHSBT Taking Organ Utilisation to 2020 [4].

Table 3.5 Reasons why solid organ donation did not occur, 1 April 2017 - 31 March 2018

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Cardiac Arrest	-	-	-	6
Coroner/Procurator Fiscal refusal	-	19	-	15
Family changed mind	-	4	-	25
Family placed conditions on donation	-	1	-	-
General instability	-	17	-	36
Logistic reasons	-	1	-	1
Organs deemed medically unsuitable by recipient centres	-	40	-	146
Organs deemed medically unsuitable on surgical inspection	-	17	-	8
Other	-	3	-	35
Positive virology	-	9	-	9
Prolonged time to asystole	-	-	-	221
Total	**-**	**111**	**-**	**502**

If 'other', please contact your local SNOD or CLOD for more information, if required.

[4] NHS Blood and Transplant, 2017.

Taking Organ Utilisation to 2020
[accessed 9 May 2018]

4. Comparative Data

A comparison of performance in your Trust/Board with national data

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section compares the quality of care in the key areas of organ donation in your Trust with the UK rate using funnel plots. The UK rate is shown as a green dashed line and the funnel shape is formed by the 95% and 99.8% confidence limits around the UK rate. The confidence limits reflect the level of precision of the UK rate relative to the number of observations. Performance in your Trust is indicated by a black cross. The Gold, Silver, Bronze, Amber, and Red colour scheme is used to indicate whether performance in your Trust, when compared to UK performance, is exceptional (gold), good (silver), average (bronze), below average (amber) or poor (red).

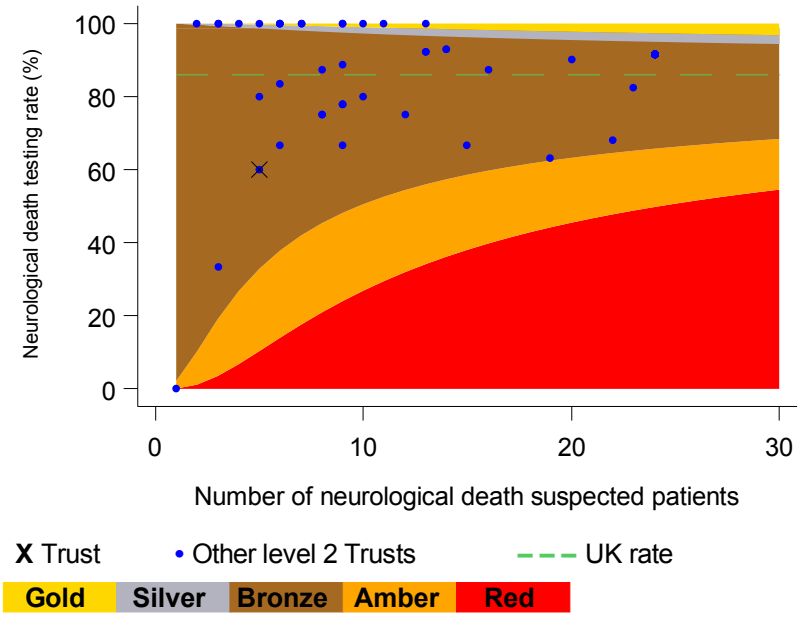
It is important to note that the differences in patient mix have not been accounted for in these plots. Further to these, separate funnel plots for DBD and DCD rates are presented in Section 7.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

4.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2017 - 31 March 2018

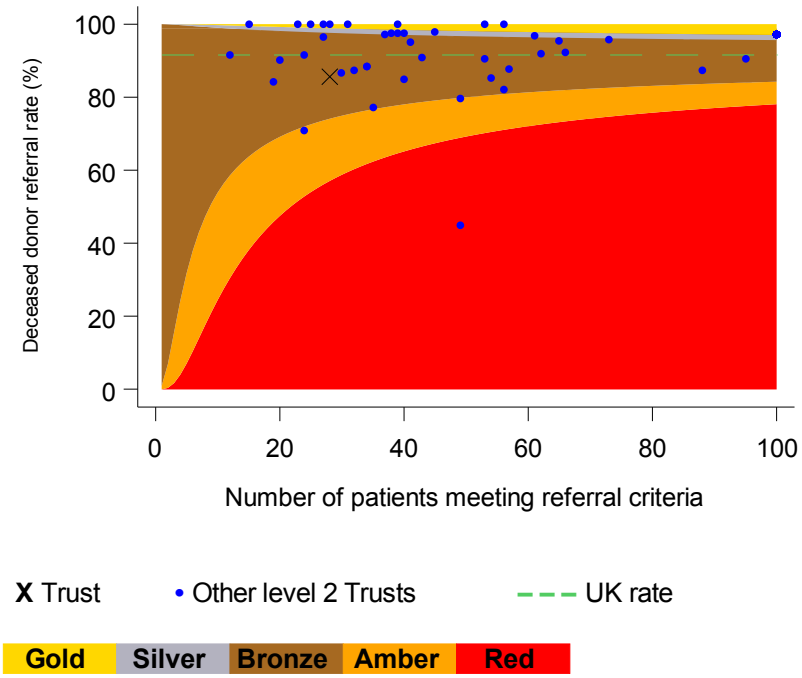


When compared with UK performance the neurological death testing rate in East Sussex Healthcare NHS Trust was average (bronze).

4.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2017 - 31 March 2018

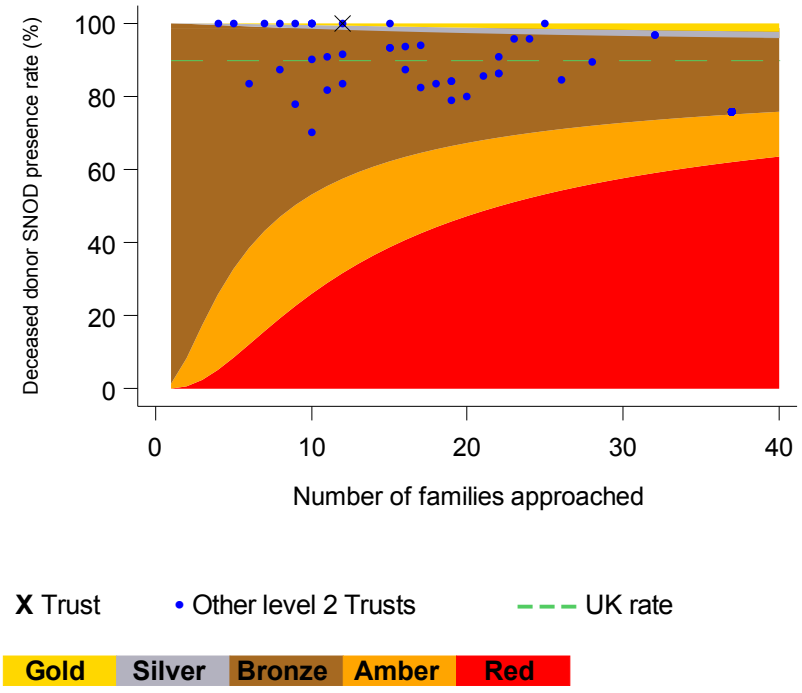


When compared with UK performance East Sussex Healthcare NHS Trust was average (bronze) for referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service.

4.3 SNOD presence

Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2017 - 31 March 2018

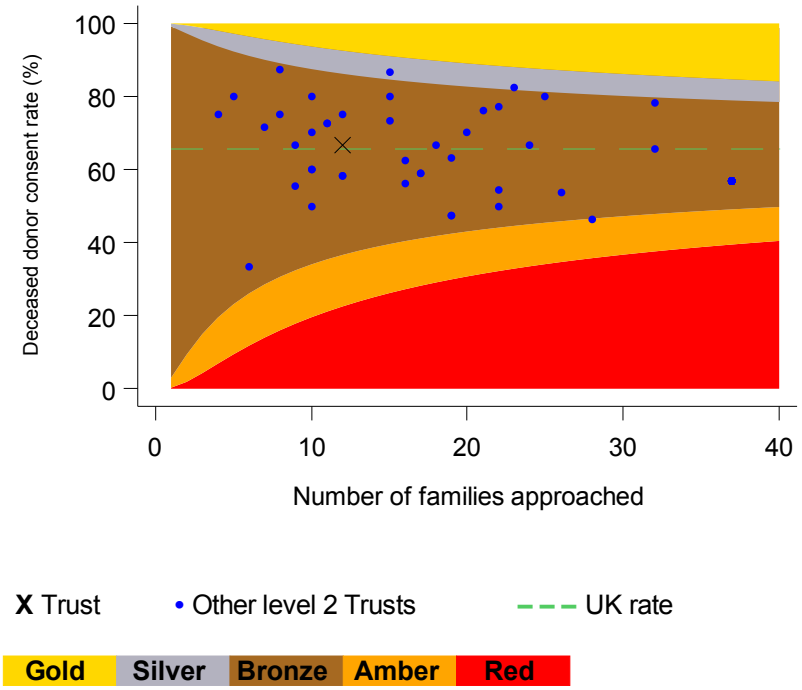


When compared with UK performance East Sussex Healthcare NHS Trust was exceptional (gold) for Specialist Nurse presence when approaching families to discuss organ donation.

4.4 Consent

Goal: The agreed 2017/18 national targets for DBD and DCD consent/authorisation rates are 73% and 67%, respectively.

Figure 4.4 Funnel plot of consent rate, 1 April 2017 - 31 March 2018



When compared with UK performance the consent rate in East Sussex Healthcare NHS Trust was average (bronze).

5. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 5.1 and 5.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 5.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2017 - 31 March 2018

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Eastbourne, Eastbourne District General Hospital													
A&E	1	0	-	1	-	0	0	0	0	-	0	-	0
Gen. ICU/HDU	2	2	-	2	-	2	2	2	2	-	2	-	2
Hastings, Conquest Hospital													
A&E	0	0	-	0	-	0	0	0	0	-	0	-	0
Gen. ICU/HDU	2	1	-	2	-	1	1	1	1	-	1	-	1

Table 5.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2017 - 31 March 2018

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DBD donors
Eastbourne, Eastbourne District General Hospital											
A&E	1	1	-	1	0	0	0	-	0	-	0
Gen. ICU/HDU	11	9	82	11	10	3	3	-	2	-	2
Hastings, Conquest Hospital											
A&E	1	0	-	1	1	0	0	-	0	-	0
Gen. ICU/HDU	12	11	92	12	11	6	6	-	3	-	3

Tables 5.1 and 5.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for East Sussex Healthcare NHS Trust in 2017/18 there were 1 such patients. For more information regarding the Emergency Department please see Section 6.

6. Emergency Department data

A summary of key numbers for Emergency Departments

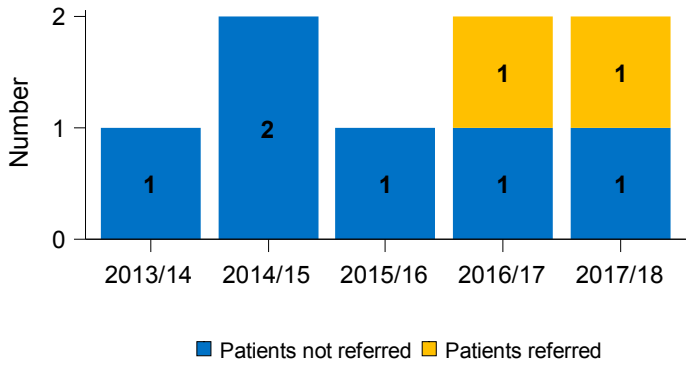
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a wish in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [5] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

6.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

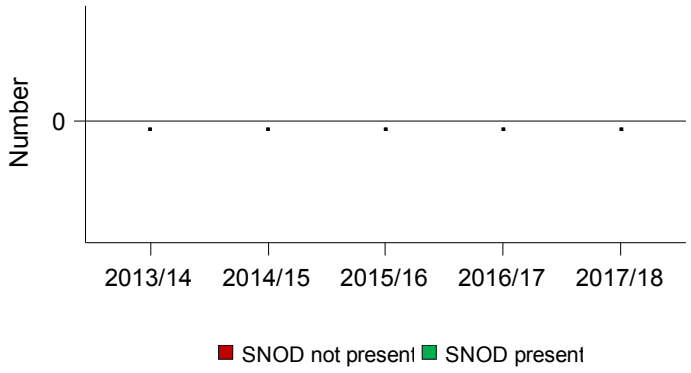
Figure 6.1 Number of patients meeting referral criteria that died in the ED, 1 April 2013 - 31 March 2018



6.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 6.2 Number of families approached in ED by SNOD presence, 1 April 2013 - 31 March 2018



[5] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 9 May 2018]

7. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

7.1 Supplementary Regional data

Table 7.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South East Coast*	UK
1 April 2017 - 31 March 2018		
Deceased donors	86	1,574
Transplants from deceased donors	224	4,012
Deaths on the transplant list	14	426
As at 31 March 2018		
Active transplant list	334	6,045
Number of NHS ODR opt-in registrations (% registered)**	1,993,087 (43%)	24,941,804 (38%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 4.63 million, based on ONS 2011 census data

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

7.2 Trust/Board Level Benchmarking

East Sussex Healthcare NHS Trust has been categorised as a level 2 Trust. Levels were reallocated in July 2016 using the average number of donors in 2014/15 and 2015/16, Table 7.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 7.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more proceeding donors per year	33
Level 2	5-12 proceeding donors per year	45
Level 3	3-5 proceeding donors per year	47
Level 4	<3 proceeding donors per year	46

Tables 7.3 and 7.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 7.3 National DBD key numbers and rate by Trust/Board level, 1 April 2017 - 31 March 2018

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	5	3	-	5	-	3	3	3	3	-	3	-	3
Level 1	1012	893	88	1002	99	878	843	791	753	95	560	71	510
Level 2	416	352	85	413	99	341	328	302	283	94	220	73	192
Level 3	322	272	84	320	99	265	255	240	230	96	184	77	165
Level 4	204	159	78	194	95	157	156	138	128	93	102	74	88

Table 7.4 National DCD key numbers and rate by Trust/Board level, 1 April 2017 - 31 March 2018

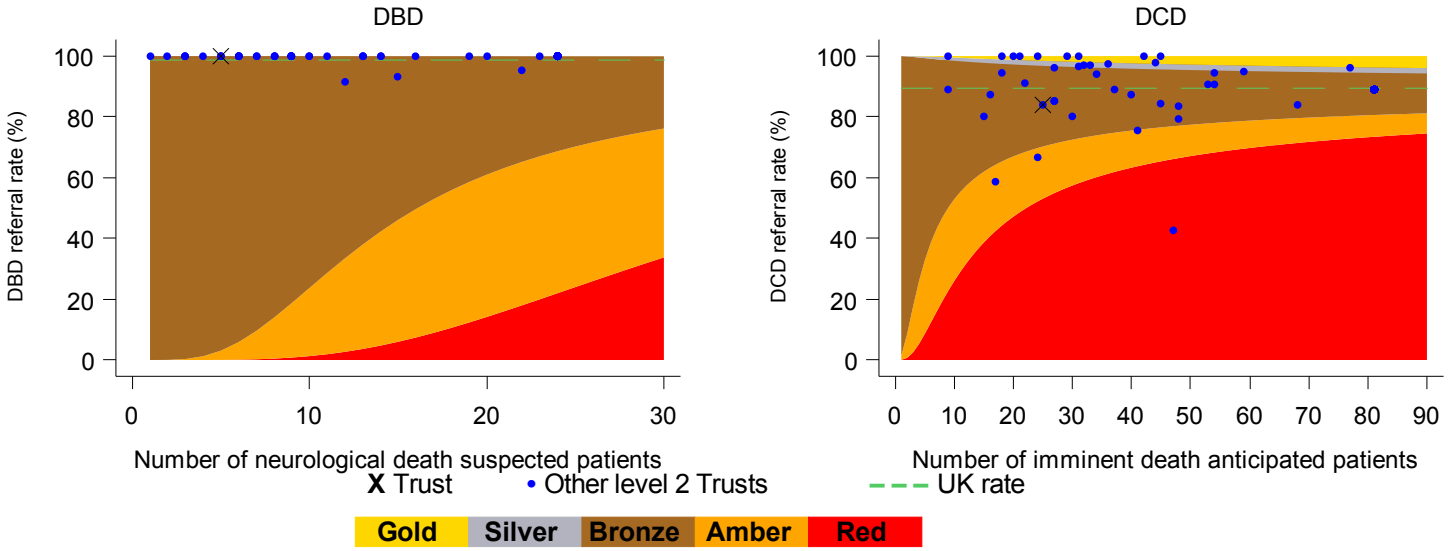
	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DBD donors
Your Trust	25	21	84	25	22	9	9	-	5	-	5
Level 1	2612	2372	91	2384	1906	978	841	86	596	61	349
Level 2	1510	1342	89	1355	1060	394	342	87	233	59	122
Level 3	1407	1253	89	1233	980	326	274	84	199	61	100
Level 4	752	648	86	668	510	160	134	84	87	54	42

7.3 Comparative data for DBD and DCD deceased donors

Funnel plots are presented in Section 4 showing performance in your Trust against the UK rate for deceased organ donation. The following funnel plots present data for DBD and DCD donors separately.

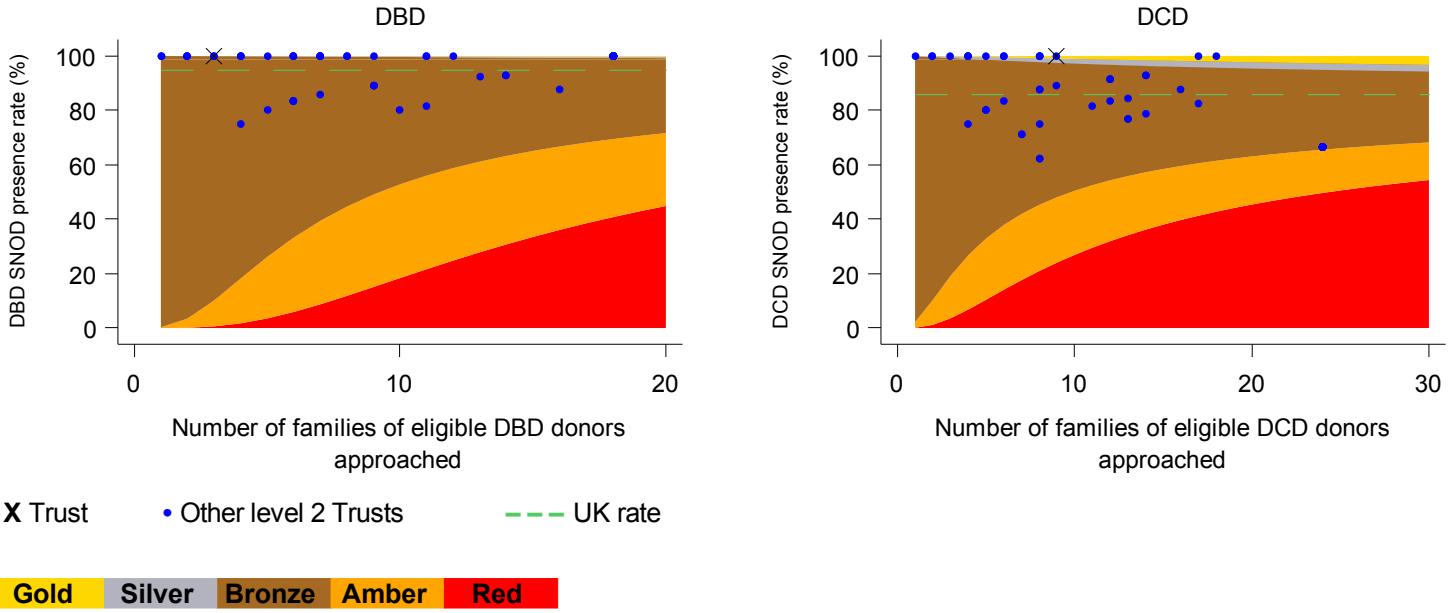
Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

Figure 7.1 Funnel plots of referral rates, 1 April 2017 - 31 March 2018



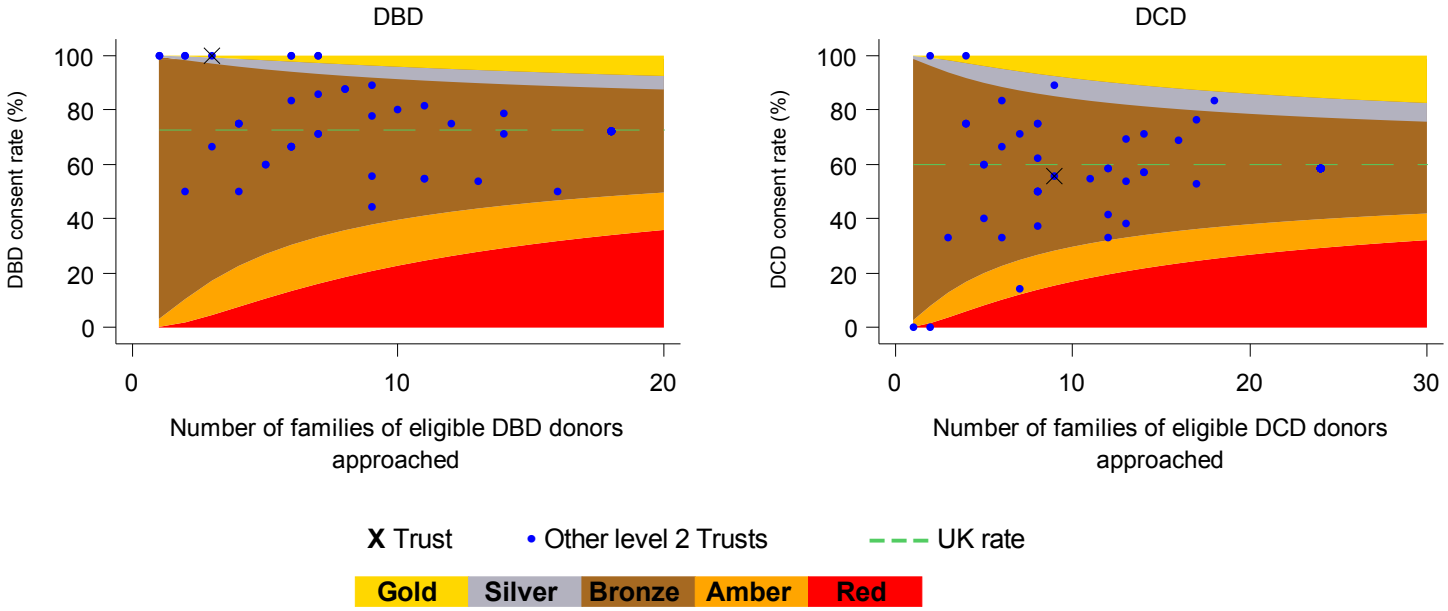
When compared with UK performance East Sussex Healthcare NHS Trust was exceptional (gold) for referral of potential DBD organ donors and average (bronze) for referral of potential DCD organ donors to NHS Blood and Transplant's Organ Donation Service.

Figure 7.2 Funnel plots of SNOD presence rates, 1 April 2017 - 31 March 2018



When compared with UK performance East Sussex Healthcare NHS Trust was exceptional (gold) and exceptional (gold) for Specialist Nurse presence in approaches to families of eligible DBD and DCD donors, respectively.

Figure 7.3 Funnel plots of consent rates, 1 April 2017 - 31 March 2018



When compared with UK performance the consent rate in East Sussex Healthcare NHS Trust was exceptional (gold) and average (bronze) for DBD and DCD donors, respectively.

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: Apnoea, coma from known aetiology and unresponsive, ventilated, fixed pupils. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term'.
Potential DBD donor	A patient who meets all four criteria for neurological death testing excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term' (ie suspected neurological death, as defined above).
DBD referral criteria	A patient with suspected neurological death
Discussed with Specialist Nurse – Organ Donation	A patient with suspected neurological death discussed with the Specialist Nurse – Organ Donation (SNOD)
Neurological death tested	Neurological death tests were performed
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DBD asked to support patient's expressed or deemed consent/authorisation, informed of a nominated/appointed representative, asked to make a decision on donation on behalf of their relative, or informed of a patient's opt-out decision via the ODR.
Consent/authorisation ascertained	Family supported expressed or deemed consent/authorisation , nominated/appointed representative gave consent, or where applicable family gave consent/authorisation
Actual donors: DBD	Neurological death confirmed patients who became actual DBD as reported through the PDA
Actual donors: DCD	Neurological death confirmed patients who became actual DCD as reported through the PDA
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested
Referral rate	Percentage of patients for whom neurological death was suspected who were discussed with the SNOD
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within a time frame to allow donation to occur, as determined at time of assessment
DCD referral criteria	A patient in whom imminent death is anticipated (as defined above)
Discussed with Specialist Nurse – Organ Donation	Patients for whom imminent death was anticipated who were discussed with the SNOD
Potential DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours
Eligible DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DCD asked to: support the patient's expressed or deemed consent/authorisation decision, informed of a nominated/appointed representative, make a decision themselves on donation, or informed of a patient's opt-out decision via the Organ Donor Register
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key rates in potential for organ donation	
Figure 2.1	Key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented in a bar chart, using data from the Potential Donor Audit (PDA). The comparative UK rate, for the same time period, is illustrated by the pink line. The key rates labels are coloured using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below.
Figure 2.2	Trends in the key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented for the past five equivalent time periods, using data from the PDA.
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Note that caution should be applied when interpreting percentages based on small numbers. Appendix A.1 gives a fuller explanation of terms used. The key rates are highlighted using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below).

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.

Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 Comparative data

Figure 4.1	A funnel plot of the neurological death testing rate is displayed using data obtained from the PDA. Each Trust/Board, of the same level, is represented on the plot as a blue dot, although one dot may represent more than one Trust/Board. The UK rate is shown on the plot as a green horizontal dashed line, together with 95% and 99.8% confidence limits for this rate. These limits form a 'funnel', which is shaded using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme. Graphs obtained in this way are known as funnel plots. If a Trust/Board lies within the 95% limits, shaded bronze, then that Trust/Board has a rate that is statistically consistent with the UK rate (average performance). If a Trust/Board lies outside the 95% confidence limits, shaded silver (good performance) or amber (below average performance), this serves as an alert that the Trust/Board may have a rate that is significantly different from the UK rate. When a Trust/Board lies above the upper 99.8% limit, shaded gold, this indicates a rate that is significantly higher than the UK rate (exceptional performance), while a Trust/Board that lies below the lower limit, shaded red, has a rate that is significantly lower than the UK rate (poor performance). It is important to note that differences in patient mix have not been accounted for in these plots. Your Trust/Board is shown on the plot as the large black cross. If there is no large black cross on the plot, your Trust/Board did not report any patients of the type presented. The funnel plots can also be used to identify the maximum rates currently being achieved by Trusts/Boards with similar donor potential.
Figure 4.2	A funnel plot of the deceased donor referral rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.3	A funnel plot of the deceased donor SNOD presence rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.4	A funnel plot of the deceased donor consent/authorisation rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.

5 PDA data by hospital and unit

Table 5.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 5.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

6 Emergency department data

Figure 6.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 6.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

7 Additional data and figures

Table 7.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. Your region has been defined as per former Strategic Health Authority. A UK comparison is also provided.
Table 7.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 7.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 7.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Figure 7.1	A funnel plot of the DBD and DCD referral rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.2	A funnel plot of the DBD and DCD SNOD presence rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.3	A funnel plot of the DBD and DCD consent/authorisation rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.

East Sussex Healthcare NHS
NHS Trust

The Workforce Race Equality Standard (WRES)

2017/18

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The Workforce Race Equality Standard

1. Introduction

The Workforce Race Equality Standard (WRES) was introduced by NHS England to all NHS organisations from April 2015. WRES consists of nine metrics that can be used to help NHS organisations identify and address race inequality. East Sussex Healthcare NHS Trust (ESHT) welcomed the new standard which has provided the opportunity to demonstrate our commitment to advancing equality of opportunity for the diverse workforce it employs.

The metrics are used as a tool to help identify and close gaps between Black & Minority Ethnic (BME) and White British, White Irish and White Other (White) staff within the organisation. The standard will continue to support the Trust in becoming an inclusive organisation and meeting its legal obligations as an equal opportunities employer. It will also assist in ensuring the Trust is fulfilling its legal duties to comply with the Public Sector Equality Duty.

Along with the Refreshed Equality Delivery System (EDS2), WRES continues to assist the Trust in ensuring its workforce can be confident that the Trust is giving due regard to using the indicators (below) contained in the WRES to help ensure inequalities are identified and addressed.

The regulators, the Care Quality Commission (CQC) and NHS Improvement (NHSi) will monitor the WRES and EDS2 to help assess whether NHS organisations are inclusive and well-led.

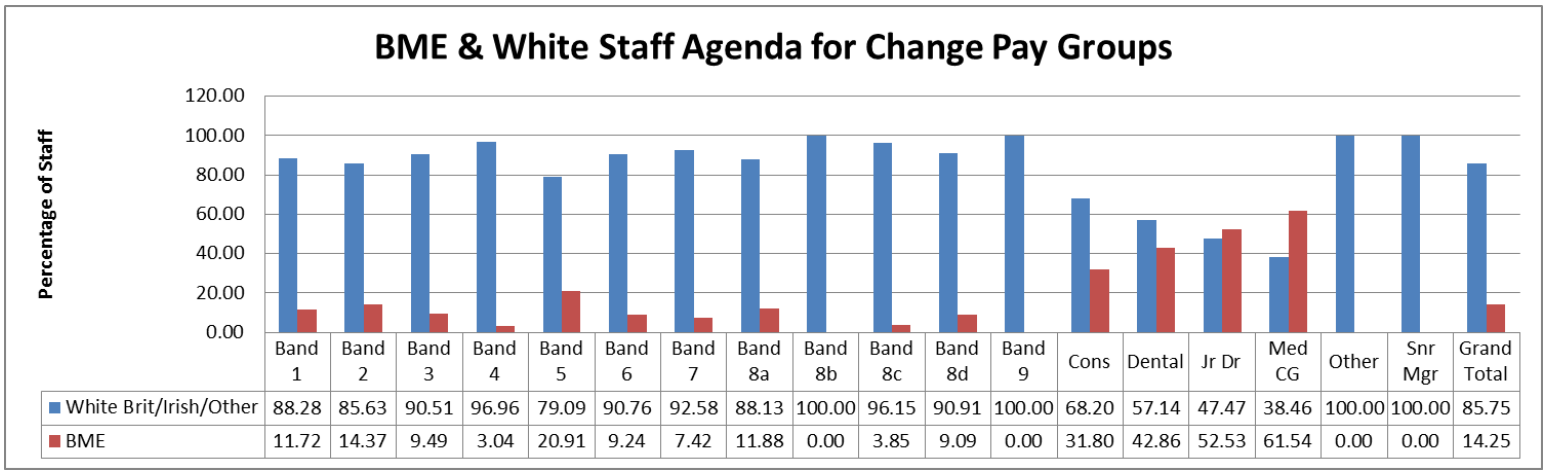
2. Data Collection and Monitoring

The first WRES report (2014/15) highlighted the importance of having processes for collecting robust data. The Trust has been seeking ways to improve the way data is collected and reported. Data collection methods of staff attending non-mandatory training has continued to prove challenging. Managers are reminded of the importance of ensuring accurate and detailed recording of staff attending non-mandatory training, however caution must still be used when forming judgements on the outcomes. The Trust will continue to include reminders for managers using Trust communication methods and will continue to explore further options to improve this data.

Each year data is produced for the WRES metrics which are then used by the Staff BME Network to identify area's that require improvement and develop an action plan. Each metric is considered at the Staff BME Network and The Equality & Access Steering (TEAS) Groups. Leads for the action are identified accordingly. Through engagement with managers, the BME Staff Network and the wider staff, each action is addressed over the year.

The 2011 Census is still the most up to date information we have available to identify Ethnicity in the local areas. According to East Sussex in Figures, East Sussex "…is less ethnically diverse than the South East region or nationally" (ESiF 2012). The local black and minority ethnic (BME) populations are around 10.5% which is lower than the South East (14%) and England (17%). Eastbourne and Hastings have the highest percentage of BME groups at 13%. BME groups include: White Irish, Other White in addition to Mixed, Asian, Black, Chinese and Other groups. ESHT calculations are formulated according to the WRES technical guidance where White Irish and White Other are not included in BME calculations.

Figures produced by East Sussex County Council Equality and Diversity Profile for Hastings and Rother Clinical Commissioning Group in February 2017, highlight East Sussex BME populations excluding White Irish and White other to be 8.3%. Organisations are expected to be representative of the populations they serve and whilst ESHT remains overall representative, there are areas within the Trust that are not. These are highlighted in the graph below. These underrepresented bands are further separated by Clinical and non-clinical positions in metric 1. The most underrepresented bands continue to be addressed through recruitment processes.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	Cons	Dental	Jr Dr	Med CG	Other	Snr Mgr	Grand Total
White Brit/Irish/Other	88.28	85.63	90.51	96.96	79.09	90.76	92.58	88.13	100.00	96.15	90.91	100.00	68.20	57.14	47.47	38.46	100.00	100.00	85.75
BME	11.72	14.37	9.49	3.04	20.91	9.24	7.42	11.88	0.00	3.85	9.09	0.00	31.80	42.86	52.53	61.54	0.00	0.00	14.25

3. Highlights of 2017/18

The East Sussex Healthcare NHS Trust (ESHT) BME Staff Network has gone from strength to strength during 2017/18. Chaired by Dr Adrian Bull (CEO) and attended by the Equality Lead, Human Resource Managers, Leadership Managers, Staff Health & Wellbeing Leads and Staff Engagement Leads. The Network aims to provide a safe place for BME staff to come and raise concerns, support one another and identify best practice. The Network also aims to identify training and development opportunities for staff. This year has seen a great amount of development opportunities communicated through the network. These include, 'The Stepping-Up Programme' and the 'Ready Now Programme' of which ESHT BME staff have successfully obtained places. Other opportunities such as the NHS England Chief Nurse Scholarship Programme and invites to participate in the development of the Kent, Surrey and Sussex (KSS) Leadership Academy Inclusion Symposium to create a new KSS Leadership Academy Inclusion Strategy. During 2017/18 ESHT BME Staff Network met bi-monthly and will continue to meet bi-monthly during 2018/19. Membership has increased month on month promoting equality across the organisation.

The Trust participated in various initiatives to promote Equality week and Black History Month during 2017/18. The focus of Equality week was the Trust Staff Networks and communicating effectively with patients. Members of the BME Network supported the Equality & Human Rights team to promote the staff networks at several of the Trust sites including, Hastings, Bexhill and Eastbourne.

The catering department supported Equality Week by offering various cuisines from around the world. A different cuisine was offered each day including, Indian, African, Chinese, Filipino and British.

During Black History Month the network welcomed Guest speaker Banji Adewumi, Associate Director of Inclusion from Barts Health NHS Trust followed up with a dedicated Career Development Workshop.

To support the Trust in meeting its legal obligations the Trust has 4 Equality Objectives including ensuring senior BME recruitment remains fair and support the Trust to continue to be representative of the population it serves. The Trust Equality Objectives were developed using the EDS2 and the WRES indicators. The full document and progress report can be accessed on the Trust website.

4. Workforce Data

2017/18 has seen small percentage increases in BME staff in clinical and non-clinical bands. Bands that have seen a reduction of BME staff is not considered statistically significant and would be considered normal variation. The positive continued increase in BME recruitment is testament to recruitment staff in continuing to have due regard to the promotion of equal opportunities in the Trust.

5. Ethnicity Undisclosed/Not stated

Data suggests junior doctors and medical career grade doctors continue to have high percentages of staff not declaring their ethnicity. 52.5% of Junior doctors currently identify as BME and 61.5% of Career grade doctors identify as BME. Due to the high number of these doctors not declaring their ethnicity, these figures maybe unreliable. When speaking with BME staff who had not declared their ethnicity, the general feedback was declaring ethnicity was seen as irrelevant to their job. Whilst this may be viewed as a positive step towards race equality to some, awareness of the benefits to declaring ethnicity will form part of the action plan.

Percentage of staff Undefined Ethnicity	
Band 1	7.32
Band 2	9.73
Band 3	8.48
Band 4	6.88
Band 5	13.54
Band 6	6.42
Band 7	4.09
Band 8a	8.05
Band 8b	11.32
Band 8c	7.14
Band 8d	26.67
Band 9	40.00
Consultant	6.87
Dental	22.22
Junior Doctor	42.96
Med Career Grade	15.22
Other	0.00
Senior Manager	44.44
Grand Total	**10.22**

42.96% of Junior doctors (Foundation years 1 and 2) did not declare their ethnicity along with large percentages of AfC bands 8d, 9, Dental, career grade doctors and executives (Senior Managers). During 2016/17 ESHT Trust Board completed an equalities data form for reporting. This exercise will be repeated for 2018/19. Further investigation is required to gain an understanding of why these figures exist.

6. Workforce Race Equality Standard Metrics 2017/18

Workforce metrics
For each of these four workforce indicators, the Standard compares the metrics for white and BME staff.

1. **Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce**

Note: Organisations should undertake this calculation separately for non-clinical and for clinical staff

- **76.99% of all staff identified as White British or White Other**
- **12.79% of all staff identified as BME**
- **10.22% of staff's ethnicity was unknown and are excluded from calculations.**

Clinical & Non-clinical

- 18.05% of all clinical staff identified as BME
- 81.95% of all clinical staff identified as White British, White Irish or White Other

- 5.99% of all non-clinical staff identified as BME
- 94.01% of all non-clinical staff identified as White British, White Irish or White Other

Percentage of BME and White staff in each clinical and non-clinical pay band

	Clinical			Non Clinical		
Pay Band	White Brit/Irish/Other (%)	BME (%)	BME 2016/17 (%)	White Brit/Irish/Other (%)	BME (%)	BME 2016/17 (%)
Band 1	100	0.00	5.88	87.43	12.57	10.49
Band 2	76.47	23.53	23.18	94.08	5.92	5.99
Band 3	87.21	12.79	10.4	96.27	3.73	4.97
Band 4	95.86	4.14	4.62	97.46	2.54	1.3
Band 5	76.58	23.42	25.53	93.02	6.98	4.43
Band 6	90.22	9.78	8.31	97.47	2.53	2.7
Band 7	91.99	8.01	7.14	97.18	2.82	1.67
Band 8a	86.00	14.00	15.05	91.67	8.33	11.54
Band 8b	100	0.00	0	100	0.00	0
Band 8c	92.31	7.69	7.69	100	0.00	0
Band 8d	100	0.00	0	90.00	10.00	9.09
Band 9	100	0.00	0	100	0.00	-
Consultant	68.20	31.80	29.27	-	-	-
Dental	57.14	42.86	50	-	-	-
Junior Doctor	47.47	52.53	47.34	-	-	-
Med. Career Grade	38.46	61.54	56.96	-	-	-
Other	100	0	-	-	-	-
Senior Manager	100	0	0	100	0	0
Grand Total	**81.95**	**18.05**	**17.75**	**94.01**	**5.99**	**5.5**

2.	**Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.**
	2017/18 The relative likelihood of white staff being appointed from shortlisting compared to BME staff was 0.91 times greater. **2016/17** The relative likelihood of white staff being appointed from shortlisting compared to BME staff is 1.02 times greater.
3.	**Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*** ***Note: this indicator will be based on data from a two year rolling average of the current year and the previous year**
	2016/17 – 2017/18 Staff identified as BME were 1.58 times more likely to enter the formal disciplinary process compared to staff identified as White British, White Irish or White other.
4.	**Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff**
	Available figures demonstrate White staff were **1.11** times more likely to access non-mandatory training compared to BME staff. This is a positive improvement from 1.95 times in 2016/17. Note: Managers are reminded to inform Learning & Development, and staff are encouraged to advise their managers of completed non-mandatory training attended; Caution must be taken when forming judgments on data due to how these data are captured. Previously line managers have block book places on conferences and university workshops, the booking forms require a line manager's name plus the number of attendees and not necessarily individual names. Identifying members of staff who had attended these non-mandatory training events proved challenging. Where staff have been identified this has been reported. Improvements to how these data are collected remains under review.
National NHS Staff Survey findings For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for white and BME staff	
5.	**KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**
	2017/18 results ❖ 27.86% of White respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. National Average was 26%. ❖ 30.85% of BME respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. National Average was 27%. **2016/17 results** ❖ 29.18% of White respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. ❖ 34.02% of BME respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

6.	**KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**
	2017/18 results ❖ 26.7% of White respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. National Average was 23%. ❖ 28.61% of BME respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. National Average was 29%. **2016/17 results** ❖ 26.76% of White respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. ❖ 29.46% of BME respondents reported experiencing harassment, bullying or abuse from staff in last 12 months.
7.	**KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion**
	2017/18 results ❖ 88.63% of White respondents believed they were provided with equal opportunities for career progression or promotion. National Average was 88%. ❖ 80.22% of BME respondents believed they were provided with equal opportunities for career progression or promotion. National Average was 83%. **2016/17 results** ❖ 87.84% of White respondents believed they were provided with equal opportunities for career progression or promotion. ❖ 75.21% of BME respondents believed they were provided with equal opportunities for career progression or promotion.
8.	**Q 17b. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues**
	2017/18 results ❖ 7.11% of White staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. National Average was 6%. ❖ 15.92% of BME staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. National Average was 15%. **2016/17 results** ❖ 7.0% White of White staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. ❖ 12.5% of BME staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background.
Boards Does the Board meet the requirement on Board membership in 9?	
9.	**Percentage difference between the organisations' Board voting membership and its overall workforce**
	All voting members of ESHT Trust Board identify as White British or White other. Vacancies for Trust Board positions are widely advertised and communicated to the NHS BME Network. In 2017/18 the Percentage difference between the organisations' Board voting membership and its overall workforce was -12.8%. In 2016/17 the Percentage was -12.3%

7. National NHS Staff Survey findings

The Key Findings (KF) 25, 26, 21 and Q17 are questions specific for helping identify race inequality in the NHS workforce. The figures show some movement which suggest the change is not statistically relevant.

KF 25 – BME respondents reported a 3.17% decrease in experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months when compared to 2016/17 survey.

KF 26 – BME respondents reported a less than 1% change in experiencing harassment, bullying or abuse from staff in last 12 months compared to 2016/17 survey. 27% was the combined (BME & White Staff) and the National Average combined was 24%.

KF 21 – 2016/17 survey suggested 75.21% of BME staff reported believing they were provided with equal opportunities for career progression or promotion. 2017/18 survey findings were 80.22%. This is a 5% increase from last year. The National Average for 2017/18 was 83%.

Q 17b – 15.92% of BME staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. This is a 3.4% increase from 2017/18 survey. The National Average was 15%.

The findings of the survey have been considered during the development of the action plan to enhance career progression and eliminating unlawful discrimination. Trust wide initiatives are in place to reduce bullying and harassment and are also included in the 'ESHT BME Staff Network Terms or Reference'.

8. Conclusion

There has been good steady progress in BME representation across the Trust. The Trust BME Staff Network has strengthened no end and continues to see new members joining each month promoting the value of a diverse workforce.

The 5% increase reported in the staff survey of BME staff believing they were provided with equal opportunities for career progression or promotion is a positive step to delivering equal opportunities to all staff and through the staff networks and other communication methods we will continue to build on the good practices and provide opportunities within the Trust.

There is always more that can be done and as outlined in the actions below and with the staff network action plan, the Trust will continue to identify opportunities to improve the working environment for all staff and to ensure equality is embedded into everyday practices as an employer and in the healthcare we deliver.

Action Plan 2018/19

The Equality Act 2010 and the Public Sector Equality Duties.

The Trust must have due regard to the 3 aims of the Equality Duty. The 3 aims of the equality duty are to have due regard to the need to:

1. Eliminate unlawful discrimination, harassment, and victimisation and any other conduct that is prohibited by the Act.

2. Advance equality of opportunity between people who share a protected characteristic and those who do not.

3. Foster good relations between people who share a protected characteristic and those who do not:

In order to demonstrate the Trusts' due regard to the NHS Workforce Race Equality Standard, the following actions for 2018/19 have been agreed by the ESHT BME Network and the Trust Board.

Eliminate unlawful discrimination, harassment, and victimisation and any other conduct that is prohibited by the Act.

- Incidents reported on Datix involving racial discrimination, harassment or victimisation continued to be reviewed monthly by the Trust Speak up Guardian, the Director of Human Resource and the Chief Executive.
- Incidents of racial discrimination continue to be closely monitored and actioned accordingly using Trust policies.

Advance equality of opportunity between people who share a protected characteristic and those who do not.

- Ensure equality is embedded in recruitment of non-clinical positions band 8 and above.
- Ensure robust processes are in place to record and monitor CPD and non-mandatory.

Foster good relations between people who share a protected characteristic and those who do not:

- Improve understanding of the benefits to declaring ethnicity on employment records.
- Promote the benefits of joining staff networks.
- Ensure managers have the necessary skills to identify and tackle discrimination and foster good relations amongst their teams.

This Report is available in alternative formats upon request. Alternative formats include (but not limited to) Large Print, Braille, Audio, Alternative Community Languages. Please contact the Equality, Diversity & Human Rights Team by emailing esh-tr.accessibleinformation@nhs.net or Telephone 01424 755255.

East Sussex Healthcare NHS Trust

Annual Report

Complaints & Patient Advice and Liaison Service (PALS) 2017/18

Executive Sponsor:	Vikki Carruth, Director of Nursing
Main Report Author:	Darren Langridge-Kemp, Complaints & PALS Manager
Date:	May 2018

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1. Executive Summary

This report details the activity of the Complaints Team and PALS at East Sussex Healthcare NHS Trust for the year 2017/18, alongside activity in key areas for 2016/17 for comparative purposes. All data provided has been extracted from Datix, which is the risk management database used by the Trust.

- The Trust received 567 complaints across all sites during 2017/18; this represents a reduction of 15.4% compared to the number of complaints received in 2016/17 (667).

- The Trust acknowledged 100% of complaints within three working days.

- The Trust's internal response rate for non-complex complaints (30 working days) at the end of 2017/18 was 83%, whilst the internal response rate for complex complaints (45 working days) was 71%. These are significant improvements compared to 2016/17, where the internal response rates were 54% and 53% respectively.

- There were 83 complaints re-opened in 2017/18; this represents a reduction of 23.8% compared to the number of complaints re-opened during 2016/17 (109).

- There were no complaints overdue at the end of 2017/18, compared to 14 complaints overdue at the end of 2016/17.

- The Complaints Team provided 69 Local Resolution Meetings during 2017/18.

- There was a very small decrease in PALS contacts for 2017/18; 7,139 contacts compared with 7,325 recorded in 2016/17, marking a reduction in activity of just 2.5%.

- The Trust received 13 contacts from the Parliamentary and Health Service Ombudsman (PHSO) during 2017/18. Of the contacts made in respect of investigations, four were to provide decisions/outcomes (one case upheld, two cases partially upheld and one case not upheld); there are six cases awaiting investigation decisions/outcomes. This represents a reduction in the rate of contacts by 18.75% compared to the number of contacts received from the PHSO in 2016/17 (16).

The objectives for 2018/19 are:

1. To sustain and further improve on the internal response rates for all complaints;
2. To audit a selection of actions identified from complaint investigations that have been reported as closed, to ensure the learning has been embedded and wherever possible prevented any further complaints of the same nature being raised;
3. To review, evaluate and report on trends and themes emerging from contact with PALS; and
4. To develop and deliver complaint management training for managers.

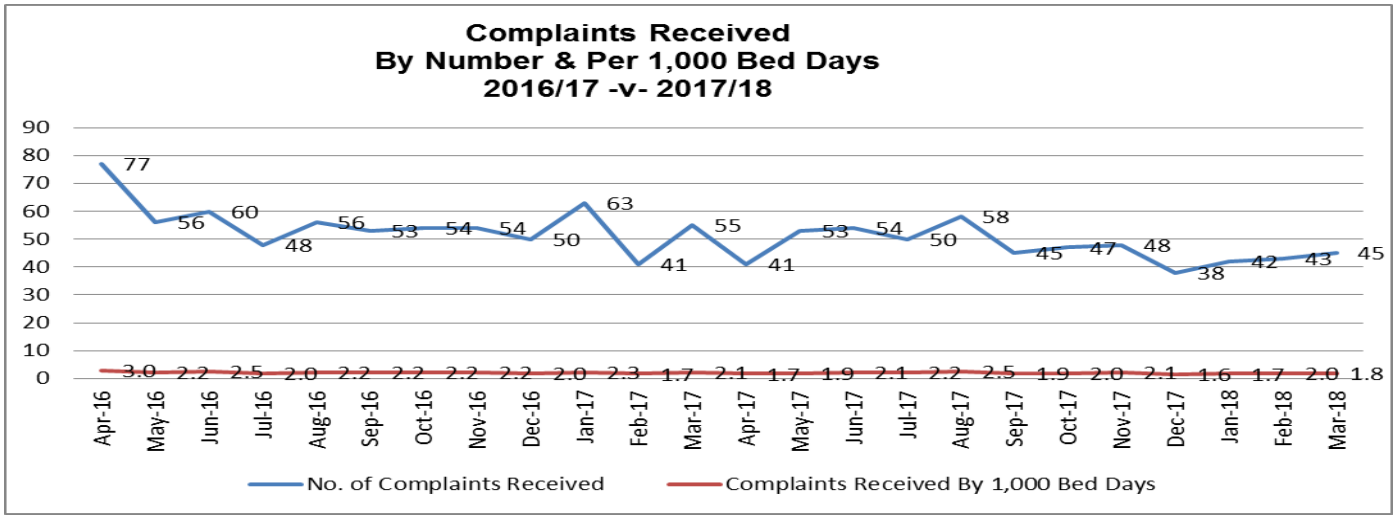
2. Complaints

The Trust considers complaints to be an important source of feedback, providing opportunities for reflection and improvement on the care and treatment provided to patients and their relatives. All complaints received are investigated in accordance with the Trust's "Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (The 4C's Model)", which itself is underpinned by the principles of The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the NHS Constitution.

The Trust makes every effort to resolve each complaint locally as far as it is possible to through comprehensive written responses, and Local Resolution Meetings. The Trust also works collaboratively with the local Advocacy Service to ensure complainants can access independent support with their complaint; our local Advocacy Service is provided by an organisation called Support Empower Advocate Promote, also known as SEAP.

2.1 Complaints Received

The following chart represents all complaints received in 2016/17 and 2017/18 for comparative purposes.



In terms of complaint themes for the Trust in 2017/18, the top three themes reflect that reported for 2016/17 as follows:

	2016/17		2017/18	
	Theme	No. Received	Theme	No. Received
1	Standard of Care	221	Standard of Care	194
2	Communication	143	Communication	137
3	Patient Pathway	127	Patient Pathway	94

The reduction in complaints coded to these primary complaint subject codes is in part reflective of the overall reduction in complaints received in 2017/18.

In terms of context in relation to the top three complaint themes for 2017/18, the following tables provide a breakdown of the top five sub-subjects under each primary complaint theme.

Standard of Care
In 2017/18, Standard of Care was the highest primary complaint subject with 194 out of 567 complaints having a complaint issue relating to it. Of this, the top five sub-subjects within this area were:

Overall Care	67
Missed Diagnosis	29
Incorrect Diagnosis	20
Lack of Confidence in Delivery of Care	18
Problems/Complications Following Surgery/Procedure	15

In September 2017, the Complaints Team reviewed and updated all primary and sub-subject complaint codes, with the implementation and use of new codes showing a marked reduction in the number of complaints coded against “overall care” in the second half of 2017/18 as complaints could be more accurately recorded against specific areas of care and treatment.

Communication
In 2017/18, the second highest primary complaint subject was Communication with 137 out of 567 complaints having a complaint issue relating to it. Of this, the top five sub-subjects within this area were:

Lack of Communication/Information	36
Verbal Information for Patients	18
Written Information for Patients	18
Listening and Respecting Patient Choice	15
Confidentiality Issues	9
Verbal Information for Relatives	9

Patient Pathway
In 2017/18, the third highest primary complaint subject was Patient Pathway with 94 out of 567 complaints having a complaint issue relating to it. Of this, the top five sub-subjects within this area were:

Delays in Access to Service/Treatment - Outpatient	47
Appointment Issues	13
Delays in Access to Service/Treatment - Inpatient	12
Lack of Follow Up/Monitoring	7
Admission Issues	6

When new complaints are recorded in Datix, they are assigned to the most appropriate/relevant Clinical Division. The following chart represents the total number of complaints received in 2017/18, alongside the figures for 2016/17 for comparative purposes, and to which Clinical Division they were assigned.

	2016/17	2017/18	Difference
Diagnostics, Anaesthetics and Surgery	221	181	↓ 40
Medicine	169	166	↓ 03
Out of Hospital	35	30	↓ 05
Urgent Care	143	72	↓ 71
Women, Children & Sexual Health	74	90	↑ 16

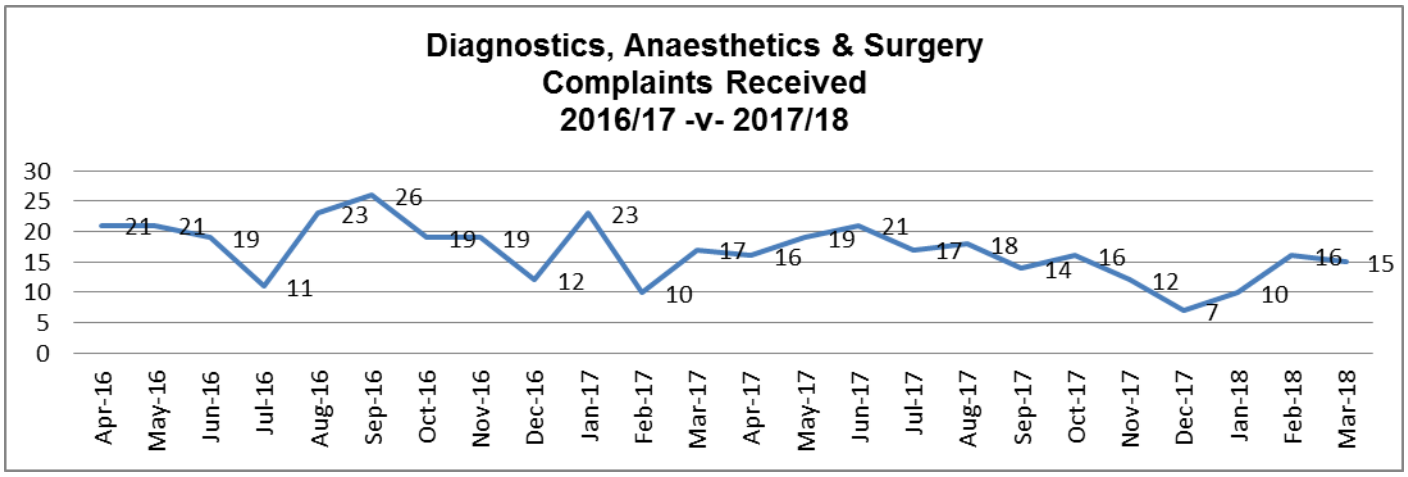
The reduction in complaints for Diagnostics, Anaesthetics and Surgery is encouraging to see, and represents the efforts made by staff and services to improve the patient experience of care and treatment. The significant reduction in complaints for Urgent Care is an exceptional achievement and demonstrates that despite the complex challenges facing Emergency Departments, staff have been able to deliver a high quality and responsive first line service to patients arriving at our hospitals for assessment and treatment of emergency presentations without giving cause for complaint.

There are no clear trends reasons for the small increase in complaints received by the Women, Children and Sexual Health Clinical Division. The Division is undertaking a full review and monitoring closely.

This report will set out the performance of each Clinical Division during 2017/18, together with data from 2016/17 for comparative purposes as follows.

2.2 Complaints by Division

Diagnostics, Anaesthetics and Surgery
The following chart represents complaints received over the last two years.



The Diagnostics, Anaesthetics and Surgery Clinical Division is one of the largest in the Trust, and incorporates a comprehensive range of specialties in both inpatient and outpatient modalities. It therefore consistently incurs a higher number of complaints. Whilst there has been a reduction of 18.1% in complaints received between 2016/17 and 2017/18, the top three complaint themes remain the same. Equally, four of the top five complaint locations remain the same across the two consecutive years.

Top 3 Complaint Themes

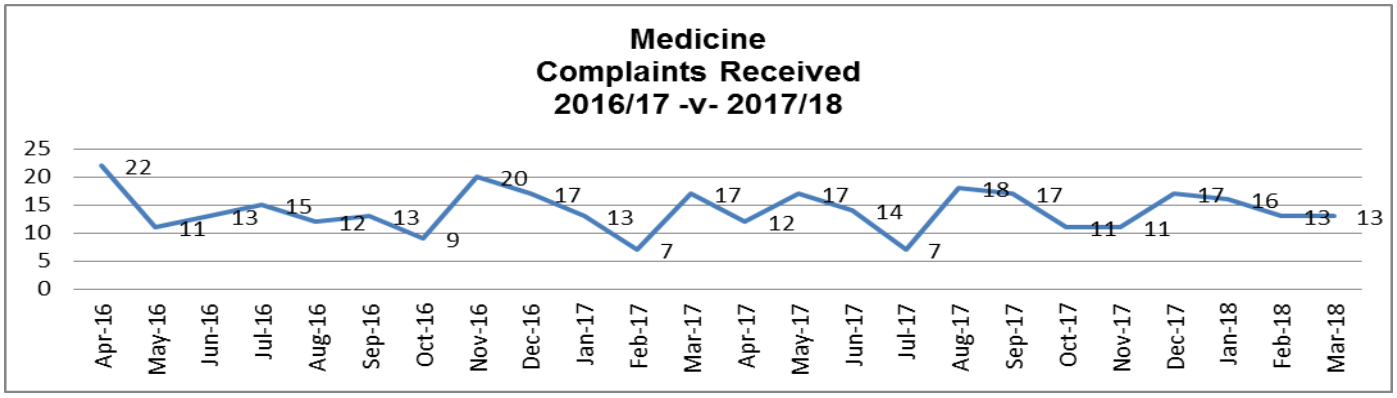
	2016/17		2017/18	
1	Standard of Care	116	Standard of Care	97
2	Communication	103	Communication	93
3	Patient Pathway	82	Patient Pathway	82

Top 5 Complaint Locations

	2016/17		2017/18	
1	Outpatients – Eastbourne DGH	38	Outpatients – Eastbourne DGH	32
2	Outpatients – Conquest	27	Outpatients – Conquest	27
3	Hailsham 4 Urology Ward	20	Richard Ticehurst SAU	14
4	De Cham Ward	12	Egerton Trauma Ward	11
5	Richard Ticehurst SAU	9	Hailsham 4 Urology Ward	8

Medicine

The following chart represents complaints received over the last two years.



This is also a large Division multiple and complex specialties in both inpatient and outpatient modalities. It too, by its size and range of services, incurs a higher number of complaints. The number of complaints received in 2017/18 compared to 2016/17 demonstrates a relatively consistent rate, with the top three complaint themes remaining the same, together with a number of consistencies in the complaint locations across the two consecutive years.

Top 3 Complaint Themes

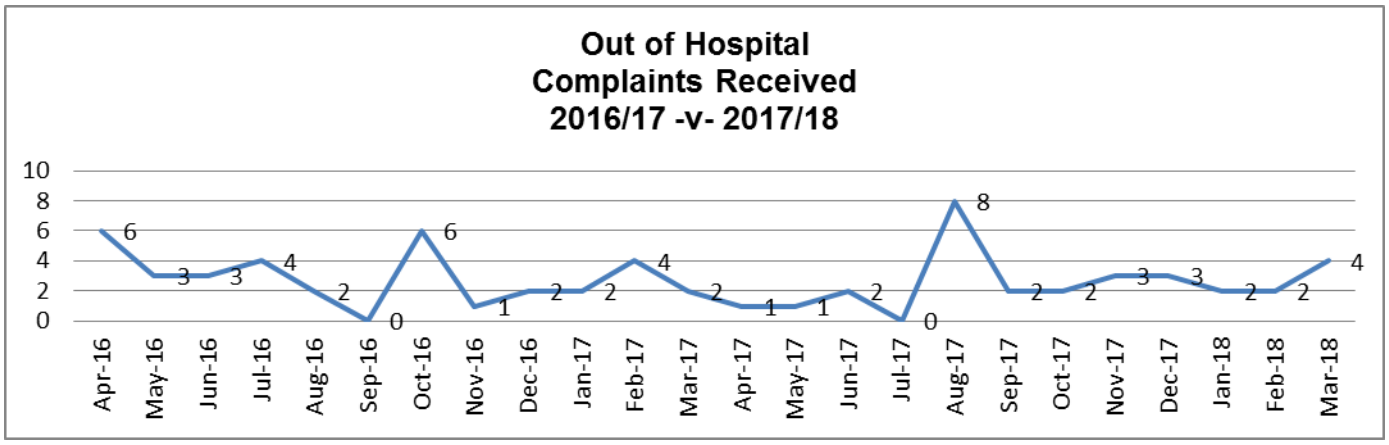
	2016/17		2017/18	
1	Communication	92	Standard of Care	100
2	Standard of Care	90	Communication	99
3	Patient Pathway	62	Patient Pathway	49

Top 5 Complaint Locations

	2016/17		2017/18	
1	Outpatients – Eastbourne DGH	18	Outpatients – Eastbourne DGH	31
2	Administration & Outpatients – Conquest	15	Acute Medical Unit – Eastbourne	17
3	Acute Medical Unit – Eastbourne	11	Outpatients – Conquest	11
4	Berwick Ward & Wellington Ward	8	Cuckmere Ward & Tressell Ward	8
5	Cuckmere Ward	7	Berwick Ward & Seaford 4 Ward	7

Out of Hospital

The following chart represents complaints received over the last two years.



The number of complaints received by the Out of Hospital Clinical Division has, as with 2016/17, remained very low with the exception of a minor spike after a month of no complaints received. There are no discernible reasons for this. Although there was a small dip in the number of complaints received in 2017/18 compared with the previous year, there are many consistencies in both the top three complaint themes and top three complaint locations.

Top 3 Complaint Themes

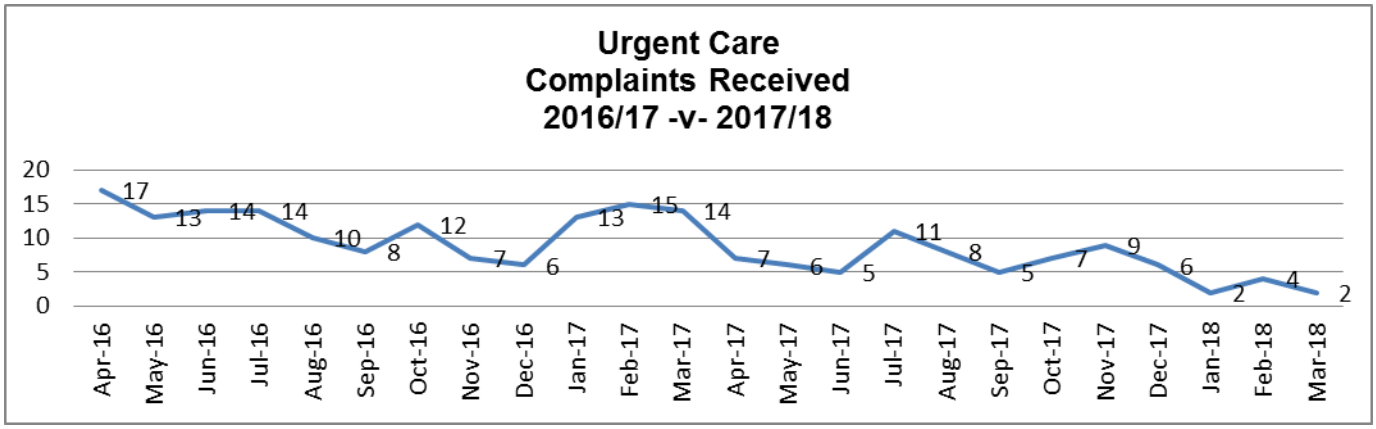
	2016/17		2017/18	
1	Patient Pathway	20	Communication	17
2	Communication	16	Standard of Care	14
3	Standard of Care	9	Patient Pathway	9

Top 3 Complaint Locations

	2016/17		2017/18	
1	Patient's Home	16	Patient's Home	13
2	Outpatients – Conquest	4	Irvine Unit	6
3	Outpatients – Eastbourne DGH	3	Outpatients – Eastbourne DGH	3

Urgent Care

The following chart represents complaints received over the last two years.



Despite the annual challenges facing our Emergency Departments, the Urgent Care Clinical Division has seen an incredible 49.36% reduction in the number of complaints received during 2017/18 compared to 2016/17. There are no immediate reasons to explain the drop however the improved 4 hour standard has had an impact. There are consistencies in the top three complaint themes and as Urgent Care is limited to a much smaller number of clinical areas that it works in, there are of course natural consistencies in the complaint locations.

Top 3 Complaint Themes

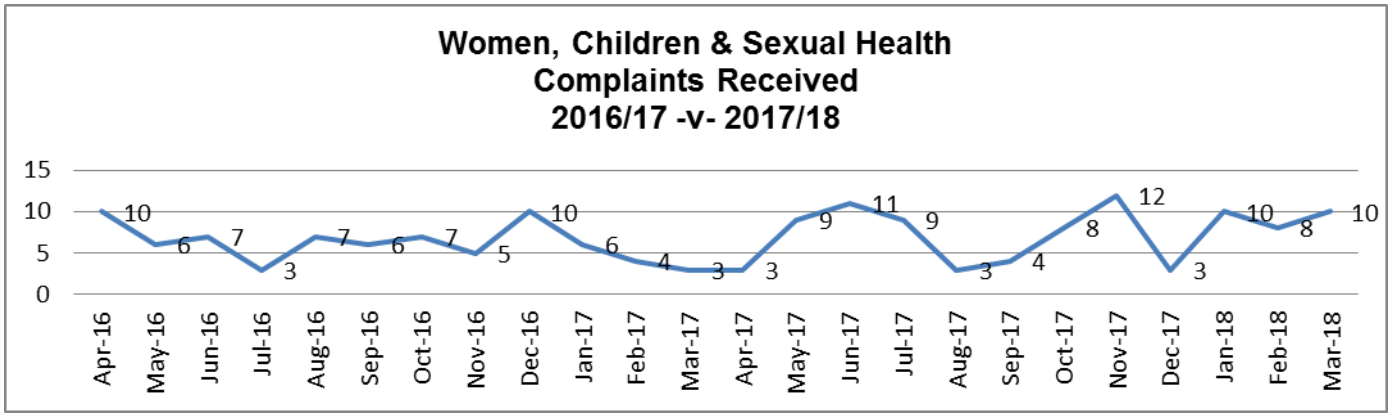
	2016/17		2017/18	
1	Standard of Care	88	Communication	17
2	Patient Pathway	52	Standard of Care	14
3	Communication	51	Patient Pathway	9

Top 3 Complaint Locations

	2016/17		2017/18	
1	Emergency Unit – Eastbourne DGH	69	Emergency Unit – Conquest	32
2	Emergency Unit – Conquest	50	Emergency Unit – Eastbourne DGH	30
3	Acute Medical Unit - Eastbourne	8	Clinical Decisions Unit - Eastbourne	8

Women, Children and Sexual Health

The following chart represents complaints received over the last two years.



In 2017/18, the Women, Children and Sexual Health Clinical Division was the only area to see an increase in the number of complaints received compared to 2016/17. There are no immediate reasons to explain the 21.6% increase in complaints, although media coverage on patients experiencing complications from vaginal mesh procedures and additional pressures on Incontinence Services may be linked to this. The increase has not affected the top three complaint themes which remain the same as 2016/17, and there are some consistencies in the complaint locations.

Top 3 Complaint Themes

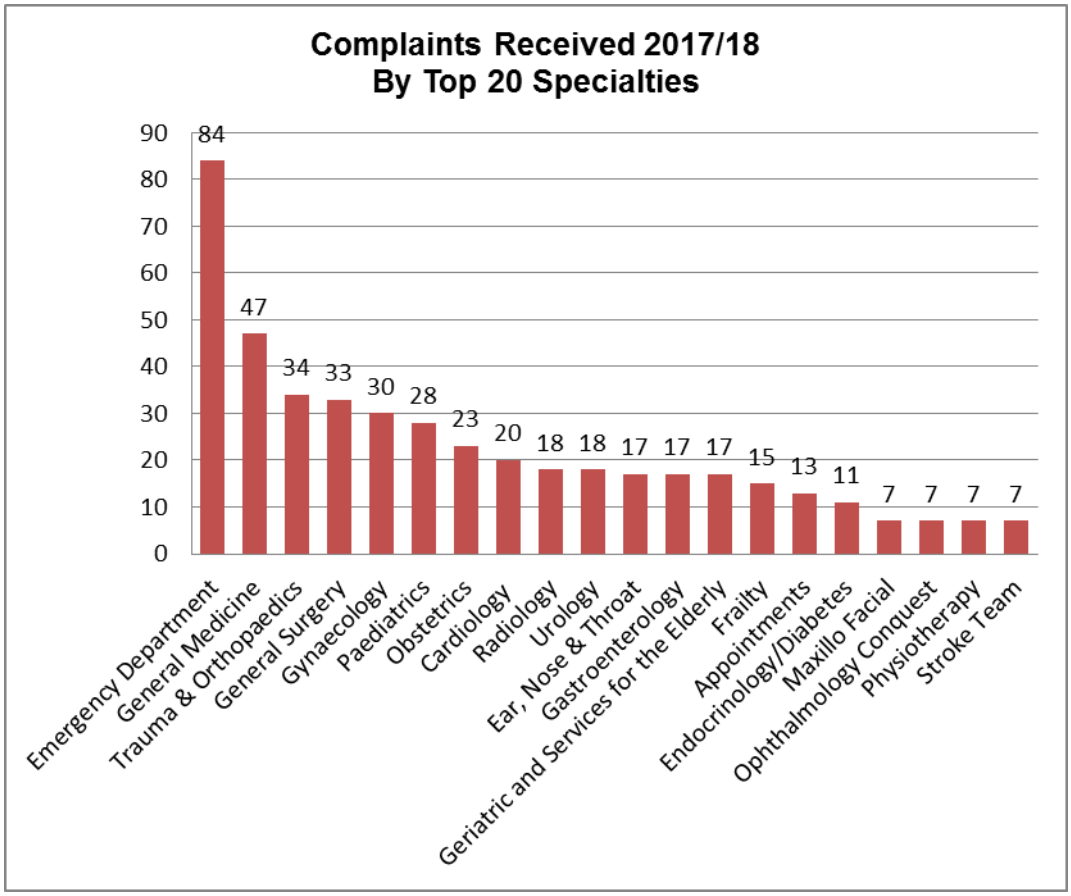
	2016/17		2017/18	
1	Standard of Care	38	Communication	55
2	Communication	34	Standard of Care	48
3	Patient Pathway	31	Patient Pathway	31

Top 3 Complaint Locations

	2016/17		2017/18	
1	Outpatients – Eastbourne DGH	18	Outpatients – Eastbourne DGH	15
2	Kipling Ward	10	Frank Shaw Ward & Mirlees Ward	10
3	Patient's Home	6	Patient's Home	9

2.3 Complaints by Specialty

In addition to coding complaints to the relevant Clinical Division(s), complaints are also recorded against the specific specialties to which they relate. Of the 567 complaints received in 2017/18, complaints were recorded against 73 different specialties across the Trust. The following chart represents complaints received by the top 20 specialties.



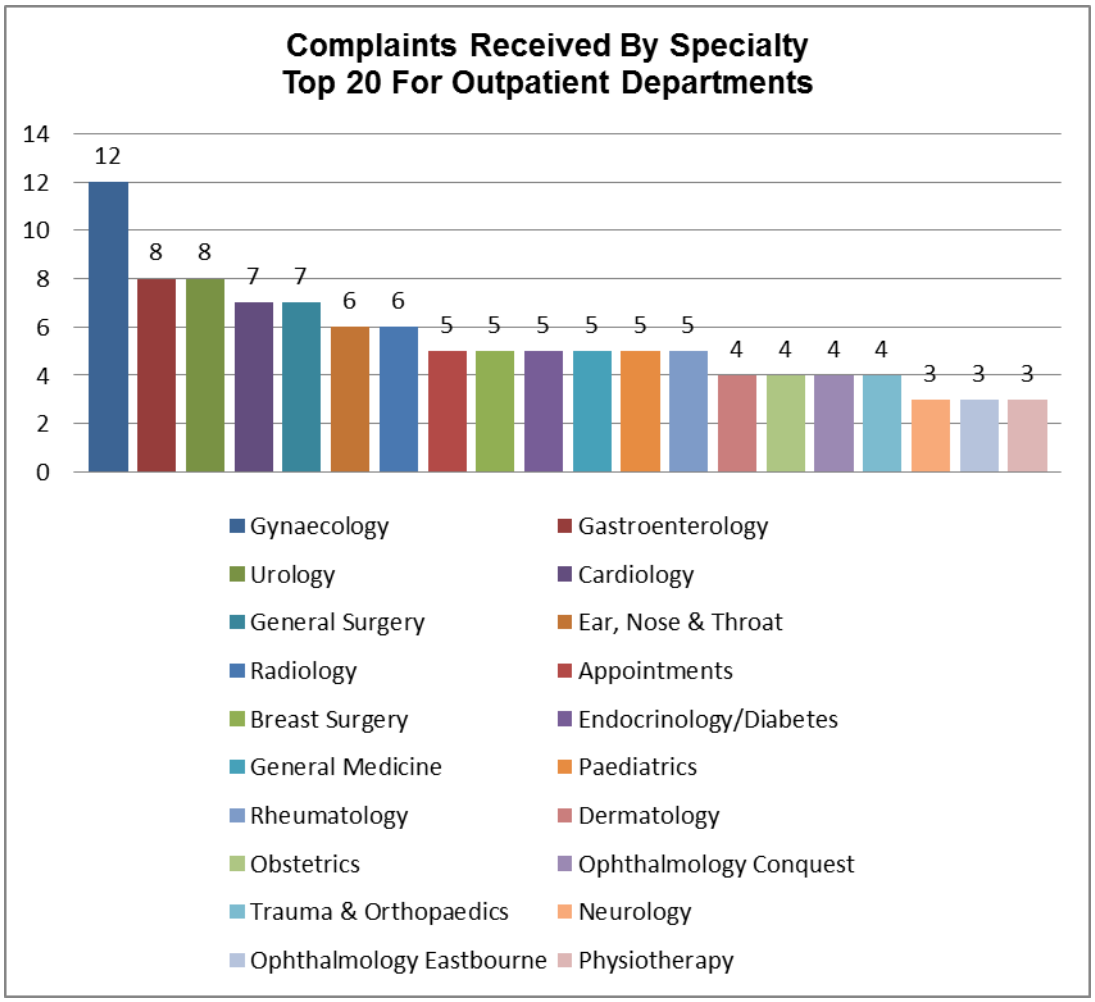
The remaining 53 specialties received between one and six complaints each.

Whilst Urgent Care received 72 complaints as a Clinical Division in 2017/18, the above chart shows the Emergency Department had 84 complaints as a specialty. This will be due to the fact that some complaints may have been assigned to another Clinical Division where the main or majority of complaint issues related, but that contained an element of dissatisfaction relating to the Emergency Department.

In terms of the primary subject for complaints recorded against the Emergency Department, the top three were:

1	Standard of Care	36
2	Communication	12
3	Attitude	10

Across the majority of the Clinical Divisions, there was a notable feature of Outpatient Departments appearing as a top three complaint location in 2017/18. The 137 complaints recorded against Outpatients were related to 40 different specialties, and the following chart represents the top 20.



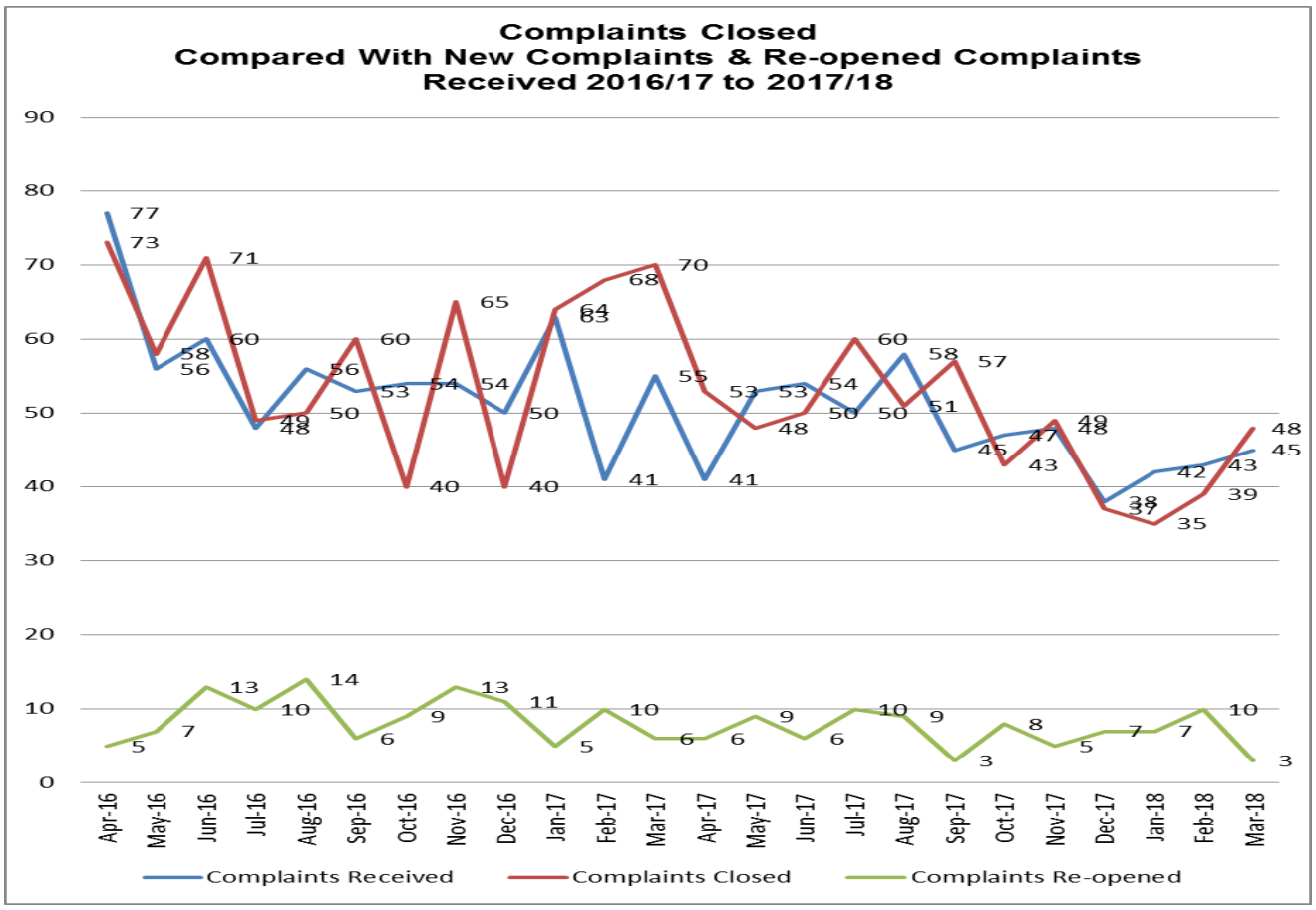
The remaining 20 specialties had either one or two complaints recorded.

In terms of the primary subject for complaints recorded against the Outpatient Departments, the top three were:

1	Patient Pathway	39
2	Communication	36
3	Standard of Care	35

2.4 Closed Complaints/Re-opened Complaints

In 2017/18, the Complaints Team sustained a high number of responses drafted, approved and closed to manage the number of new and re-opened complaints received. The following chart represents the performance of the Complaints Team, reviewing activity for 2016/17 with that for 2017/18.



In 2017/18, there was a reduction in the number of complaints re-opened. This was in part due to the review of the complaint handling process that was initiated towards the end of 2016/17, which involved the introduction of a more robust investigation escalation process, together with a more collaborative working relationship with staff in Clinical Division's to improve the quality of investigations and findings provided. There will always be a number of complaints where we are unable to meet the expectations of the complainant, and we ensure in these cases that they are correctly signposted to Advocacy Services or the Parliamentary and Health Service Ombudsman (PHSO) for consideration of further support and resolution. There are also a number of cases where following receipt of a written response, a complainant may wish to have a meeting to discuss the investigation findings or have an opportunity to speak to staff to gain greater clarity or closure on the matter; these file would account for part of the re-opened complaints statistics.

Whilst mindful of the significant clinical and operational pressures experienced by the Trust during 2017/18, the Complaints Team continues to experience difficulties and delays in the timely receipt and quality of complaint investigations required to allow them to draft a response for the Chief Executive to review and approve. In some cases, the delays and quality of complaint investigations have caused some responses to breach the published response times, or created the need for a complaint to be re-opened as a result of the Complaints Team being unable to secure a satisfactory investigation.

Given the Trust's commitment to learning from complaints raised, there is a noticeable disconnection between the Complaints Team and the ongoing monitoring and implementation of actions identified from complaint investigations. In 2018/19, the Complaints Team aim to place greater emphasis on trying to improve the quality of actions identified, and support the Clinical Divisions in monitoring and implementing these actions.

There will also be a programme of work during 2018/19 to look at reviewing actions that have been completed and establish, wherever possible, if these actions have prevented further complaints of a similar nature being raised.

Finally, and of some disappointment, receipt of and the process for investigating complaints continues to be viewed by Clinical Divisions in a negative light, rather than considering them as a helpful source of feedback to offer reflection and opportunity to improve the care and treatment we provide.

2.5 Complaint Outcomes

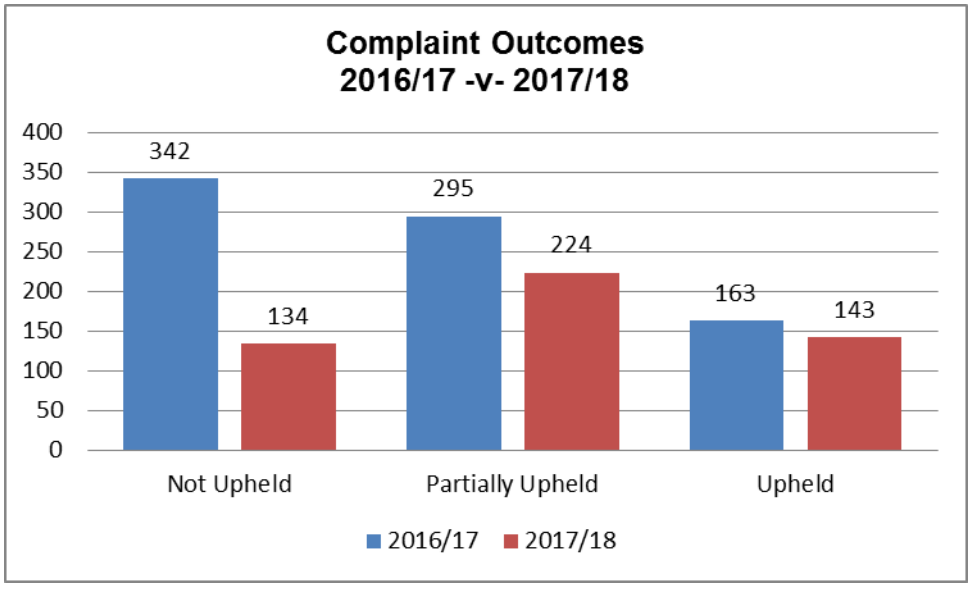
All complaints are welcomed and managed in the same way within the trust however it is useful to know where we could have improved our services. Once a complaint has been investigated and a response has been drafted the Complaints Team will, wherever possible with the relevant Clinical Division(s), assign an outcome code. The outcome codes for complaints are:

Fully Upheld:
Where the complaint investigation has identified multiple and/or significant failings in the provision of care that require an explanation, an apology (and/or condolence) and actions/learning.

Partially Upheld:
Where the complaint investigation has identified minor failings in the provision of care that require an explanation, apology and any actions/learning.

Not Upheld:
Where the complaint investigation has identified no failures in the provision of care.

The following chart represents the outcome of complaints received in 2017/18, with comparative data for 2016/17. The figures for February and March 2018 are low as not all of the complaints received in these months have been closed at the time of this report.



2.6 Local Resolution Meetings (LRM's)

In cases where it is considered to be of help to the complainant in place of a written response or where complainants request it to help them understand the written response

given to their complaint, LRM's have been offered. During 2017/18 the Complaints Team provided 69 LRM's, which may help to account for the small number of contacts received from the PHSO.

2.7 Learning from Complaints

In addition to the routine handling of complaints, the Trust is also committed to the implementation of learning arising from complaints to prevent, as far as it is possible to, any recurrence of the situation. The following are examples of learning embedded during 2017/18;

Podiatry
A complaint was raised with regards to the way patients were being discharged from the clinic. As a result of the complaint, the Podiatry Team now write to all patients they plan to discharge, and provide an explanation as to the reason for the discharge.

Intensive Therapy Unit (ITU) – Eastbourne DGH
A complaint was raised with regards to the communication between staff and relatives when a loved one was being settled on the unit (which could take up to two hours). As a result of the complaint, staff on the ITU have developed a pathway "tree" so that relatives can see at a glance how staff settle patients, what is involved and how long the process can take. They now also ensure relatives are met with and updated every 30 minutes.

Clinical Decisions Unit (CDU)
A complaint was raised with regards to the inability of patients to get to a telephone to call and speak to relatives and loved ones. As a result of the complaint, the CDU now has a portable telephone so that patients can make telephone calls from their bed.

Day Surgery Unit (DSU) – Litlington Ward
A complaint was raised with regards to the fact that patients were being asked to attend the SDU at 7.00am, but were often not seen until 1.00pm with no explanation as to what was happening. As a result of the complaint, the DSU now send a leaflet with the appointment letter to explain to patients there may be a wait between arrival and being seen, and staff deliver a speech to all patients about the process so they are aware of what is happening on the day.

Urgent Care
A complaint was raised with regards to the way in which staff treated a patient with learning disabilities. As a result of the complaint, Urgent Care staff have reviewed and updated their policy to ensure the pathway for patients with learning disabilities is clear, equitable and appropriate.

3. Parliamentary and Health Service Ombudsman (PHSO)

If a complainant is unhappy with the Trust's response(s) to their complaint, they have the right to take the matter to the PHSO if all local avenues of resolution have been exhausted. The PHSO are an independent body who will consider all referrals made to them; the PHSO may request copies of the Trust's complaint file and the patient's medical records to help them decide if they wish to undertake a further review or investigation of the matter. The Trust fully complies with all requests made by the PHSO, and appropriately acts upon decisions and direction give in any case.

In 2017/18, the Trust received 13 contacts from the PHSO. Of the contacts made in respect of investigations, four were to provide decisions/outcomes (one case upheld, two

cases partially upheld and one case not upheld); there are six cases awaiting investigation decisions/outcomes. This represents a reduction in the rate of contacts by 18.75% compared to the number of contacts received from the PHSO in 2016/17 (16).

In terms of the actions arising from the cases partially or fully upheld by the PHSO in 2017/18:

Fully Upheld:
The PHSO directed the Trust to provide the complainant with an apology within four weeks, and to develop two action plans within three months to address the failings they identified in respect of catheter insertion and complaint handling.

Partially Upheld:
In the first case, the PHSO felt the learning and actions identified by the Trust in the complaint response were an appropriate response to the failings they had identified, and gave no further direction. In the second case, the PHSO directed the Trust to provide the complainant with an apology within four weeks, and to consider the development of a policy for inter-specialty referrals.

4. Post-Complaint Survey

In September 2016, the Complaints Team launched an initiative to seek the feedback of individuals who had used the Trust's complaint process by sending them a 12 question survey approximately a month after they had been sent their complaint response. During 2017/18, this initiative continued and was enhanced with the option of allowing complainants to complete the survey online.

Since the inception of this initiative, 151 surveys have been completed either in part or in full, and 72 (48%) were submitted during 2017/18. Of the 72, 59 (82%) surveys were submitted in paper whilst disappointingly, only 13 (18%) were submitted online.

In terms of the three questions scoring the highest positive feedback (by combining all responses scoring questions with Strongly Agree or Agree), these were:

I was able to communicate my concerns in the way I wanted	74%
It was easy to find out how to make a complaint	64%
I was able to understand the response as everything was clearly explained, including names and terminology	60%

Conversely, the three questions scoring the highest negative feedback (by combining all responses scoring questions with Disagree or Strongly Disagree) were:

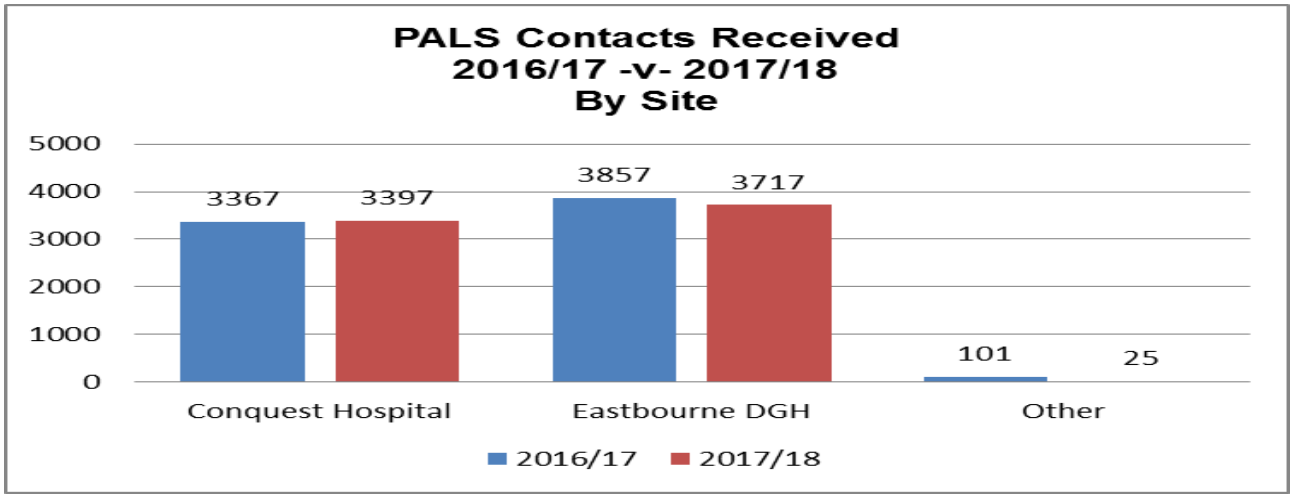
I felt the response answered all of the concerns I had raised	58%
I felt assured that the Trust would learn from my experience	52%
I felt the Trust understood my concerns and what I wanted from raising a complaint	46%

The Complaints Team have already undertaken a piece of work to improve key negative feedback areas, and will continue to do so during 2018/19.

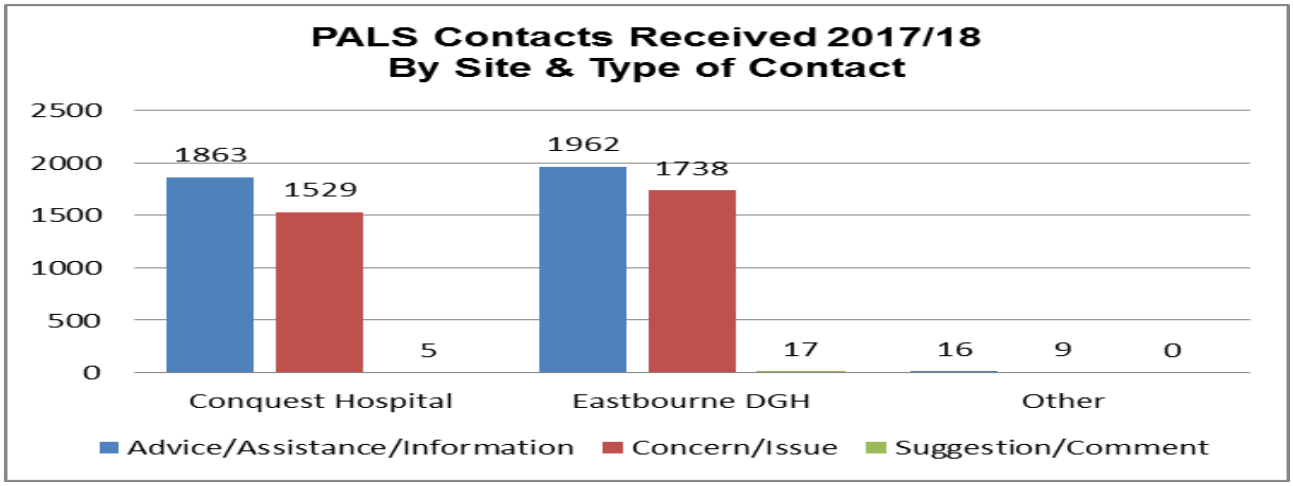
5. Patient Advice and Liaison Service (PALS)

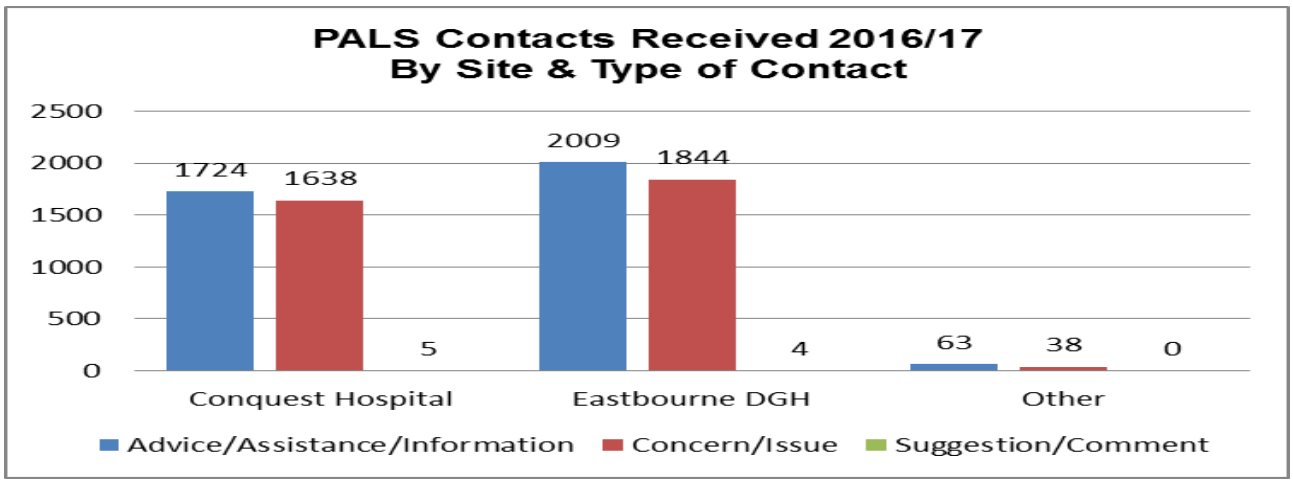
PALS provide a vital role for the Trust in supporting and assisting patients, their relatives and members of the public with general advice, questions, and concerns that can be handled quickly and locally without the need for a formal resolution approach. There is a PALS office based in, or very close to, the main reception areas at both Conquest Hospital and Eastbourne District General Hospital (DGH). These small teams are a regular source of advice to everyone accessing them, and often prevent concerns from needing to become a formal complaint by working with Clinical Divisions to deliver the best outcome as close as possible to the source.

The following chart represents all PALS contacts received over the last two years.

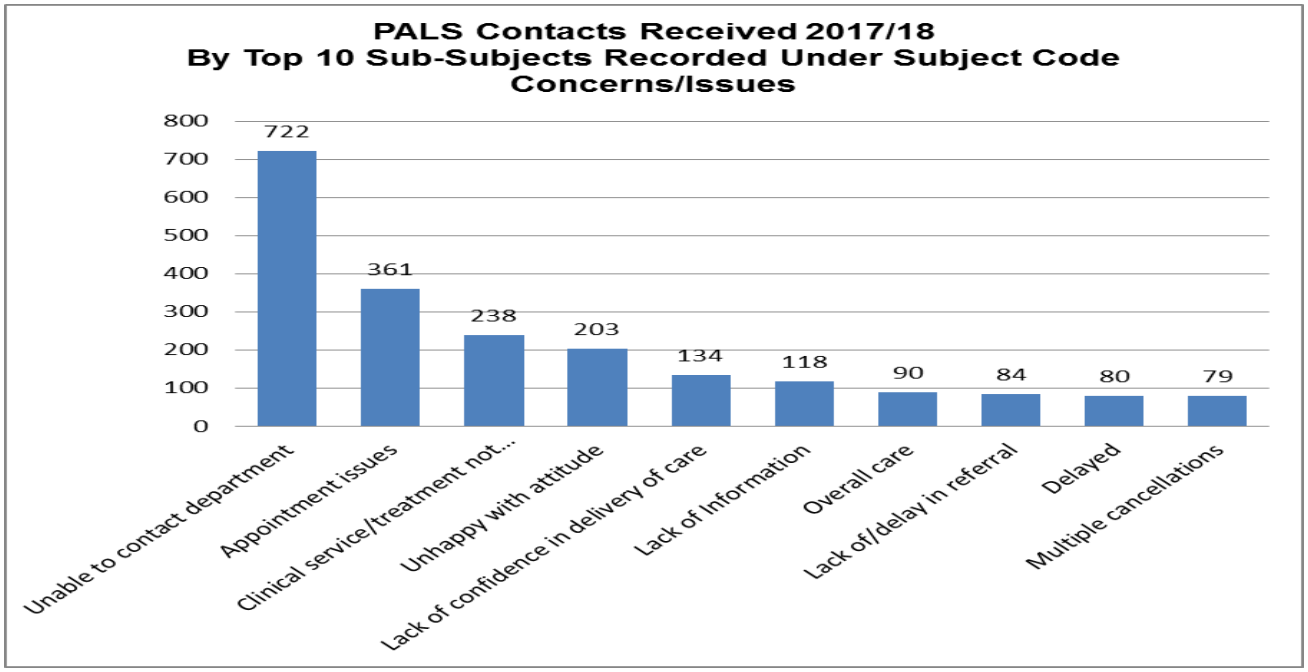


PALS record their activity to cover a wide range of data parameters and the following charts represent PALS activity for 2017/18, with data from 2016/17 for comparative purposes under four key areas.



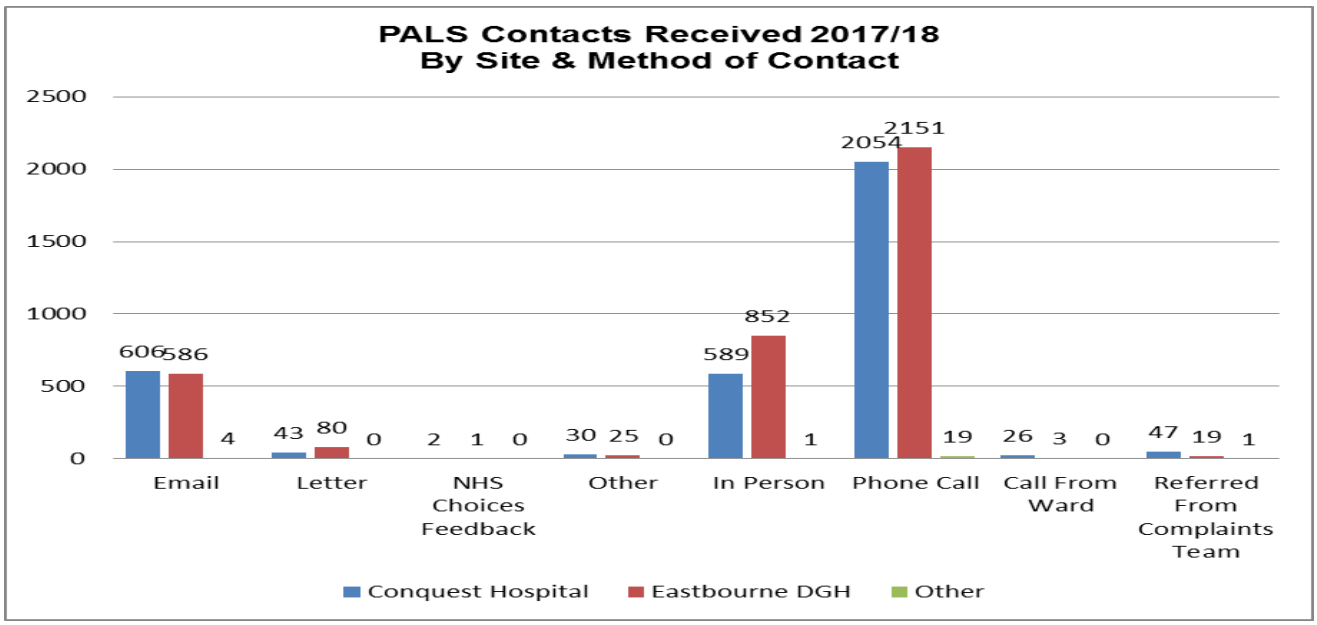


Whilst not the highest recorded type of contact, Concerns/Issues are a significant reason for people to contact PALS and account for a two year average of around 47% of all contacts made with PALS. The following chart represents the top 10 sub-subject's recorded for PALS contacts in 2017/18.

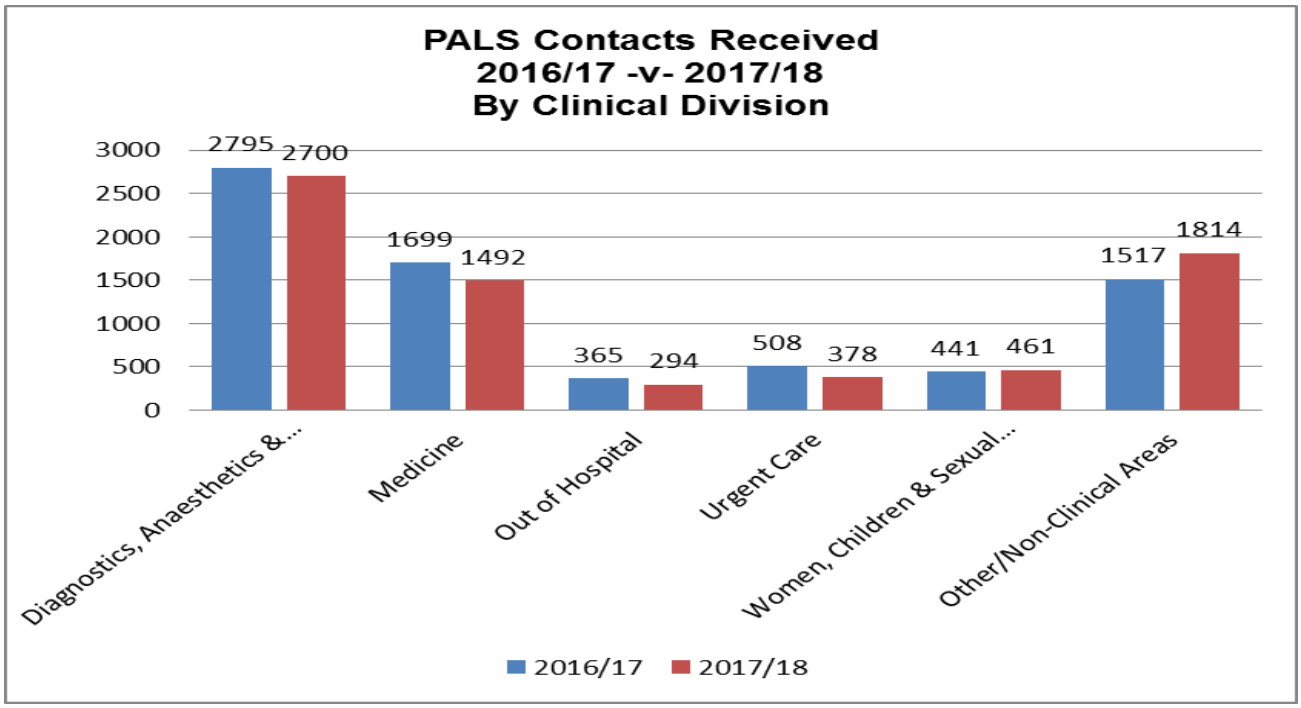


The top 10 sub-subjects are, in the main apart from multiple cancellations, the same as 2016/17 and whilst it is encouraging to see the number of contacts about patients or their relatives not being able to contact the department has dropped by 21%, the figure is still too high. However, the Trust is embarking a significant project to update the existing telephone systems and over time, this should have a positive impact on the ability of patients and their relatives to contact the department they want with more ease.

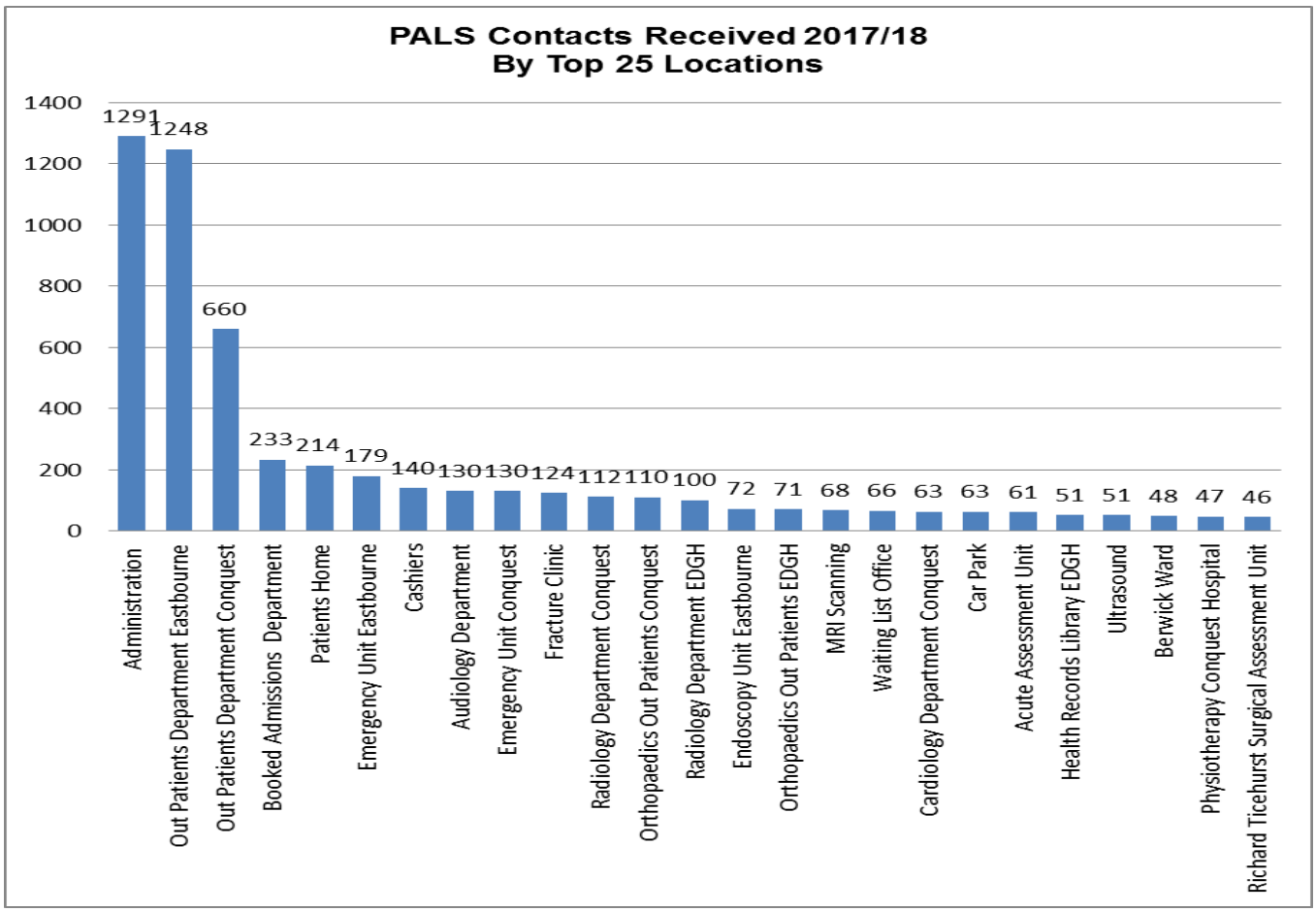
The following chart represents PALS activity by the site the contact raised relates to, and the way (method) in which the contact was made.



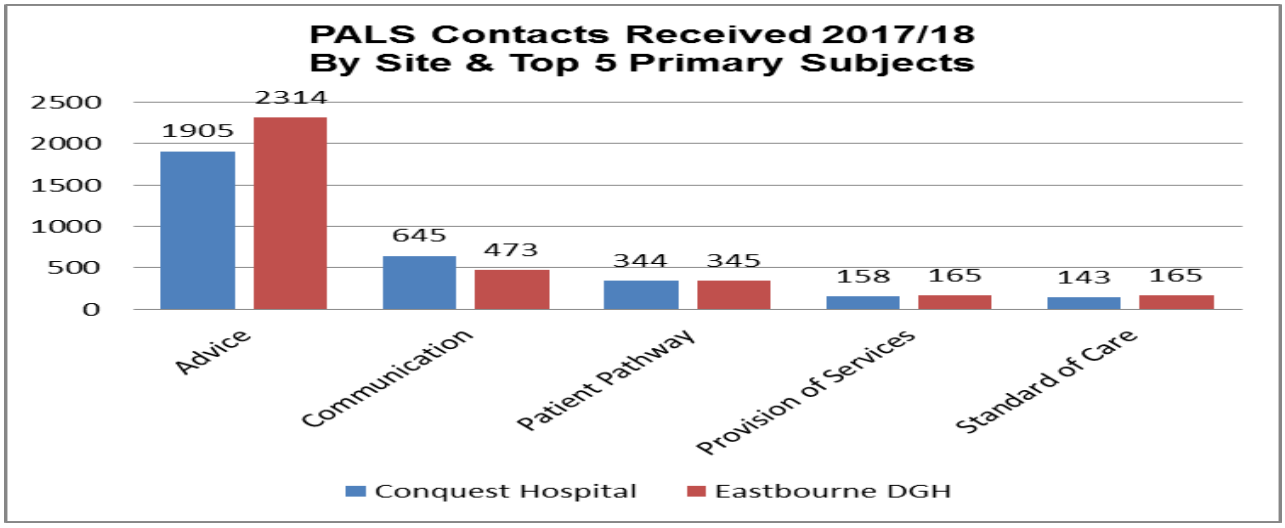
The following chart represents PALS activity by the Clinical Division the contact raised relates to over the last two years.



During 2017/18, PALS contacts were attributed to 233 different locations. The following chart represents the top 25 locations.

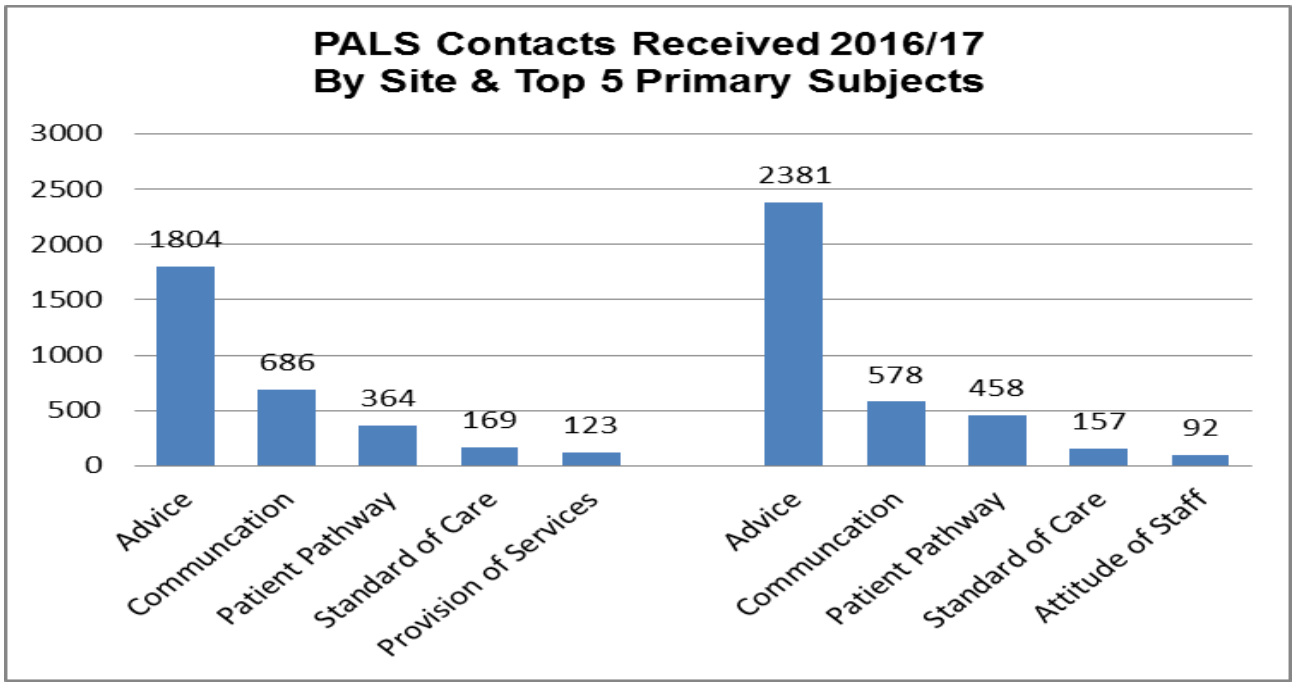


The following chart represents PALS activity by the top five primary subjects recorded for contacts by the site the contact raised relates to. The sequence of the top five primary subjects for both main hospital sites is identical; the number of primary subjects for other sites equates to just 25 (16 were recorded against Advice), and have therefore been excluded from the chart.



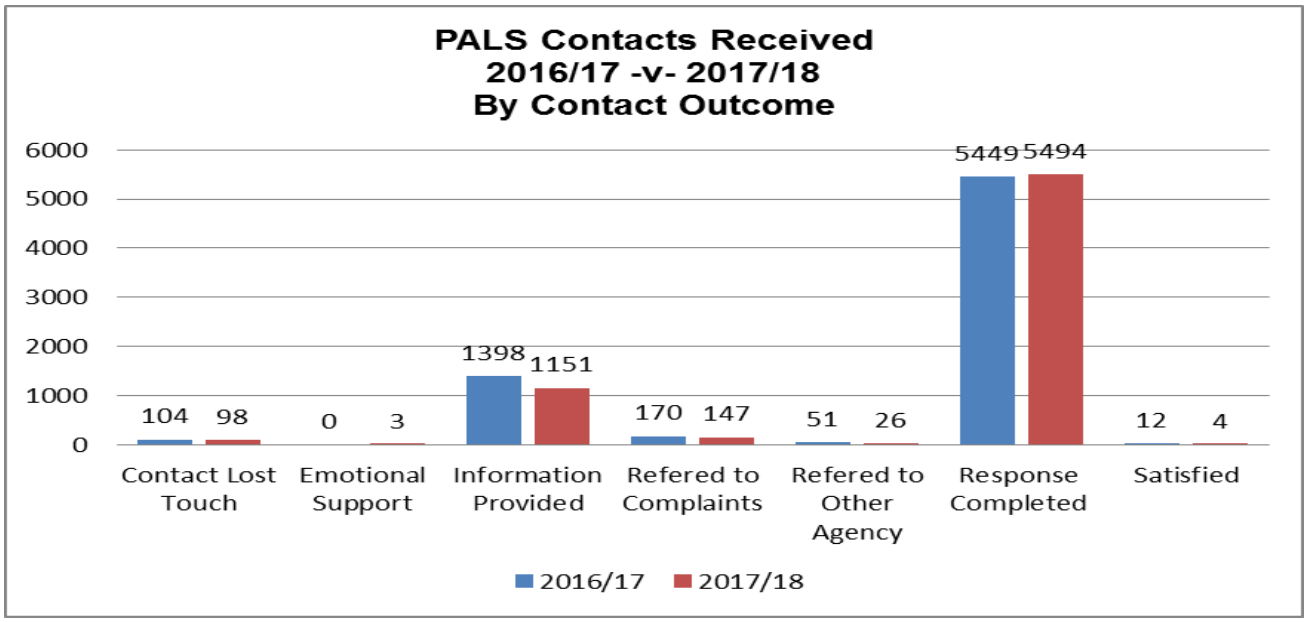
In 2016/17, there was a slight variation on the top five primary subjects recorded for contacts between the main hospital sites. In the chart below, the figures to the left represent Conquest Hospital, whilst those to the right represent Eastbourne DGH. As before, the number of primary subjects for other sites account for a very small proportion

of contacts; out of 101 contacts, 73 were recorded as Advice and have therefore been excluded from the chart.



A key objective for PALS is to address or resolve as many contacts as possible through liaison with Clinical Divisions and Corporate Teams within 72 working hours. In 2017/18, PALS closed 86% of all contacts within this target which is a significant achievement given the size of the team, the number of contacts made (7,139) and the complexity of some of the issues they handle.

The following charts represent PALS activity by the outcome of contacts recorded in 2017/18, with data from 2016/17 for comparative purposes.



6. Closing Statement

2017/18 has been another busy, challenging year for both the Complaints Team and for PALS however, they have been consistent in their commitment and sustained high levels of activity and productivity despite the Trust experiencing a backdrop of service changes and regular episodes of operational and clinical pressures. Of particular success, the Complaints Team not only reduced the number of overdue complaints to zero, but have sustained that position at the end of each month, whilst of the 7,139 contacts received by PALS, 86% of these were responded to in just three working days.

In addition to the 2018/19 objectives set out in the Executive Summary at the start of this report, there are also plans in place to review and refresh all aspects of the complaints handling process to maintain and build on the successes of 2017/18, explore the possibility of developing an online complaint form to help simplify the process for patients and relatives wishing to make an online complaint, introduce a PALS Satisfaction Survey and trial an extension of PALS opening hours within current budgets.

Receiving, investigating and learning from complaints is crucial to the Trust as part of its improvement journey and goal to be outstanding by 2020. The ability and capacity for Clinical Divisions to learn and act on the findings will be closely monitored during 2018/19, with regular tracking of overdue actions highlighted within Integrated Performance Reviews and the Complaints Team reviewing completed actions to ensure they are embedded in practice.