EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 2nd October 2018, commencing at 09:30 in Oak Room, Hastings Centre

	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 7th August 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 5 (August) 1. Quality and Safety 2. Access and Delivery 3. Activity 4. Leadership and Culture 5. Finance 6. Sustainability	Assurance	G	DN/MD COO HRD	1015 - 1115
10	Elective Performance Assurance Submissions to NHSI	Assurance	H	COO	
11	Learning From Deaths (Quarter 4)	Assurance	I	MD	

BREAK

STRATEGY

					Time:
12	3+2 and FRP	Assurance	J	DS	1130 - 1145

GOVERNANCE AND ASSURANCE

					Time:
13	Winter Preparedness	Assurance	K	COO	1145 - 1215
14	EPRR	Assurance	L	COO	
15	Winter Flu Self-Assessment	Assurance	M	HRD	
16	Annual Reports: • Infection Control • Safeguarding	Assurance	N	Various	
17	Board Sub Committee Minutes	Assurance	O		

ITEMS FOR INFORMATION

				Time:
18	Use of Trust Seal	P	Chair	1215 - 1230
19	Questions from members of the public (15 minutes maximum)		Chair	
20	Date of Next Meeting: Tuesday 4th December 2018, St Mary's Boardroom, EDGH		Chair	

David Clayton-Smith

Chairman

5th September 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, 7th August 2018 at 09:30 in the Hydro Hotel, Eastbourne.

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 Catherine Ashton, Director of Strategy
Ms Vikki Carruth, Director of Nursing
Mrs Joe Chadwick-Bell, Chief Operating Officer
Ms Monica Green, Director of Human Resources
Mrs Lynette Wells, Director of Corporate Affairs

In attendance:
Miss Jan Humber, Joint Staff Committee Chairman
Dr James Wilkinson, Assistant Medical Director
Miss Saba Sadiq, Deputy Director of Finance
Mrs Angela Ambler, NHSI Next NED Programme (observing)
Mr Pete Palmer, Assistant Company Secretary (minutes)

061/2018 **Welcome**

1. Chair's Opening Remarks

Mr Clayton-Smith welcomed everyone to the meeting of the Trust Board held in public. He noted that a concerted effort had been made to reduce the volume of papers for Board meetings, and that full copies of the annual reports presented at the meeting were available as an appendix to the Board papers.

It was noted that this was the last meeting of Mrs Bernhauser and Mr Clayton-Smith thanked her for her significant and valuable contribution to the Board during her term of office.

2. Apologies for Absence

Mr Clayton-Smith reported that apologies for absence had been received from:

Mr Mark Friedman, Director of Recovery
Mr Jonathan Reid, Director of Finance with Miss Sadiq attending on his behalf.
Dr David Walker, Medical Director with Dr Wilkinson attending on his behalf.
Mr Christopher Langley, System Improvement Director, NHSI

3. Monthly Award Winners

Mr Clayton-Smith reported that the monthly award winner for May had been Tracey Dougan, matron of Hailsham 3 and the Michelham Unit at EDGH.

There had been two winners in June; Dr Hiten Patel, Chief Registrar and

Cardiology Registrar and Giti Mukherjee, Hospital Intervention Team Lead, Conquest.

062/2018 **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.

063/2018 **Minutes**

The minutes of the Trust Board meeting held on 5th June 2018 were considered. Two amendments were noted, and the minutes were otherwise agreed as an accurate account of the discussions held. The minutes were signed by the Chairman and would be lodged in the Register of Minutes.

064/2018 **Matters Arising**

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

Mrs Chadwick-Bell reported that re-admission rates for the crisis response team had been confirmed as being significantly higher than expected. An audit would be undertaken and plans would be developed to address the issue. She agreed to provide feedback to the Board once the audit had been completed.

049/2018 – IPR Month 1 - Leadership & Culture

Miss Green confirmed that the Trust's establishment had increased at the start of the Year. Miss Sadiq explained that workforce budgets had been set in conjunction with divisions using recognised staffing calculations.

051/2018 – Quality Improvement Priorities 2018/19

Ms Carruth reported that she had met with Mrs Churchward-Cardiff and Mrs Bernhauser and that the final Quality Improvement Priorities for 2018/19 had been agreed.

065/2018 **Quality Walks**

Mr Clayton-Smith noted that seventeen quality walks had been undertaken during May and June. He reported that he had recently visited the Ambulatory Care Unit (ACU) in EDGH where he had spoken to patients who had praised the treatment they were receiving on the unit. ACU's matron had spoken positively about the support she received from medical colleagues. Mrs Chadwick-Bell reported that work was being undertaken to extend opening times for the ACU into evenings and weekends. A review of patient pathways through the ACU was being undertaken to ensure that they were as efficient as possible.

Mr Clayton-Smith reported that he had also visited the podiatry service. The Trust remained an outlier for diabetic amputations, and the service had outlined a new pathway that had been developed to address the issue. The service would be working in conjunction with GPs, and considerable improvements had already been realised. Dr Bull noted that a new walk-in centre had been opened that week to help further address the issue.

066/2018 **Board Committees' Feedback**

1. Audit Committee

Mr Stevens explained that the Audit Committee sought assurance on both financial and clinical audit within the organisation. Over the last year the Committee had monitored the hard work to reduce the number of clinical audits

that were being undertaken by the Trust, as previously a large number of incomplete audits had been reported, often as a result of junior staff leaving the Trust. This situation had greatly improved and he reported that he had recently been asked to judge the annual clinical audit awards and had been very impressed by the quality of clinical audits being undertaken within the Trust.

Dr Wilkinson explained that a robust decision process had been introduced to assess which audits should be approved, and support was offered for junior doctors to undertake quality improvement and national audits. Dr Bull added that the Trust continued to strengthen governance and accountability for audit programs, and that would be an important factor in the Trust's goal of becoming Outstanding by 2020.

Mr Clayton-Smith asked how assured Mr Stevens was that a whole health economy approach would be taken to cybersecurity. Mr Stevens explained that while it was impossible for the organisation to be wholly secure, he was assured that the Trust did not have unsupported, readily accessible programs. He noted his confidence in the approach being taken by the Trust and within the STP. Dr Bull reported that an STP cybersecurity group had been formed, attended by the Trust. It was agreed that an update on cybersecurity would be presented to the Board at November's seminar. **JR**

2. Finance and Investment Committee

Mr Nealon reported that the annual review of the Finance & Investment (F&I) Committee and updated Terms of Reference were presented for the Board's approval.

He explained that since the start of the financial year, the F&I Committee had sought assurances about the areas of savings that had been identified by the Trust. A key aspect in meeting financial targets for 2018/19 would be in converting identified savings opportunities into results and Mark Friedman had joined the Trust as Recovery Director in order to assist with this process.

Mr Nealon reported that Cost Improvement Programs (CIPs) totalling £16.1m had been identified against a target of £23m, with work continuing to identify further deliverable CIPs. He was pleased that the Trust had met its financial targets for the first three months of the year.

He explained that the F&I Committee would continue to seek assurance that the quality of care delivered by the Trust was not affected by financial plans. The Committee would be scrutinising the Trust's long term "3 year plus 2" strategy. The strategy looked at sustainability, prioritising grip, control and productivity in the short term in order to exit financial special measures, as well as longer term strategic initiatives to ensure that the Trust was sustainable for the future and able to manage the demands of an aging population

Mrs Kavanagh asked whether Mr Nealon was assured that sufficient urgency and leadership had been applied by the Trust to the reduction of the deficit. Mr Nealon explained that he was fully assured about the focus being given to reaching financial sustainability, explaining that a significant amount of work was taking place to enable the Trust to meet the financial challenge.

Dr Bull explained that improving the financial position of the Trust was as high a priority for the organisation as quality, safety and staff. He reported that a dedicated program support office had been introduced, focussed entirely on delivering financial savings.

The Board approved the updated Finance and Investment Committee Terms of Reference.

3. People and Organisational Development Committee

Mrs Kavanagh reported that the People and Organisational Development (POD) Committee had discussed recent improvements in medical engagement. Plans had been developed to address concerns identified in a few areas, but the overall picture within the Trust was greatly improved. More doctors were applying for positions within the organisation as a result of its improving reputation. A recent increase in the turnover rate amongst Allied Healthcare Professionals would be discussed by the Committee in September.

4. Quality and Safety Committee

Mrs Bernhauser noted that the Quality and Safety (Q&S) Committee had met once since the previous meeting. She explained that two previous sets of minutes were included within the Board papers for approval. At the last meeting the Committee had received an overview of the work of the "After Trauma" team and how feedback was used to enhance the patient pathway. The Committee also reviewed the cancer recovery programme plans and there was a thematic deep dive into complaints and pressure ulcers.

The Board noted the Committee Reports.

067/2018 **Board Assurance Framework**

Mrs Wells reported that the proposals presented within her paper had been discussed and approved by both the Audit Committee and Quality and Safety Committee. She proposed that, following the publication of the CQC reports and the Trust's removal from special measures for quality, the assurance level for risk 1.1.1 should be changed from amber to green. She noted that risk 3.3.1 should have been rated as amber, with the rating having been omitted from the Board Assurance Framework.

Mr Clayton-Smith asked about risk 2.1.2, concerning young people being admitted to medical wards with mental health issues. Mrs Wells explained that the matter had been discussed by the Q&S Committee in July, where it had been agreed that the issue should be raised with Sussex Partnership Trust. Dr Bull confirmed that discussions about the issue had taken place within Divisional reviews and that Sussex Partnership Trust had made additional resources available to address the issue. The CCG were aware of the issue. Mrs Chadwick-Bell noted that resolution of the issue was outside of the control of the Trust and suggested that amending the wording of the risk should be discussed at the next meeting of the Q&S Committee.

Mr Nealon asked whether the Trust had considered stockpiling medicines prior to Brexit. Dr Bull explained that the Trust had not considered this as individual NHS organisations stockpiling could cause problems throughout the NHS. He noted that the Chief Pharmacist would be presenting an update on the Trust's plan to the F&I Committee in September.

Mrs Kavanagh asked whether risk 2.2 concerning lack of leadership capability should make explicit reference to finance due to the Trust being in Financial Special Measures. Dr Bull responded that he didn't feel that this was necessary as during the recent CQC inspections the Trust had been assessed as good for Well Led, with use of resources considered during the inspection. There was also monitoring and challenge by NHS Improvement to test the

Trust's plans.

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.

068/2018 **Chief Executive's Report**

Dr Bull reported that mortality within the Trust had improved significantly during the last three years due to work led by Dr Walker, Dr Wilkinson and other clinicians. The Trust's latest Summary Hospital-level Mortality Indicator (SHMI) was 104, the lowest for at least 10 years. A number of factors had contributed to this success including better treatment of sepsis, and improved capture and reporting of patient complications.

Improved organisational operational performance had led to regular performance of over 90% against the four hour A&E target, putting the Trust in the top 20 nationally. Length of Stay for non-elective patients had reduced from six to four days. These improvements had led to the development of plans to reduce the number of beds within the Trust by 74, out of a total of 650 beds, with additional capacity available during busy periods. However, the recent heatwave had resulted in increased levels of demand normally only seen in the winter, and some plans to reduce beds had been deferred as a result.

Dr Bull reported that the Trust had developed ambitious financial plans to reduce its financial deficit. Mr Friedman's appointment would help with this ambition and the Trust continued to be supported by Christopher Langley and NHSI. Mr Friedman had significant previous experience in helping organisations to meet financial challenges.

The recent Trust annual awards had seen over 300 nominations for staff. 200 members of staff had attended the event, which had been supported by a significant number of sponsors.

069/2018 **QUALITY, SAFETY AND PERFORMANCE**

Integrated Performance Report Month 3 (June)

Access and Responsiveness

Mrs Chadwick-Bell reported that system wide performance against the 4 hour A&E standard for June had been 96.75%, which included performance at walk in centres in Hastings and Eastbourne. Trust performance had been 95.7%, an increase of 7% on the same time in 2017. The organisation was maintaining its position in the top quartile of Trusts and was regularly in the top 20 for four hour performance. Work was being undertaken with the CCG to better understand continued increases in attendances and admissions, with a focus on improving length of stay and stranded and super-stranded patient performance.

Mrs Chadwick-Bell thanked staff for their support during the recent heatwave, when they had maintained quality, safety and performance in very difficult conditions.

The Trust would be focussing on musculoskeletal (MSK) services and the Community front door, services aimed at both keeping patients out of hospital and on ensuring that patients who did attend hospital were correctly treated if they didn't require admission. Attention would also be given to frailty, as the

Trust had the fourth oldest population demographic in the country. An eleven week program of rapid improvement would be undertaken, including a focus on treatment within the first 72 hours after admission.

18 week Referral To Treatment performance remained at around 90% for the Trust, with an ambition to get to 92%. The Trust's waiting list had slightly increased, and Mrs Chadwick-Bell anticipated that this would reduce again in the autumn once staff and patients returned from annual leave.

Diagnostic performance had been 1.4%, although waits for CTs had increased due to capacity issues and equipment failure. A new CT scanner was due to be installed, which should lead to improved performance, and a new manager of radiology services would be joining the Trust, focussing on further improvements.

Mrs Chadwick-Bell reported that the Trust continued to meet two week cancer targets. A 7.2% increase in cancer referrals had been seen across the Trust including a 12% increase in gynaecology referrals, a 30% increase in breast referrals and a 32% increase in colorectal referrals. These increases were impacting patient pathways and reviews of capacity and demand by speciality would be undertaken.

Mr Nealon asked about the impact on patients of missing the 62 day cancer targets. Mrs Chadwick-Bell explained that a full Root Cause Analysis was undertaken for every patient who missed the 62 day target. Any patient who waited for over 104 days was discussed with the CCG, and the case reviewed by Consultants to ascertain if any harm had resulted. No harm as a result of lengthened treatment times had been identified. Dr Walker would be asked to review any patients waiting over 104 days in the future to provide additional assurance.

Cancer pathways were being redesigned to minimise any avoidable delays. Some missed appointments were inevitable as a result of patients not attending or not accepting appointments. Pathways were often very complex, with patients attending appointments in Brighton and London leading to delays which were outside of the control of the Trust.

Dr Bull reported that the Trust had been challenged by the CCG over levels of non-elective referrals during month one. The disputed amount was around £1million which posed a significant risk to the Trust's financial plans. He explained that the Trust was confident that there was an appropriate clinical explanation for the increased activity.

<u>Quality & Safety</u>
Ms Carruth reported that a slight increase in falls had been seen recently and that an in-depth review would be undertaken to look at the reasons for this. She noted that numbers of falls naturally fluctuated during the year.

She reported that the Trust had seen a 29% reduction in e-coli infections from 2017/18. 12 c-diff cases had been reported against a target of 10 for 2018/19, with no lapses of care having contributed to these infections. A significant reduction in pressure ulcers had been seen.

Patient feedback about the Trust continued to be largely positive. No responses to complaints were overdue and three historic complaints had been submitted to the Ombudsman with no concerns raised as a result.

Dr Wilkinson reported that mortality performance continued to be good with the SHMI at 104 having been 115 in 2016. Risk adjusted mortality indicators (RAMI) was 78 compared to 89 the previous year. Learning from deaths and completing mortality reviews within set timescales continued to be an area of challenge but improvements were being seen. A change to the way in which deaths were reviewed was being considered and it was hoped that this would realise further improvement.

Mr Clayton-Smith asked how learning from reviews of deaths was shared within the organisation. Dr Wilkinson explained that teams discussed deaths locally, and raised any areas of concern within speciality Mortality and Morbidity (M&M) meetings. Learning and conclusions from these were fed back to divisional teams and actions shared across all divisions. The information was centrally collected with learning and themes discussed by the mortality review group and then fed up to the clinical outcomes group and Q&S Committee. Reviews of mortality statistics and themes provided evidence of whether interventions were effective and actions arising from mortality reviews were recorded in database, and tracked to ensure that they were completed.

Mrs Churchward-Cardiff noted that while the number of falls had reduced, a proportionate rise in those rated as causing moderate harm had been seen, asking if this was a result of the introduction of the new falls assessment. Ms Carruth explained that the new assessment was very different to what had previously been in place and that some areas were struggling to undertake it. Support was being offered to matrons to manage what was a big change. Work would be undertaken to look at very high risk patients, who were most likely to fall in their first 72 hours in hospital.

Activity

Mrs Chadwick-Bell reported that day case activity was slightly under plan for the year to date. Capacity constraints had affected performance in ophthalmology and dermatology and the services were addressing these issues. Trauma and Orthopaedics was also under plan due to a considerable reduction in demand for some orthopaedic services, and work was being undertaken to understand this.

Elective activity was also under plan. Referrals for outpatient appointments were down for the year, but numbers of follow-up appointments had increased. Work was being undertaken to ensure that follow up appointments took place in a timely fashion, with ratios of new to follow up appointments to be reduced in some specialities.

Mr Clayton-Smith asked whether adjustments would be made to the anticipated levels of activity for the year. Mrs Chadwick-Bell explained that she anticipated that activity would move back to plan as the year progressed for all specialities with the exception of orthopaedics.

Mrs Churchward-Cardiff asked whether reported MSK waiting times included the integrated MSK service. Mrs Chadwick-Bell was unsure, noting that both specialities had issues with waiting times. She agreed to confirm this at the next Board meeting. **JCB**

Mrs Churchward-Cardiff asked whether the Trust had been awarded a new contract for the provision of paediatric audiology. Dr Bull explained that while the Trust had not received an explicit contract, it had continued to provide the

service so as not to effect patient care. The CCG had agreed that the service would form part of a rebasing.

Leadership & Culture

Miss Green reported that the total number of substantive staff employed by staff had slightly increased in June, with a slight reduction in non-substantive staff. The use of agency and bank staff had led to increased costs, particularly in some medical specialities where recruitment was challenging. Fill rate had remained stable within the month, and she was encouraged to see a reduction in Allied Health Professional vacancies from 16.2% to 12.8%. Turnover rates had remained stable across the Trust.

Monthly sickness had reduced slightly since May, and was substantially reduced in comparison to 2016. Miss Green explained that the Trust's proactive approach to looking after the health and wellbeing of staff was having a positive impact.

A review of staff who had undergone an appraisal during the previous 16 months had been undertaken, demonstrating that over 90% had been appraised. Mandatory and statutory training rates remains stable. 2018's staff survey was due to launch in September, and the Leading Excellence Service and Management programme for leaders continued. August's handover of junior doctors had been very successful.

Mrs Churchward-Cardiff asked for clarification about the long term sickness figures contained within the IPR. Miss Green explained that 54% of staff sickness within the organisation was long term. Staff with chronic health conditions were supported through occupational health and the Trust had a strict absence policy.

Mr Nealon asked what impact would be felt by the redeployment of staff as a result of ward changes. Miss Green explained that no staff would be made redundant as a result of the changes with all being redeployed into other areas. This would lead to reduced use of bank staff, with very few agency nursing staff being used already. Ms Carruth noted that over 90% of the effected staff within the nursing division had been placed in their first choice area for redeployment.

Finance

Miss Sadiq reported on month 3 performance, explaining that the Trust remained slightly ahead of plan by £19k. Income was on plan, but behind plan on agency and pay budgets. Payments for Waiting List Initiatives had reduced in comparison to the previous year and grip and control of agency and bank usage had strengthened.

£19.2 million of Cost Improvement Programmes (CIPs) had been identified, with delivery of £2.7 million of savings against a plan of £3.1 million in month three. It was anticipated that bed remodelling assumptions, reductions in temporary staffing and reduced costs associated with endoscopy scopes would realise additional savings from 1st June. Dr Bull note that reductions to costs associated with temporary workforce had not yet been attributed as CIPs.

Mrs Kavanagh commented on the large adverse variance in pay, and asked when this would be addressed. Miss Sadiq explained that Mr Friedman would be undertaking a review of pay variances and presenting a report to the F&I Committee in August. Dr Bull explained that costs associated with locums were a key area of focus, and that the fill rate for medical appointments had reduced

from 14% to 4%. However, some areas of serious concern remained, including haematology, histopathology, dermatology and orthodontics. Where possible locums were appointed in the short term to reduce costs. An electronic system for advertising locum posts to all doctors in the South East had been piloted by anaesthetics.

Mr Clayton-Smith asked what proportion of staff costs were a result of special nursing requirements. Ms Carruth explained that costs varied, with some areas, such as those with frail patients, having a greater requirement than others. Requests for special nursing were not always made appropriately and work was being undertaken with ward staff to improve this.

Sustainability

Ms Ashton reported that the Board had discussed the development of a long term financial and strategic plan at the previous month's seminar. This would be developed without compromising the quality and safety of the organisation, and would be presented to the Board for the approval in September prior to being submitted to NHSI.

The Board noted the IPR for Month 3.

070/2018 **ESHT 2020**

Ms Ashton explained that ESHT 2020 was the Trust's overarching strategic document setting out the Trust's values and the ambition of the organisation to be outstanding by 2020. The document was revisited, refreshed and recommitted to every year and was used both internally and externally as a reference document. It was referenced in staff appraisals and in service development and everything the Trust did was linked to the ambition to be outstanding by 2020. The recent CQC inspection had provided assurance that the Trust was heading in the correct direction. Ms Ashton explained that the document and its ambition were now recognised throughout the Trust.

Mr Clayton-Smith asked how the Board would receive assurance about progress being made in meeting the targets set out in the document. Ms Ashton noted that that all of the metrics were already measured and reported to the Board or its Committees. She agreed to present a regular focussed update to the Board.

Mrs Chadwick-Bell asked how the revised document would be promoted, as it was important that staff knew about the refresh. Ms Ashton explained that communications would be circulated to all staff promoting the changes. A small pamphlet would be produced summarising the document, and the updates. Miss Green added that the document was discussed during Trust induction for new staff and during management and leadership courses.

Mrs Churchward-Cardiff asked whether some of the metrics included within ESHT 2020 were ambitious enough, as they were below levels already being achieved by the Trust. Dr Bull explained that the Trust had been directed not to over-perform due to the potential cost implications of doing so.

Mrs Bernhauser explained that she could remember a time when the Board met and had aspired to be better than neighbouring trusts. She was proud of the aspiration to be outstanding and explained that the Board, the staff and the Trust had come a very long way in a short time. She felt that it was much better to fall just short of being outstanding than to be mediocre.

071/2018 **ESBT Alliance Agreement**

Mrs Wells explained that the Alliance test bed year had ended in March 2018, and that the Alliance had been extended to March 2019. The approval of the Board was being sought to further extend the Alliance to March 2020, an extension which had been included within the framework of the agreement. A review of governance arrangements was being undertaken, and changes to commissioning processes would be reflected. She explained that a large number of small amendments were likely to be made to the agreement, and asked the Board to delegate authority to Dr Bull to agree the minor amendments. Mrs Wells explained that any large changes that were proposed would be bought before the Board for approval, and that she would prepare a high level briefing for the Board once the agreement had been finalised.

Mr Clayton-Smith noted that he felt that the Alliance agreement was essential. Working broadly across the health economy would provide a route for success and sustainability for the Trust. He explained the importance of the Trust demonstrating its commitment to the Alliance, noting that the additional year would allow the development of governance and management arrangements that would ensure that the Alliance worked in the most productive way possible.

Mrs Kavanagh noted her disappointment that Mr Langley's new role in overseeing system-wide financial improvements had not ended contractual disputes between the Trust and the CCG. Dr Bull noted that the first system wide financial improvement meeting had not taken place. He noted that statutorily the different organisations remained responsible for their own finances, and there were a defined set of processes which had to be undertaken if there was a dispute. He hoped that the Trust and CCG could resolve the issue amicably.

Board approved delegated authority to Dr Bull to undertake the detail of alliance agreement. Fundamental changes would come back to Board for approval.

072/2018 **Medical and Nursing Revalidation**

Ms Carruth reported that the Trust had an excellent system in place for managing revalidation, with processes that were well embedded within the Trust. Dr Wilkinson reported that the Trust was 100% compliant for revalidation, and thanked the revalidation team for the work that they did to support staff.

The Board received the Medical and Nursing Revalidation report, and approved the signing of the annual statement of compliance by Mr Clayton-Smith.

073/2018 **Annual Reports**

i) Organ Donation

Dr Wilkinson reported Dr Goswami, the clinical lead for organ donation, would be stepping down after 8 years in the role. He reported that while the Trust was an average performer in terms of patients referred for donation, it remained a good performer for specialist nurses being present for every potential donor.

Mr Clayton-Smith thanked Dr Goswami for his 8 years of leadership and hoped that a worthy successor would be found quickly.

ii) Workforce Race Equality Standard

Mrs Wells explained that the WRES was a national requirement and that the annual report had been presented to and discussed at POD. A couple of areas had been identified where the Trust was potentially an outlier, and these were being reviewed.

Mr Clayton-Smith asked what plans were in place to continue to improve against the standard in the Trust and Mrs Wells explained that that Trust performed well nationally. She noted that there was always more that could be done and that the Trust strived to improve but that there were limited resources available.

iii) Complaints

Ms Carruth reported that there had been a 15% reduction in complaints during 2016/17 and significant improvement in response times. There had also been a small decrease in contacts with PALS. She thanked Ashley Parrot, the Associate Director of Governance, and his team for the fantastic work they had done on improving complaints processes and performance within the organisation noting the instrumental role that the Complaints Manager, Darren Langridge-Kemp, had played in the improvements. Mr Clayton-Smith noted that he was very pleased to see learning from complaints included within the annual report.

In response to a question from Mr Stevens, Mrs Wells explained that the complaints team worked hard to ensure that complainants were satisfied with outcomes, and that Dr Bull reviewed every complaint that was sent. She suggested that it might be beneficial to review the questionnaire that complainants were asked following closure of complaints.

iv) Guardian of Safe Working Hours

Dr Wilkinson reported that the number of breaches being reported had reduced, reflecting better understanding of the system by trainees and the hard work that had gone into addressing the concerns of trainees and improving rotas. Junior doctor representatives had been constructive and helpful in their approach. He noted that the money from fines for breaching safe working hours amounted to £18,000 which had to be spent on education and training of junior doctors. Junior doctors had been asked to develop plans on how this could be spent.

Mr Clayton-Smith asked how the recommendations from the report would be taken forward and Dr Wilkinson explained that issues raised by specific teams were discussed with the Guardian of Safe Working Hours group and then taken to Divisions to resolve.

Mr Stevens asked whether doctors had rest rooms, suggesting the money could be used for these. Dr Wilkinson confirmed that rest rooms were provided, and that a lot of work had been done by the estates teams with junior doctors to ensure that these were appropriate.

074/2018 **Board Subcommittee Minutes**

The following sub-committee minutes were reviewed and noted:

- Audit Committee 24th May 2018
- POD Committee 9th May 2018
- Q&S Committee 21st March 2018 and 16th May 2018

The Minutes were received by the Board

075/2018 **Use of Trust Seal**

Mrs Wells noted that the Trust Seal had been used on one occasion since the last meeting to seal a three year agreement with HC-One for the provision of non-weight bearing beds.

076/2018 **Questions from Members of the Public**

3+2

Ms Medway noted that 3+2 had been mentioned a couple of times during the meeting and ask what this meant. Ms Ashton explained that the Trust had an obligation to produce a long term financial plan. The 3+2 plan referred to a five year strategic and financial plan with the ambition of the Trust exiting special measures within three years, with an additional plan for two further years.

Excess income in A&E

Ms Medway asked what was meant by excess income in A&E and Dr Bull explained that when activity was greater than expected then it generated additional income for the Trust, while causing a problem for the CCG.

Staff Consultations

Ms Medway asked whether consultation with staff prior to ward changes had taken place due to a legal requirement. Miss Green confirmed that staff were consulted prior to any organisational changes as a matter of Trust policy. Mrs Chadwick-Bell explained that consultation with nursing staff had only been undertaken with those impacted by the changes.

PA Consulting

Ms Medway asked whether Mr Friedman would be doing the same work already done by PA Consulting, and whether it was beneficial for a further layer of scrutiny to be added to the Trust. Dr Bull explained that, under the Financial Special Measures regime, NHSI valued external expertise and validation of the Trust's plans. He explained that the Trust was engaging with several different consulting firms on different issues at the behest of NHSI and that the Trust worked hard to keep this to a manageable level.

Mrs Chadwick-Bell noted that Divisions had been consulted about support that they would find beneficial, and that NHSI had paid for the first six weeks that PA Consulting had spent in the Trust working with Divisional leads to develop robust plans for the future.

ESHT

Ms Medway commended the Board on the excellent papers that had been presented and on the leadership of the Trust. She explained that she was assured by Dr Bull's oversight of each Board Committee.

077/2018 **Date of Next Meeting**

Tuesday 2nd October 2018, Oak Room, Hastings Centre

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 7th August 2018 Trust Board Meeting

Agenda item	Action	Lead	Progress
066/2018 Board Committees' Feedback - Audit Committee	Mr Clayton-Smith requested that an update on cybersecurity within the Trust be presented to the Board at November's Seminar.	**JR**	Added to the agenda for November's Board Seminar.
069/2018 - Integrated Performance Report Month 3 (June) - Activity	Mrs Chadwick-Bell agreed to confirm whether MSK waiting times included within the IPR included iMSK waiting times.	**JCB**	Verbal Update to be given at Meeting

Quality Walks July and August 2018

Meeting information:			
Date of Meeting:	2nd October 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

18 services or departments have received visits as part of the Quality Walk programme by the Executive Team between 1st July and 31st August 2018. In addition to the formal programme the Chief Executive has also visited 22 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, JULY AND AUGUST 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 patients, 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 July and 31st August 2018. In addition the Chief Executive also visited several departments and staff groups.

Date	Service/Ward/Department	Site	Visit by
2.7.18	End of Life Care Team	Eastbourne DGH	Catherine Ashton
3.7.18	Hospital Intervention Team	Eastbourne DGH	Jackie Churchward-Cardiff
9.7.18	Seaford 3 Ward	Eastbourne DGH	Jonathan Reid
10.7.18	Discharge Lounge	Eastbourne DGH	Jackie Churchward-Cardiff
18.7.18	Podiatry Department	Conquest Hospital	David Clayton-Smith
19.7.18	Diabetic Eye Screening Service	Bexhill Hospital	Miranda Kavanagh
23.7.18	Cookson Attenborough Ward	Conquest Hospital	Jonathan Reid
23.7.18	Health Visiting Team	St. Leonards	Monica Green
23.7.18	Dietetics Department	Conquest Hospital	Jonathan Reid
25.7.18	Looked After Children Team	Centenary House Eastbourne	Jackie Churchward-Cardiff
31.7.18	Hospital Intervention Team	Conquest Hospital	Miranda Kavanagh
31.7.18	Seaford 1 (Medical Assessment)	Eastbourne DGH	Catherine Ashton
2.8.18	Health Visiting Team	Eastbourne	Monica Green
2.8.18	Community Bladder and Bowel Advisory Service	Bexhill Hospital	Lynette Wells
9.8.18	Audiology department - adults and paediatrics	Eastbourne Park Primary Care Centre	Catherine Ashton
13.8.18	Medical Photography Department	Conquest Hospital	Monica Green
15.8.18	Pevensey Ward and Day Unit	Eastbourne DGH	Catherine Ashton
21.8.18	Safeguarding Team	Hailsham Health Centre	Miranda Kavanagh

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

- The staff visited reported that communications were generally good within teams and with other departments, however one community team commented that although they had excellent support from their immediate line manager they felt they lacked contact with other senior Trust staff.

Incidents Risks and Safety Issues

- Staff working within services that are integrated with East Sussex County Council raised concern regarding current cuts in services locally due to recent financial constraints and the impact it may have.
- In the Health Visiting service staff commented that the team has a mixture of staff some employed by the NHS and some employed by the Council, the staff do the same jobs but are paid a different rate, have different terms and conditions of service and are governed by different workforce policies which can sometimes lead to problems. There are also differences in the IT systems which are not always compatible.
- It was noted that proactive planning of discharging patients and working to expected discharge dates were not routinely embedded within the acute wards.

Environment, Equipment and IT

- One team reported that they had vacated their office to allow for building work for a neighbouring department but to date a permanent replacement space had not been found for them. They were being temporarily housed in another area but it was not ideal as it lacked space for team handovers, patient discussions and discharge planning.
- Some community staff continues to find SystmOne challenging due to poor coverage and slow functionality, and in one area staff reported inadequate amount of phone lines and docking stations for the number of staff in the team.

Staffing

- The audiology service reported difficulty in recruiting for audiology staff and that the number of patient referrals is increasing.

Good Practice / Service redesign

- The Safeguarding team has named nurses for each category under the Care Act 2014 and has established a structure considered to be ahead of its time.
- Audiology are keen to explore new developments in order to enhance the service

Education and Training

- Health Visiting had concerns about access to training and development and felt that there is a lack of available professional development for furthering their expertise in some areas. They also raised the issue regarding the lack of practice teachers and the impact that this could have on health visiting numbers in the future.

Patient feedback

- Comments from patients included ‘lovely food’ ‘excellent care’ ‘lovely staff’.

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.

POD Committee 5th September 2018 Executive Summary

Meeting information:			
Date of Meeting:	2nd October 2018	Agenda Item:	6
Meeting:	Trust Board	Reporting Officer:	Miranda Kavanagh

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

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

Summary:

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

Executive summary attached for POD Committee meeting held on 5th September 2018.

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

N/A

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

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

East Sussex Healthcare NHS Trust

People & Organisational Development (POD) Committee

1. Introduction

Since the Board last met a POD Committee meeting was held on 5th September 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. Workforce Costs

The Committee received a verbal overview from the Head of Workforce Planning of the submitted report. The Workforce Plan would be submitted with workforce numbers and costs into the financial plan for the next 3 years. The workforce response to the clinical strategy was in the early stages and work was being undertaken with the planning department.

4. Recruitment and Retention

Trust Retention Plan

The Committee received a verbal overview from the Assistant Director of HR – OD of the submitted report. The target was to reduce retention to 11.3 as outlined in ESHT 2020 strategy but based on current performance this would have to be reviewed. Work to be commenced with each division on retention, the learning process and how exit interviews would be utilised, challenges around age groups and encouraging staff to attend listening conversations targeted on specific areas.

It was confirmed that a comprehensive plan was in place, although a living document, where priorities would be highlighted and the data used to focus on challenging areas.

Retention of Allied Health Professionals (AHPs)

The Committee received a verbal overview from the Associate Director of AHPs of the submitted report. The recruitment report in May showed a turnover rate of 13.2% for AHPs in March 2018 against an overall Trust rate of 11%. This was following a rising trend throughout the year. Work was underway with the workforce team to ensure that the correct data had been captured for the number of leavers, a report had been developed for themes and trends for AHP sickness across the groups, talent management and role development tool kit had been launched across the Out of Hospitals division, along with actively working together with the Strategic Workforce Resource Group to develop the AHP workforce intelligence.

Junior Doctors Survey

The Committee received a verbal overview from the Director of Medical Education of the submitted report. This was an annual survey hosted by the GMC sent out to all doctors within the UK. The Trust's compliance rate was 99.1%. The Trust was the 4th best region for training and many speciality areas had shown an improvement.

An action plan had been put in place, discussed with speciality leads and response and reports would be submitted to Health Education England (HEE) by the end of the month.

5. Workforce Equality

Yvonne Coghill, Senior Programme Lead for Inclusion and Owen Chinembiri, Senior Health Informatics Manager, from NHS England were welcomed to the meeting. The committee received a verbal overview of the submitted report. Key findings for the Trust were highlighted:

- 12.3% of ESHT Trust were from a BME background
- BME staff under-represented in Senior AfC pay bands
- BME staff are
  - More likely to enter the formal disciplinary process
  - Less likely to access non-mandatory training
- For all four WRES NHS staff survey questions, BME staff reported a worse experience than white staff
- For five out of the seven indicators benchmarked, ESHT is worse that the peer Trusts median
- In 2017 four indicators improved and three deteriorated
- There is no BME representation on the board.

It was highlighted that the Chief Executive Officer chaired the BME Network for ESHT and that the Trust were encouraging BME representation on interview panels.

6. Finance

The Committee received a verbal overview from the Director of HR regarding the proposal adopted by Financial Improvement and Sustainability Committee (FISC) to set up a Workforce Efficiency Programme Steering Group to be chaired by the Director of HR. This group would have 4 workstreams:

- Medical Workforce
- Nurse & Midwifery
- AHP & Technical Services
- Corporate Services and Enabling Tactical Schemes

The Director of HR reported that a lot of good work had been undertaken in terms of some of the enablers across the organisation i.e. Health Roster, Job Planning, Time to Recruit and work around agency and bank spend. The next step would be to review the governance and commence looking at areas that were driving the continued overspend in terms of workforce.

7. Feedback from Sub Groups

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

Approved minutes of the meeting held on 11th July 2018 are attached for the Board's information.

Miranda Kavanagh
Chair of POD Committee

4th September 2018

Board Assurance Framework

Meeting information:			
Date of Meeting:	2nd October 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. There are no additions or proposals to remove gaps in control or assurance from the BAF this month. The Board are asked to note and consider the following:

2.1.1 Achievement of the 62 day cancer targets still remains challenging. There are a number of controls in place but the Board is asked to consider whether the RAG rating should be moved to red due to insufficient assurance.

3.3.1 A comprehensive update has been provided in respect of ongoing work to achieve compliance with 7 day service standards.

4.1.1 There is only one area rated red related to Finance and this is reviewed at both F&I and Trust Board. A system wide Financial Recovery Plan is being developed with the CCG.

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

Due to timing of Committees none have reviewed the BAF this month. The high level risk register has been reviewed at both Quality and Safety Committee and Senior Leaders Forum.

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.

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.	Mar-17 CQC 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. Sep-18 Framework being developed in respect of what constitutes "outstanding" - review being undertaken to ensure consistency and strengthen divisional governance structures.	end Dec-18	◄► Jul-19	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 17 -Jan 18 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. 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. 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 to be appointed 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 scheduled for deployment week commencing 16th July. Sep-18 NHSI High Impact Actions reviewed and are being incorporated into a revised recovery plan. Urology service has re-designed their pathways and capacity to meet Cancer and RTT targets, full implementation due March 19, but will require completion of the UIS. Colorectal implementing new 'straight' to test' pathway from September. New Cancer tracking Matron in post in DAS. Demand for some tumour sites has remained above plan and hence a review of demand and capacity taking place.	end-Mar 19	◄►	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.	Jan-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-Nov 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. Meeting arranged end Sept to review issues. Audit of children admitted to the paediatric ward with mental health diagnosis complete. Jan-18 Audit presented, confirmed children with mental health difficulties primarily present after 4pm and so the majority cannot be assessed until the following day by the mental health nurse. These children require a hospital bed until the assessment is undertaken. Mar-18 Met CAMHS Feb and shared audit results. Acknowledged 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/Jul 18 Division are assured adequate Trust 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. Sep-18 A number of mitigations in place including on site MH (CAHMS) Liaison on both sites Monday – Friday 9am – 5pm which has significantly improved access for MH reviews, Ongoing discussions with SPFT with regards to the provision of on-site support until 22.00hrs. The on call service runs well out of hours, however as it covers the whole of Sussex, there can be a significant wait for review out of hours CAMHS commissioner agreed to write a business case for increased on-site provision from 17.00 – 22.00hrs, ESHT have not had sight of this BC to date. For children admitted there is availability for review on both sites, however if an Eastbourne child is admitted to the Conquest Hospital, this review is by telephone as routine, however Hastings children have a physical review, this does cause disparity for Eastbourne and Conquest children and is an ongoing issue Eating Disorder and in-patient bed availability remains an issue across the country Training continues for staff as indicated	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 -Nov 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 Position resolved with community paediatrics due to data transition to Systm One. All doctors validating Follow Up waiting lists and telephone Longest waiter 36 weeks (aug 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. 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; aim to complete by end May18. 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. Sept-18 Database developed and populated in all areas except Oncology (interim system already in place),T&O, Haematology & cardiology. There will be a transition period to clear backlog in all specialties and link up patient who FU has been booked and then cancelled, expected to be complete by Spring 2019.	end Mar-19	◄►	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.	Jul-Dec 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.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. Sep-18 A draft integrated (ESHT and CCGs) sustainability plan was submitted to NHSI and NHSE at the beginning of September 2018. A further more detailed iteration of this is being prepared for submission in November 2018. The request from our regulators to prepare and submit integrated plans is a key mitigation to alignment of Trust and commissioner plans and to developing an integrated plan to achieve system sustainability.	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.	7 Day Service Steering Group established. PMO project support with dedicated project lead assigned. PID agreed by 7DS steering group. Working closely with NHSE/NHSI to gain best practice/lessons learnt from other Trusts also liaising with neighbouring Trusts (MTW, EKH) Baseline template to be reviewed prior to distribution, gap analysis underway. Sep-18 7DS Steering group met in Sept. Participating in regional STC 7DS collaboration event on 25th Sept. • Documentation requirements relevant to 7DS (Esp standards 2, 8) included in induction for new medical staff in August and email communication also sent to existing staff. • Further Grand Round presentations made to medical staff in Aug/Sept on 7DS core standards, the Trust's performance in the national audits and what needs to be done by clinical teams and individuals. • Requirements for 7DS form part of the remit in the financial recovery planning (streams) and clinical strategy at Trust and Divisional level. Standard 2 - Feedback given to Divisional core teams and clinical specialty leads on detail of performance in April audit; particularly where teams are failing to achieve. • AMU consultant presence at weekends has been strengthened consistently, with regular presence at EDGH and, from next month also at Conquest at both sites Standards 5 / 6 - Changes in medical consultant on call rotas made (from 1st Oct) to support 24/7 endoscopy service diagnostic and therapeutic). Endoscopy nursing support still to be fully upgraded • Radiology working on radiographer work patterns to increase scope of weekend ultrasound service. • Signposting information on how to access specialist services inside and outside the Trust (eg renal, neurology/neurosurgery, radiotherapy) now in induction and in place on all wards and Trust intranet. Standard 8 - Feedback from initial pilot being analysed and teams continue with acuity assessment and review delegation on ward whiteboards. • The Trust is bidding for funds to enable electronic whiteboards with real time patient tracking. Exploration of whether these can also be used to document acuity and delegation of review. • Procurement process for replacement to current clinical information systems is proceeding. Clinical engagement being sought for determining functionality requirements. • Roll out of Careflow (part of the VitalPAC software suite) as handover and task management tool. • Audit of frequency and participants in board and ward rounds for all acute hospital wards conducted Aug. Results currently being analysed.	end Dec-18	◄► **Jul-17**	COO	SLF Q&S

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. Sep-18 At Month 5, the Trust has secured a further improvement in run-rate to £3.2m deficit. This is behind plan, but is consistent with delivery of the financial plan with continued focus through the balance of the year. The new Recovery Director is supporting the Trust with intensive work to ensure both an increased pipeline of efficiency schemes, and to move the balance of 'green' CIP from the current £19m to £23.2m. Income for the Trust is considerably above baseline plan, due to significant growth in non-elective activity – and this represents both a challenge to delivery of efficiency schemes and a payment risk. The Trust is working closely with CCGs and NHSI/E to develop an appropriate response to the emergency activity levels, and to understand the financial implications. Confirm & Challenge sessions are in place for all Clinical Units to support delivery of the CIP programme, and the DoF is holding control total review meetings with CUs and specialties to monitor overall financial performance, with issues from both streams escalated to the Executive Team as appropriate.	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.	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. Sep-18 Trust has two capital bids with NHSI (for MRI approvals, and medical equipment), a bid with the STP for fire remediation work, and a bid to NHS Digital for EPMA investment. Capital programme remains oversubscribed, but receipt of loan funding would support delivery of the key infrastructure improvements required across the organisation. A 'plan B' is in development to ensure that, in the case of non-receipt of the various loans, the Trust can deliver the capital budget within national target levels, and that any clinical or operational impact is mitigated. This will be provided to the Sept Finance and Investment Committee for review, following executive review and agreement.	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- Dec 17 Ongoing programme behind schedule as unable to decant wards and asbestos issues. Fire doors replaced and stairwells upgraded. 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 Fire compartmentation business case developed, Board review Jun-18 before submission to NHSi. Fire stopping works being carried out to reduce the size of the Seaford and Hailsham fire compartments in line with the recommendations by ESFRS. ESFRS visited 10th May and were impressed by 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 targets; 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. Business case drafted, approved by Trust Board June 2018 and submitted in the STP wave 4 bids @ £11.16m. Sep-18 Works were substantially completed by Mid July and ESFRS have been updated with regular meetings and have noted progress made within a letter to the Trust. One final piece of work needs to be completed and is proving difficult due to access issues, once complete a final "project closure" meeting (TBC) will be held with ESFRS.	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-Mar 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. Ongoing development and implementation of action plan, progress presented to IG Steering Group. Phishing simulation being undertaken. May-Jul 18 Number of workstreams in place to ensure adequate controls in place. Update paper will go to Audit Committee. 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 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. Sep-18 Information Security Paper presented to Audit committee and Execs. Funding approved to initiate a structured approach to addressing the Information Security Agenda; to be known as the ESHT Information Security Maturity Programme and to be implemented as part of the Trusts Digital Strategy which is due at Nov Trust Board. Third party has been engaged to carry-out an initial assessment with the aim to plan a 18-24 month programme of work. The same approach is being presented to the SPT Digital Steering group with the aim to create joined up STP wide approach. ATP is deployed to 10% of Trust devices in-line with NHS planning, aiming for 100% deployment by Jan 2019. DNS security being implemented 13.9.2018 Information Security table top exercise run by the Serious Organise Crime Quad organised for Nov board seminar.	end Mar-19	◄►	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	Mar-18 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. Sep-18 International recruitment continuing in Philippines and Indian sub-continent for Medical and AHP staff groups. European recruitment will be reviewed post Brexit. 32 International Nurses joining by July 2019. 54 International Nurses in recruitment pipeline.Targeted Recruitment campaigns commenced to support Radiology Department, Histopathology and Haematology (Consultant posts) Social media activity supported by Headhunters. Medacs (RPO- Recruitment Practice Optimisation)Medacs are on site 13th Sept to start the Discovery process to understand our existing end to end recruitment process. Medacs will be targeted to recruit 50 'hard to recruit' medical posts over the next two years. Successful recruitment and on boarding of July intake of Junior Doctors. October Intake - 61 posts 9 vacancies. 3xCardiology/1xDiabetes/2xGeneral Surgery/2x Geriatrics/1xObs and Gynae. Recruitment activity underway to fill these vacancies.	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.	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. Sep-18 We have refreshed our plans and approach to Staff retention. Each division has received workforce information about why staff are leaving /dissatisfied . we will be using this information to carry out further deep dives with staff groups/specific work areas to identify how we can improve retention/improve their response to recommending ESHT as a place to work. Launching our Health and well Being plan for staff that sets out 7 priorities we will be focusing on to proactively support Physical and emotional wellbeing.	end Apr-19	◄►	HRD	POD SLF

Chief Executive's Report

Meeting information:			
Date of Meeting:	2nd October 2018	Agenda Item:	8
Meeting:	Trust Board	Reporting Officer:	Dr Adrian Bull, Chief Executive

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. Introduction

This paper summarises highlights from the major areas of the Board reports.

2. Quality and Safety

The latest Summary Hospital-level Mortality Indicator (SHMI) for the period April 2017 to March 2018 has been published and is 1.01 which is within the 'expected' range. This is the lowest score for the Trust since the first SHMI experimental statistics were published in 2011. The Risk Adjusted Mortality Index 2017 (RAMI 17) for the latest period, July 2017 to June 2018, currently stands at 79, an improvement on the score for the same period last year and lower than the acute hospital peer average of 88 (a lower score is favourable).

The Trust recently hosted a Getting It Right First Time (GIRFT) visit from Tracey Irvine, National Clinical Advisor for Breast Surgery. The clinical engagement was excellent and the Trust were complimented on the quality of the care provided to patients. A high number of good practice points were highlighted e.g. well informed patients, non-ageist policy, low complications and normal/low readmissions, lean follow up programme. Opportunities for improvement were few, but included ensuring that the cancer pathways were equitable across sites. The Breast Surgery clinicians have added all opportunities to the agenda of the next cross site Breast Surgery AGM.

We are part of a national collaborative study for orthopaedic surgery under the auspices QIST (Quality improvement in Surgical Teams). This includes two arms: screening and/or treatment of MSSA and the management of perioperative anaemia, both in patients undergoing joint replacement surgery. We have organised a local implementation team with orthopaedic, anaesthetic, pharmacy, managerial and executive representation and we have been assigned to the MSSA arm first. We plan to start recruitment in November.

Falls reduction - year to date the trust rate is 6.1 per 1000 bed days which is above last year's end of year figure of 5.6 per 1000 bed days. There was a spike in falls reported during June and July that has affected the overall rate but August reported 5.4 per 1000 bed days so more positive. Refreshed falls assessment training commenced recently to support robust assessment for falls prevention. Report provided to all senior nursing leads 3 days a week highlighting every/any patient fall with details of any previous fall in same hospital episode. 17 wards have now started to use new assessment tool.

Failure to follow up appointments has resulted in some incidents causing moderate or above harm. These cases were mainly system errors where patients were not seen within the required timescale and not flagged if the appointment could not be booked within the time requested by the Consultant. A new out-patient follow up database has been developed to improve the management of these review lists. It is being introduced for diabetic retina screening in the first instance. A review of patient letters is also underway to remind patients to escalate concerns about delays in their follow up appointments.

The Trust has signed up to a number of national improvement collaboratives supported by NHSI. Most recently this has included the Nutrition Collaborative. A number of frontline staff continues to participate in other collaborative including Mixed Sex Accommodation, Maternity/Neonatal Care, Urinary Tract Infections, Falls and Pressure Ulcers.

3. People, Leadership and Culture

Recruitment

The substantive staff fill rate is 90.5 % for August. The international recruitment programme is continuing in India and the Philippines. 32 International Nurses will join the Trust by July 2019. 54 International Nurses are in the recruitment pipeline. Targeted recruitment campaigns have commenced to support Radiology, Histopathology, and Haematology (Consultant posts) following Department review meetings. 34 newly qualified nurses are due to start in October. The first nurse associate students start in September with much excitement and considerable support from Learning & development colleagues as well as our clinical teams. Workforce remains one of our biggest challenges, as is the case nationally. Nursing and HR colleagues continue to work closely together to ensure we maintain the necessary focus and drive to support this agenda.

Medacs (RPO - Recruitment Practice Optimisation) have been engaged to support the recruitment to 'hard to recruit' medical posts over the next two years and have started the process to understand our existing end to end recruitment methodology

Consultations

The consultation with staff affected by the ward reconfiguration plans was completed in August, although formal staff moves are not due to commence until 17th September due to operational pressures. The TUPE transfer of Outpatient staff at Crowborough to Maidstone & Tunbridge Wells NHS Trust is due to complete this month. Consultation with staff affected by the closure of Firwood House has commenced. Consultations have been launched in August and September with staff affected by the corporate review.

A mobilisation and communications plan is in place for the launch of the National staff survey 2018, which will be distributed in late September. 45 % of staff will receive an on-line survey with the rest receiving paper forms. The target response rate is 52% with a stretch target of 56%.

4. Access and Delivery

The Trust continues to maintain its four hour performance although there have been some challenges at Eastbourne which are being addressed. RTT performance is holding at 90% despite elective activity being behind plan. Actions are in hand to recover the level of activity within the system's overall activity plan. The 62 day performance for cancer continues to be a challenge. An in depth redesign of the Urology cancer pathway will make a significant improvement. Its implementation is dependent on the capital changes to create the Urology Investigation Suite. Recover of this level of performance will be toward the end of the financial year. Any risk to individual patients through delayed treatment is being monitored through MDTs.

The ward reconfiguration programme continues but is delayed because of the activity surge through the summer. The plans are being re-tested in light of the new levels of activity. Staff redeployment continues. Benson and Seaford 4 wards remain open at this stage.

5. Communication and engagement

The Trust continues to receive positive media coverage relating to the 70th birthday of the NHS. A number of double page features have been published in the main local newspapers, including archive images and photographs of the Trust. We also received positive coverage about Eastbourne Midwifery Unit's 1500th baby, donations from our Friends groups and awards and accreditations received by members of staff and services. Between April and July 2018, the Trust received 141 pieces of coverage in print and broadcast media, in both local and national news. 89% of the coverage was positive, 7% was neutral, 3.5% was negative.

In August, the Trust's AGM saw over 70 members of public come together to listen to a review of our year and find out more about 16 services that had stands showcasing their work. During the event we launched our "highlights from our year" publication which summarised some of the successes of the last year, and our priorities for next year.

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.

6. Finance

Working Together as a System

Extensive work has been undertaken over the summer months across the system to develop a sustainable financial plan for East Sussex Better Together, both for 2018/19 and for the next five years.

In 2018/19, the CCGs and the Trust have an agreed deficit (control total) across the system of £77m; a £45m deficit for ESHT and a £32m deficit for the CCGs. If the CCGs reach their £32m target deficit, then NHS England will make a Commissioner Sustainability Fund available of £32m. Delivering this plan is a key priority both for the system and for the organisations within the system – and all key stakeholders are working together to identify the appropriate governance and resources. This work is managed across the ESBT system through the System Financial Recovery Board, and support from regulators is aligned through the System Improvement Director, Christopher Langley.

Non-Elective Activity Pressures

The Trust initially planned for receipt of £397m in income in 2018/19 (£272m of which is paid from the ESBT CCGs allocation for local services). This income is largely distributed in line with activity levels at the Trust, on the basis of 'payment by results.' Actual activity levels, particularly for urgent and non-elective care, have been significantly above planned levels in the first half of the financial year, creating operational and financial pressures for the Trust, and a further financial challenge for the system and commissioners. Initial estimates of the scale of this additional challenge are £7m, but continued growth in activity over the summer months means that this estimate is expected to increase. Recent months have seen an intensive programme of joint work, supported in part by NHSI and NHSI, to understand the drivers of demand for urgent care services, and to develop collaborative plans for reducing this activity – this marks a step forward for the system, in undertaking aligned and detailed work to mitigate this significant growth in activity.

Delivery of the Trust's 2018/19 Financial Plan

At Month 5, the Trust's underlying run rate has reduced again by £400k – from £3.6m deficit to £3.2m. However, last month we were adverse to the planned run-rate by £300k, and this shortfall persists into M5, taking our total adverse variance to £588k in the year to date. We are targeting a run-rate equivalent to securing a £40m deficit and our plan required a run-rate in Month 5 of £2.9m. So, despite the good progress on the overall run rate, we must continue to seek opportunities to improve the position and recover the position fully over the remaining months of the financial year.

Run-rate analysis suggests that the Trust has the opportunity to deliver the financial plan, and to recover the shortfall as at Month 5. However, the run-rate does not capture the full risk to the financial position as we move into winter and an initial review of forecasts indicates that there are three key areas of risk to the financial position – delivery of the CIP programme, management of cost pressures, and activity/income management. The Executive Directors have a programme of action in place to address each of these three issues, reviewed on a regular basis, and considered in detail at the Finance and Investment Committee. A financial update is included in the Board papers and further information will be provided to the Trust Board during the meeting.

7. Strategic Development and Sustainability

The Trust submitted the first iteration of a medium to long term sustainability and financial recovery plan (3+2) to our regulator NHSI at the beginning of the month. Further work is being undertaken to further develop this and to facilitate alignment of the Trust and CCG plans moving forward. We will be engaging with stakeholders, including our staff, patients, public and the HOSC to outline the key parts of the sustainability plan and to discuss how we can ensure that we involve stakeholders in any redesign of services as we move forward.

There have been some key changes in the CCGs with the former Chief Officer, Amanda Philpott being seconded to a new post with the CCG Alliance (all 8 CCGs in the Sussex and East Surrey STP). Adam Doyle who has been the Accountable Officer for 6 of the 8 CCGs will now expand this role to cover all 8 including Hastings and Rother and, Eastbourne, Hailsham and Seaford. We will continue to work closely with our CCG and ESCC partners to ensure that we are driving the development and delivery of sustainable health and social care services for our population.

We continue to work closely with other acute providers locally to ensure that together we can explore areas of mutual benefit such as closer working with BSUH on our ENT services and with MTW on Urology provision. We continue to explore wider network opportunities in areas such as pathology.

The annual planning cycle has started with first iteration of divisional and corporate plans being prepared and we will have the opportunity to review these as a Board in February 2018.

East Sussex Healthcare NHS
NHS Trust

Month 5 – August 2018

TRUST INTEGRATED PERFORMANCE REPORT

East Sussex Healthcare NHS
NHS Trust

Contents

East Sussex Healthcare NHS
NHS Trust

July 2018

Key Successes

•A&E performance remains above the trajectory despite increases in attendances and accuity.

•RTT position remains stable with a continued reduction in the waiting list.

Key Issues

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

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

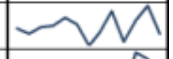
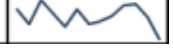
Action: The board are asked to note and accept this report.

Quality and Safety

QUALITY AND SAFETY

Indicators

East Sussex Healthcare NHS
NHS Trust

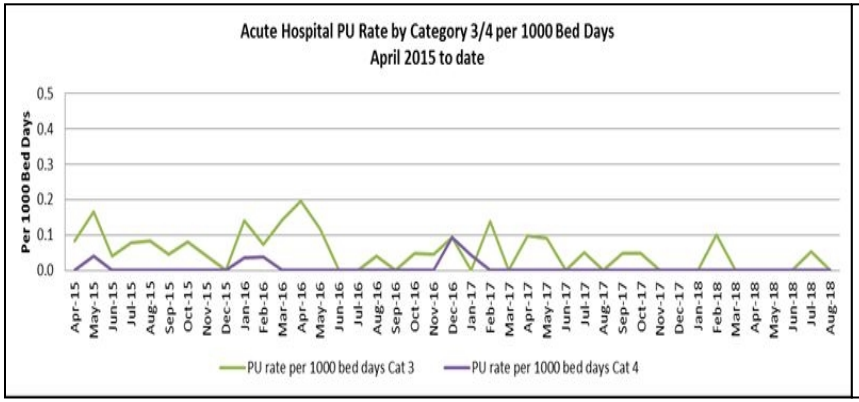
Indicator Description	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
	Aug-17	Aug-18	Var	2017/18	2018/19	Var		
Total falls	129	119	-7.8%	681	666	-2.2%	133	
Number of no-harm falls	80	86	7.5%	497	471	-5.2%	98	
Number of minor/moderate falls	48	32	-33.3%	183	193	5.5%	34	
Number of major/catastrophic falls	1	1	0	1	2	1	1	
All patient falls per 1000 Beddays	5.6	5.3	-0.3	5.8	6.0	0.20	5.6	
All patient falls with harm per 1000 Beddays	2.1	1.5	-0.7	1.6	1.8	0.19	1.5	
Falls assessment compliance	88.9%			89.6%	91.8%	2.1%	83.2%	
Total grade 2 to 4 pressure ulcers per 1000 Beddays	2.2	1.8	-21.5%	2.1	1.8	-14.9%	1.9	
Number of grade 2 pressure ulcers	50	39	-22.0%	237	198	-16.5%	41	
Number of grade 3 to 4 pressure ulcers	1	0	-1	13	3	-10	2	
Pressure ulcer assessment compliance	89.5%			88.7%	97.9%	9.2%	84.3%	
VTE Assessment compliance	96.0%	94.4%	-1.6%	96.1%	95.7%	-0.4%	95.7%	

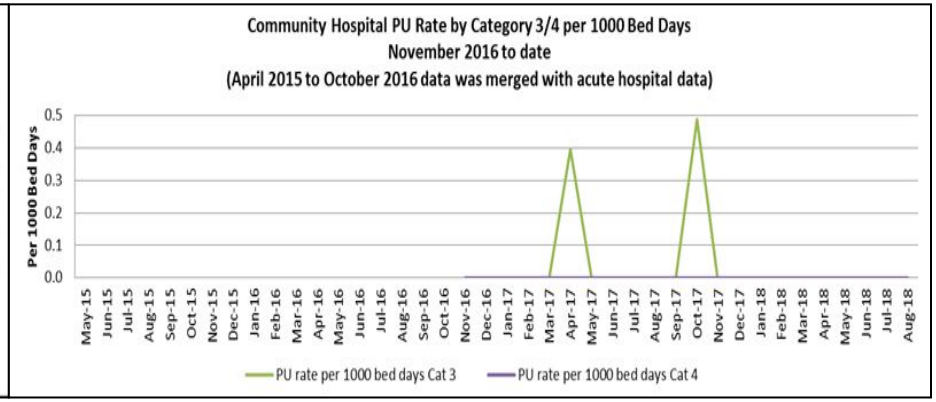
Please note: The falls and pressure ulcers by bed days are still subject to change as the bed day figures change for at least 4 months after the initial report.

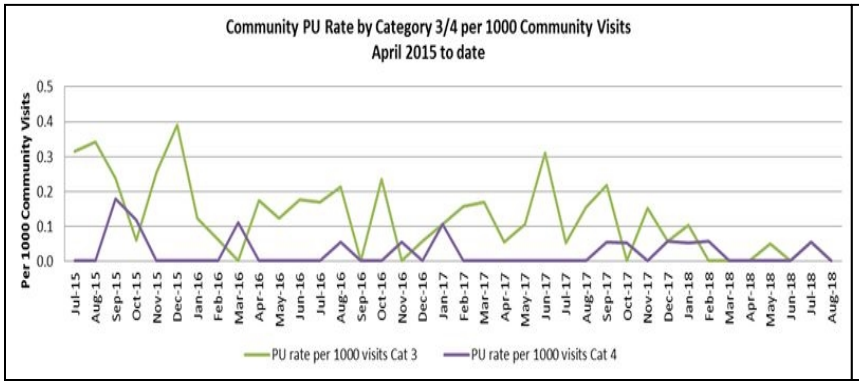
- The percentage of no harm/near miss patient safety incidents for August is 80% (national figure 73%).
- Falls Assessment compliance from the Excellence in Care Quality reviews for August is 92% and Pressure Ulcer Assessment compliance is 98%.
- Falls decreased in August following the spike in June and July. Additional support and training commenced in September. 21 wards now using the new assessment tool. If used effectively the tool will assist with identifying all risk factors and ensure the correct actions in place to prevent a fall.
- VTE Assessment compliance is below the target. Diagnostics, Anaesthetics and Surgery Division is above the target, Medicine and Women Children and Sexual Health are both just below the target.

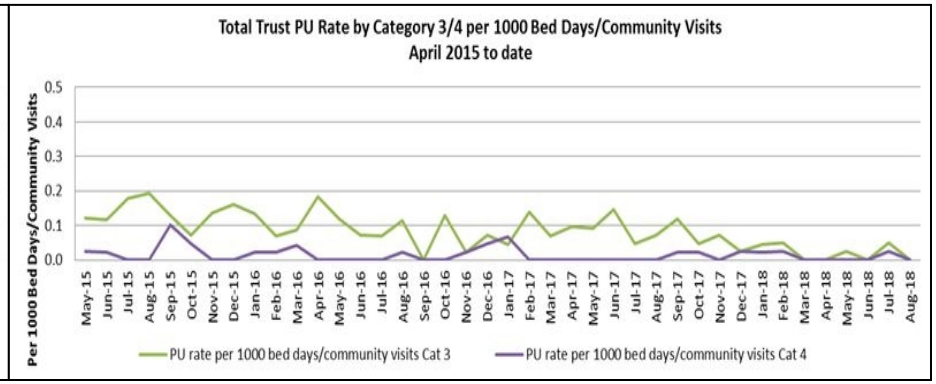
PRESSURE ULCERS – Grade 3 & 4 – Aug 2018

East Sussex Healthcare NHS
NHS Trust









Acute hospital acquired cat 2 PUs have dropped from 27 in July to 12 in August. The numbers of Community acquired cat2 PUs remains fairly static with 21 in August. There have been no cat 3 or 4 PUs reported in August although there were 11 unstageable PUs reported. There will be quarterly reports for unstageable and grade 2 ulcers going forward. Community Hospitals have reported no PUs for the second month running.

All unstageable PUs now have a PU RCA completed and submitted to PURG for review.

East Sussex Healthcare NHS
NHS Trust

INFECTION CONTROL & RE-ADMISSIONS

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Aug-17	Aug-18	Var	2017/18	2018/19	Var		
Number of MRSA Cases	0	0	1	1	1	1	0	0	
Number of Cdiff cases	4	6	5	-1	17	22	5	3	
Number of MSSA cases	M	2	3	1	3	8	5	1	
Emergency Re-Admissions within 30 days	10.0%	9.5%	11.0%	1.5%	10.0%	11.0%	0.9%	10.5%	

C. Difficile – limit for 2018/19 is 40.

24 cases to date which is 4 above trajectory for the time of year. Post infection review (PIR) is undertaken on all cases.

The increase in cases does not appear to be related to cross infection and all positive samples are sent for ribotyping to help exclude this.

Action plan has been implemented - strengthening antimicrobial prescribing, documentation and use of the diarrhoea assessment tool.

***MRSA bacteraemia* –** limit is zero preventable.

1 case reported this year. Patient underwent complex procedure at another Trust, presented to ESHT ten days later with AKI. **PIR assessed case as unavoidable** as patient had been diagnosed as MRSA carrier at another Trust but ESHT unaware of this and therefore antimicrobial prescribing did not cover MRSA until the results of the screen taken by ESHT was positive for MRSA.

East Sussex Healthcare NHS
NHS Trust

Serious Incidents (SI) reported in August

Indicator Description	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
	Aug-17	Aug-18	Var	2017/18	2018/19	Var		
Number of Serious Incidents	8	5	-3	24	15	-9	3	
Number of Never Events	0	0	0	2	0	-2	0	

There were **5 serious incidents** reported during August 2018 which involved a fall to fracture, obstetric injury, complication from surgery , endoscopy delay, and complication during a C-section. Further details are within the full serious incident report.

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

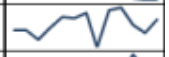
There are currently 19 Serious Incidents open in the system all within the correct timescales. The Amber incident backlog is improving (49 at time of writing this report). The Divisions need to complete the investigation to an acceptable standard, in order to share with the patient/family. A full breakdown of those overdue by number of days is presented to the Patient Safety and Quality Group on a monthly basis.

Duty of Candour compliance for all moderate and above harm incidents is at 89% informed verbally, 88% followed up in writing and 94% findings shared with patient or family upon completed investigation.

Excellence in Care (EiC)

26 wards now live on the system with the last 2 booked for implementation. Leadership and Culture measures that include finance data for wards now in the dashboard. Monthly reports sent out to the wards and their leadership team to review and act on the findings. A&E Excellence in Care not yet developed. Maternity EiC on hold as they currently already have many projects on-going .

PATIENT EXPERIENCE

Indicator Description	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
	Aug-17	Aug-18	Var	2017/18	2018/19	Var		
Inpatient FFT response rate	44.9%	42.9%	-1.9%	38.0%	42.6%	4.6%	42.2%	
Inpatient FFT score	96.2%	97.8%	1.6%	96.9%	97.8%	0.9%	97.6%	
A&E FFT response rate	13.3%	3.5%	-9.8%	9.8%	4.1%	-5.7%	5.8%	
A&E FFT score	90.1%	92.8%	2.6%	88.2%	93.0%	4.8%	91.5%	
Outpatient FFT Score	95.2%	97.7%	2.5%	95.4%	97.6%	2.2%	97.2%	
Maternity FFT response rate	29.3%	26.5%	-2.7%	37.0%	11.0%	-26.0%	20.6%	
Maternity FFT score	96.1%	95.7%	-0.5%	97.8%	96.7%	-1.1%	98.3%	

The A&E response rate remains low, albeit the score is good.

NHS Choices

- Overall rating at EDGH = 4 Stars Overall rating at Conquest = 4.5 Stars
- A total of 947 plaudits were received in August.

Examples of FFT/ questionnaire comments in August:

Positive comments;

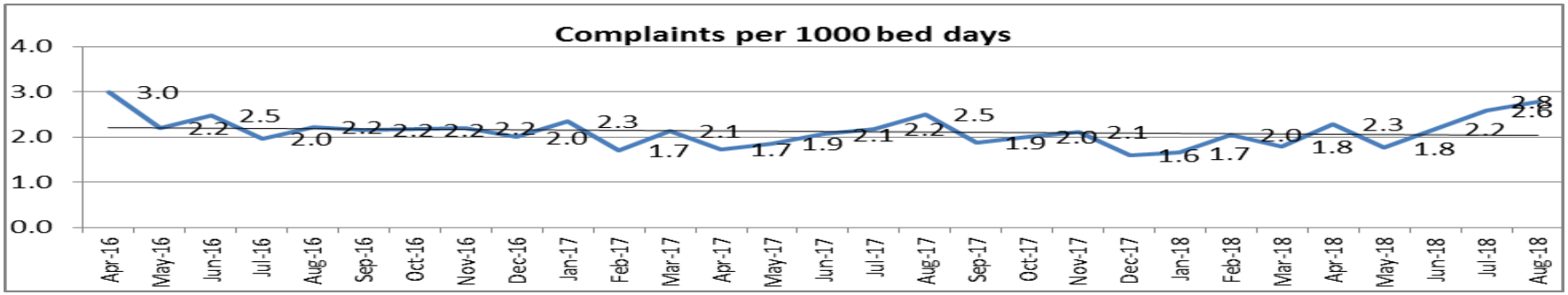
- Staff professional, helpful and polite.
- Variation of food.
- Friendly approachable clinical staff, knowledgeable and explained things clearly. Housekeeping staff also excellent.

Negative comments:

- Include patients more in the ward rounds rather than talk over them to the nursing staff.
- The discharge more efficient, I was told 1pm it is now 1505 and I am waiting.

Complaints

East Sussex Healthcare NHS
NHS Trust



61 new complaints were received in August and at the end of the month there were no overdue complaints. There was an increase for the third month running. The only specialty showing a significant increase during this time is the Accident and Emergency departments. There are nearly twice the number of complaints in the A&E at the EDGH site compared to the CQ site. A breakdown of these complaints has been completed and shared with the department for action on the themes. The complaints per 1000 bed days for the Division are as follows:

- Medicine – 1.4 per 1000 bed days (20 complaints)
- DAS – 3.6 per 1000 bed days (18 complaints)
- Out of Hospital – 2.4 per 1000 bed days (4 complaints)
- Women, Children and sexual Health – 4.0 per 1000 bed days (6 complaints)
- Urgent Care - 11 complaints.

Unable to contact department remains the highest PALS activity.

The Parliamentary and Health Service Ombudsman (PHSO) had 4 contacts in August. 3 were first line enquiries and the other was to request the trust seek further local resolution before considering the case.

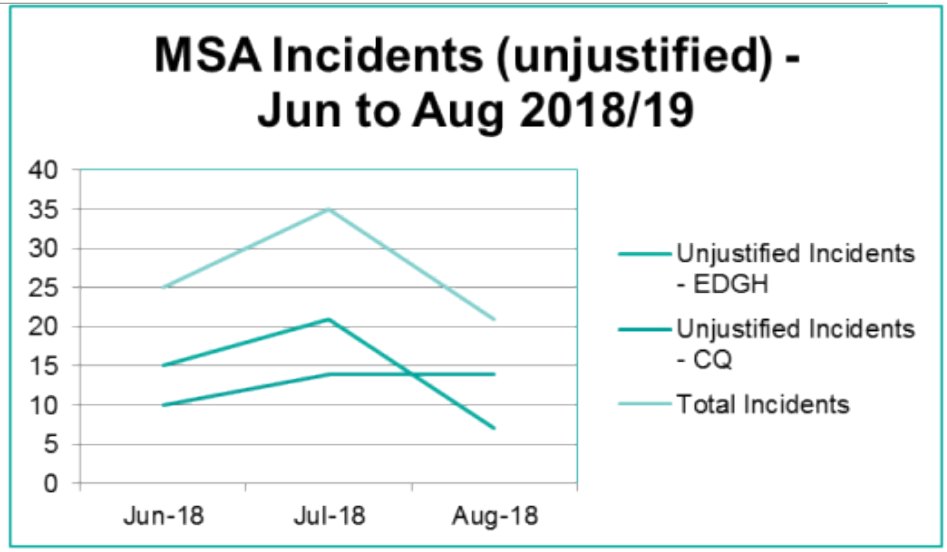
MIXED SEX ACCOMMODATION

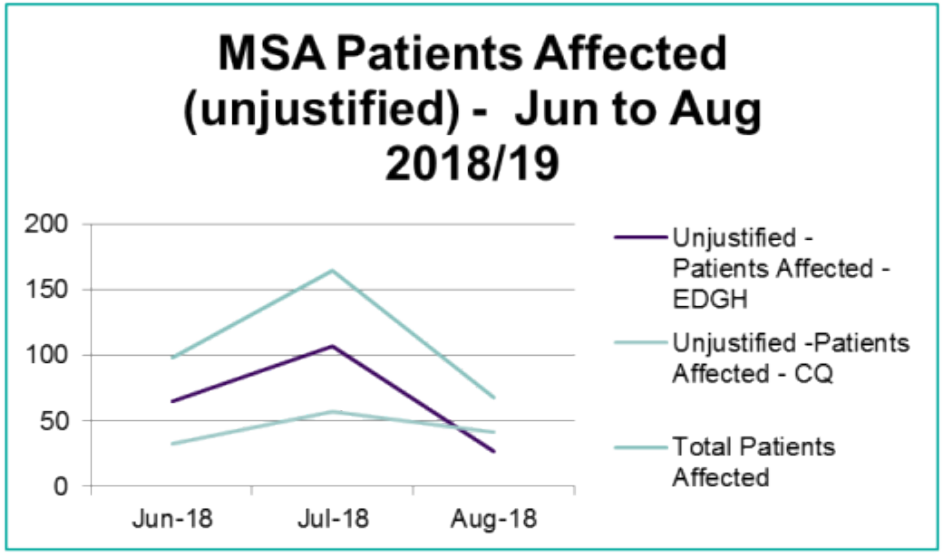
East Sussex Healthcare NHS
NHS Trust

In August the total number of validated and reportable unjustified incidents for the Trust was 21, affecting 68 patients – a reduction from July (35 incidents affecting 168 patients).

All breaches in August were associated with ITU patients. For EDGH this is an improvement on July when approximately half of the breaches were related to non-ITU wards.

Now that the new system of reporting has been in place for a number of months a review of the process is underway to ensure that it is robust and provides appropriate assurance.





Nursing and Midwifery Workforce - including Safer Staffing

East Sussex Healthcare NHS
NHS Trust

Safer Staffing – From September 2018 NHSI will be publishing Care Hours Per Patient Day (CHPPD) as the key metric for safer staffing in bedded areas. This report provides the Board with a view of both % fill rate and CHPPD*. Variances in the actual fill rate from the planned fill rate are investigated at ward level and reported to the Director of Nursing and will go to the Quality & Safety Committee and the People & Organisational Development Committee. Headlines will go to Trust Board for assurance.
During Month 5 higher actual HCA usage above planned generally related to enhanced care or leave cover. Lower than expected RN usage generally related to leave and the inability to provide RN backfill.
The Trust has near live safe care reporting, which considers not only the numbers of patients and nurses (as reported in the national metric used in the CHPPD table) but also includes the acuity of the patients scored 3 times per day. This supports safe staffing decisions, management of patient flow and safe site management.

Challenges

- The bed remodelling is moving toward conclusion for most areas with Benson ward and Stroke wards having a longer trajectory. There are still a number of surge beds open requiring staffing above the funded bed base.
- Staff moves from affected wards have occurred over a longer time than anticipated which has impacted rostering. Leave already agreed was honoured creating a higher than anticipated % of staff on leave in some areas, with cancellation and re-booking of TWS shifts to accommodate staff moves and some vacancies on hold.

The TIAA audit of the Trust's Safer Staffing processes has concluded and will be reported at the Trust Audit Committee.
Establishment Reviews;
The Maternity establishment review, based on the Birthrate Plus national guidance, is being reported to the Finance and Investment Committee during the autumn.
The Inpatient annual strategic review is being planned for autumn 2018 and aligned to the business planning/budget setting process to ensure divisions can include as part of their overall planning.

**CHPPD = day + night shift hours for registered and unregistered nurses/midwives divided by daily count of patients in beds at 23.59 hrs.*

SAFER STAFFING

East Sussex Healthcare NHS
NHS Trust

The Safe care tool provides occupancy scoring of acuity and staff on shift three times daily giving a near live picture of staffing and clinical need. This system continues to be embedded with a focus on divisional ownership and scrutiny to ensure accuracy of the information on staffing and acuity.

The additional duties grip and control processes, introduced by the Director of Nursing, have been live for just over 2 months.

	Day		Night		
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	CHPPD Averages
BEXHILL HOSPITAL - RXC03	87.1%	102.5%	89.6%	119.8%	6.5
EASTBOURNE DISTRICT GENERAL HOSPITAL - RXC02	91.7%	109.1%	94.2%	120.1%	12.62
CONQUEST HOSPITAL - RXC01 (INCLUDES RYE HOSPITAL)	84.8%	107.4%	86.0%	114.5%	10.92

Fill rates are relatively steady – with gaps for registered nurses being supported by healthcare assistant colleagues. Usage overall is felt to be safe and appropriate with daily oversight by the Director of Nursing.

A full breakdown by area for fill rates and Care Hours Per Patient Day (CHPPD) will be presented at POD with any concerns also escalated to QSC. A headline assurance report will be presented to the Trust Board.

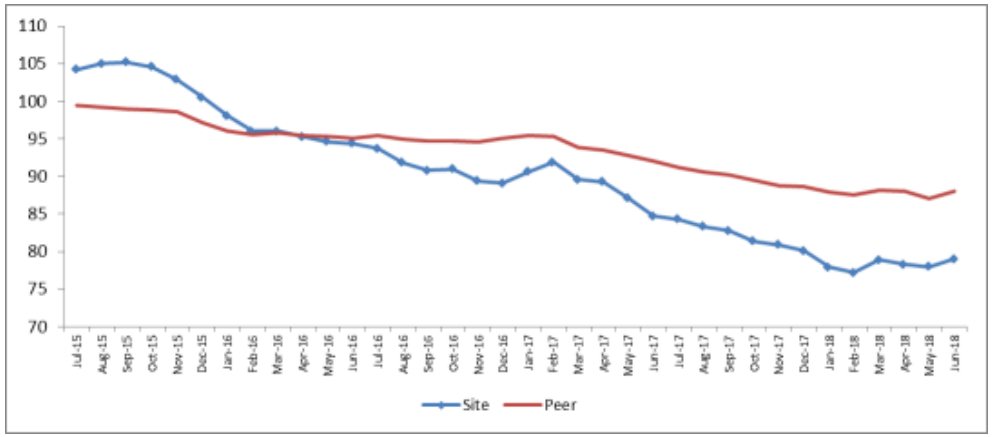
The CHPPD will vary according to clinical specialty. For example in Critical Care areas and those with higher dependency, the CHPPD will be higher so will affect the overall average for a particular site.

**CHPPD = day + night shift hours for registered and unregistered nurses/midwives divided by daily count of patients in beds at 23.59 hrs.*

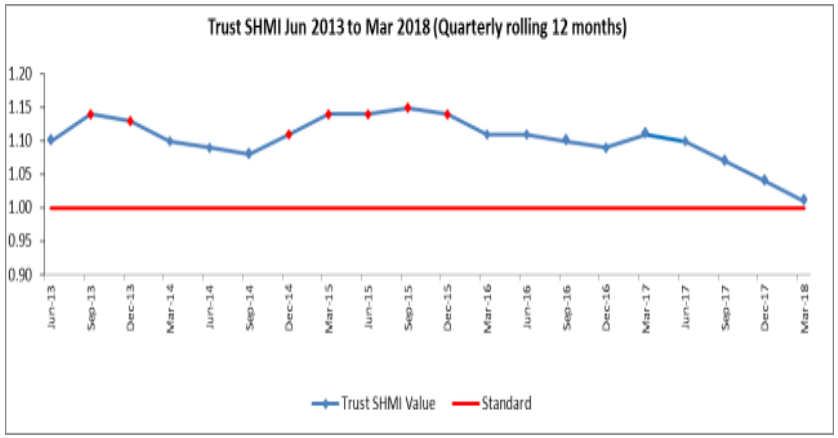
Mortality Metrics

East Sussex Healthcare NHS Trust

RAMI 17 (Rolling 12 months)



SHMI (Rolling 12 months)



SHMI for the period April 2017 to March 2018 is **1.01**. The Trust remains within the EXPECTED range.

RAMI 17 - July 2017 to June 2018 (rolling 12 months) is **79** compared to 85 for the same period last year (July 2016 to June 2017). June 2017 to May 2018 was 78.

RAMI 17 shows a June position of 67. The peer value for June is 83. The May position was 68 against a peer value of 81.

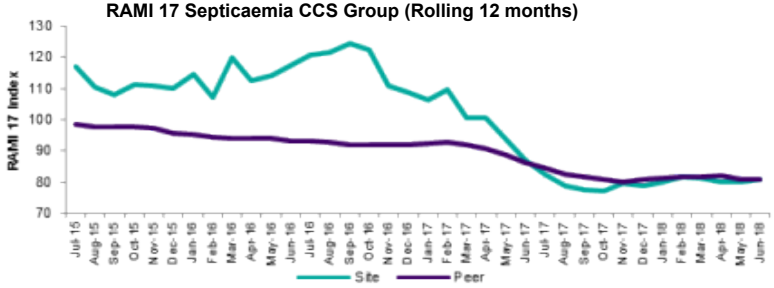
Crude mortality shows July 2017 to June 2018 at 1.76% compared to 1.81% for the same period last year.

The percentage of deaths reviewed within 3 months was 83% in May 2018, compared to 74% in April 2018.

SHMI (NHS Digital) Top 5 diagnostic groups by Volume April 17 to Mar 18	Observed deaths	Expected deaths	SHMI
Septicaemia (except in labour), Shock.	496	504	0.98
Pneumonia (except that caused by tuberculosis or sexua	387	399	0.97
Acute cerebrovascular disease.	143	137	1.04
Congestive heart failure; nonhypertensive.	102	87	1.17
Urinary tract infections.	73	70	1.04

Main causes of death during August 2018 (Mortality Database)	
Pneumonia	23
Sepsis/Septicaemia	13
Cancer	11
Heart failure	3
Chronic Obstructive Pulmonary Disease (COPD)	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
		Aug-17	Aug-18	Var	2017/18	2018/19	Var		
Four hour standard	95.0%	92.5%	90.4%	-2.1%	86.1%	92.2%	6.1%	90.1%	
A&E Minor Performance	98.0%	98.7%	99.3%	0.6%	96.6%	98.9%	2.3%	98.6%	
Four hour standard (Local System)	95.0%		92.7%			94.0%			
12 Hour DTAs	0	0	0	0	0	0	0	0	
Unplanned re-attendance to Emergency Department	5.0%	2.5%	3.9%	1.3%	2.9%	3.3%	0.4%	3.0%	
% Patients waiting less than 15 minutes for assessment in ED	M	83.9%	81.9%	-2.1%	83.3%	85.5%	2.2%	83.6%	
% Patients waiting less than 60 minutes for treatment in ED	M	44.5%	47.4%	2.8%	42.2%	49.7%	7.5%	49.4%	
% Patients waiting less than 120 minutes for treatment in ED	M	75.4%	77.4%	2.0%	71.1%	80.7%	9.7%	79.9%	
% Patients that left without being seen in ED	M	2.1%	2.7%	0.6%	1.5%	2.3%	0.7%	2.1%	
% Patients admitted from ED (Conversion rate)	M	28.3%	29.3%	1.0%	27.0%	28.8%	1.8%	29.9%	
Number of ambulatory care admissions with zero length of stay	M	639	803	164	2690	4044	1354	722	
% of ambulatory care admissions with zero length of stay	M	62.2%	62.5%	0.3%	58.6%	65.6%	7.0%	63.2%	
Emergency Department attendances	M	10476	11105	6.0%	50756	54682	7.7%	10231	
Ambulance conveyances	M	3187	3249	1.9%	16002	15541	-2.9%	3189	
Admissions via A&E	M	28.3%	29.4%	1.0%	27.0%	28.8%	1.8%	29.9%	

The Trusts' 4 hour performance was 90.4% for August

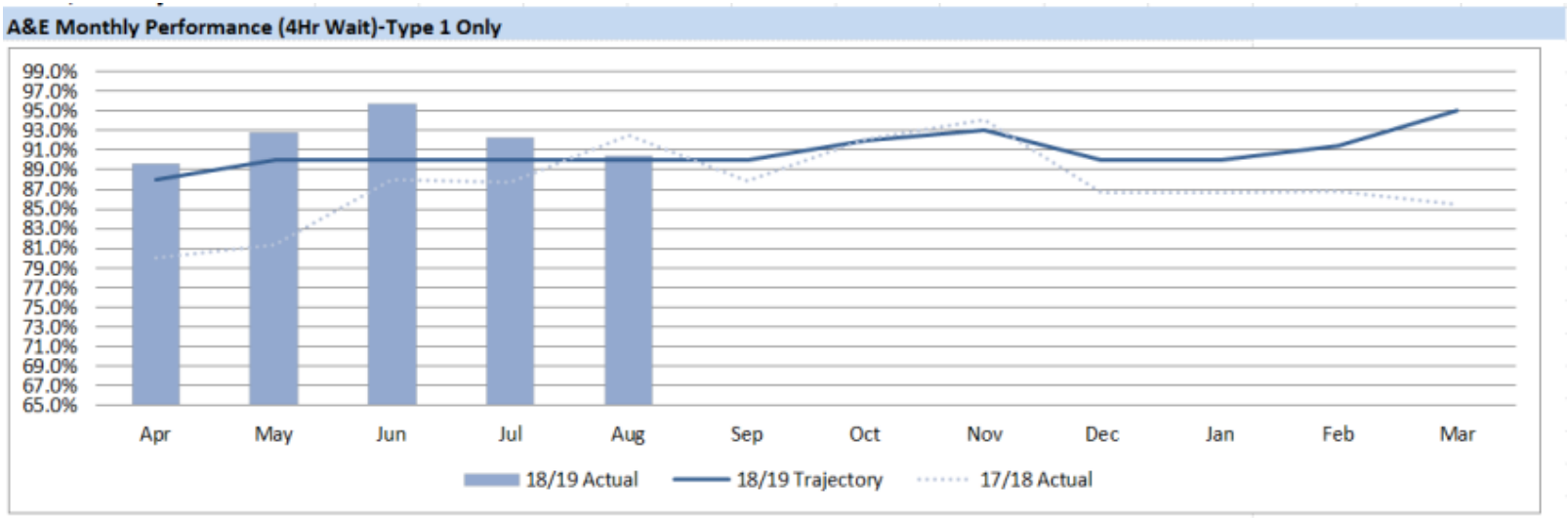
The system, walk in centres and the acute trusts combined performance was 92.7%

Activity continues to be higher than previous years, A&E attendances are up 7.7% year to date and on non-elective spells up 13.4%.

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%	92.2%	90.4%							
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%

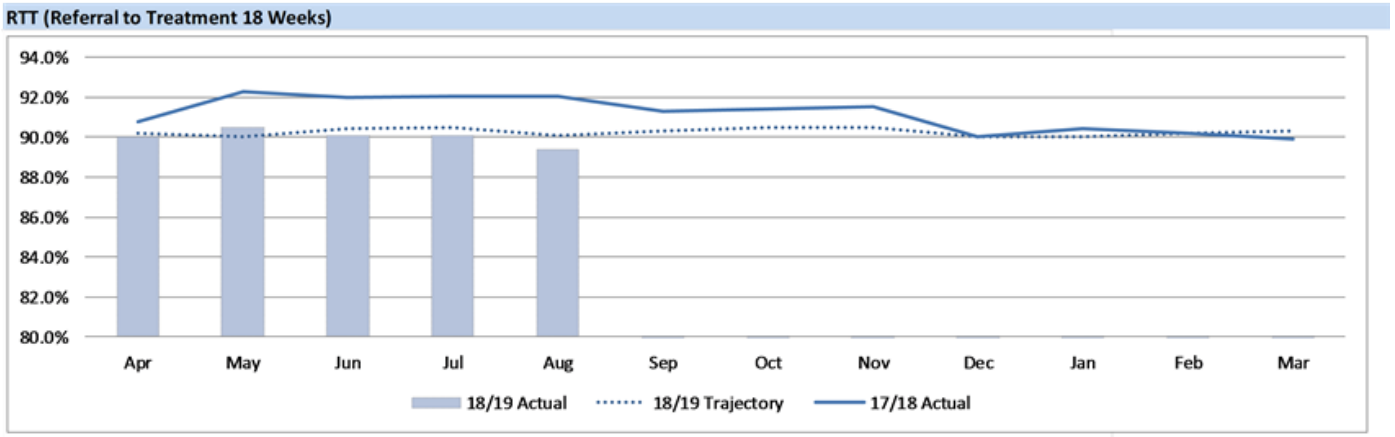
The Trusts' 4 hour performance for August was 90.4%, above the planned trajectory.
EDGH – 88.6%
Conquest – 92.2%

- Minors performance for August is 99.3%
- Attendances in August increased by 6% on the previous year.
- Ambulance conveyances increased by 1.9% against July 2017.

East Sussex Healthcare NHS
NHS Trust

RTT

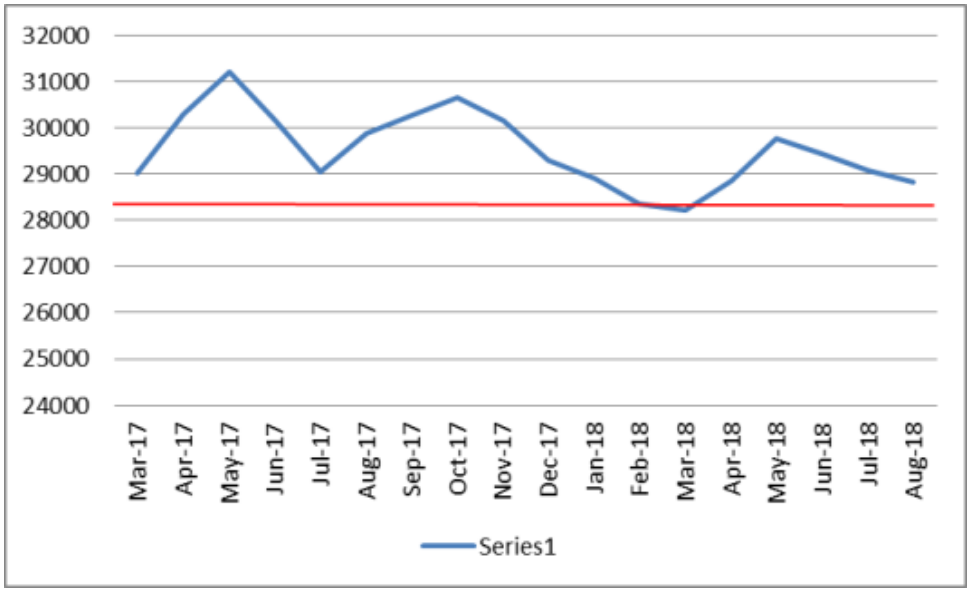
Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Aug-17	Aug-18	Var	2017/18	2018/19	Var		
RTT Incomplete standard	92.0%	92.0%	89.4%	-2.6%	91.9%	90.0%	-1.9%	90.4%	
RTT Backlog (Number of patients waiting over 18 weeks)	M	2385	3062	677	2385	3062	677	2778	
RTT Total Waiting List Size	28221	29886	28818	-1068	29886	28818	-1068	29358	
RTT 52 week waiters	0	0	0	0	0	0	0	0	
RTT 35 week waiters	M	172	194	12.8%	172	194	12.8%	182	



	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%	90.1%	89.4%							
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 August was 89.4%. This is slightly below trajectory.
- Daycase activity has decreased by around 150 cases against July although elective activity remained consistent with July. Primary care referrals remain down against last year however 2 week wait referrals are continuing to increase.
- Focus is on out-patient and theatre productivity to better manage demand and capacity without additional costs.

RTT Waiting list



Target

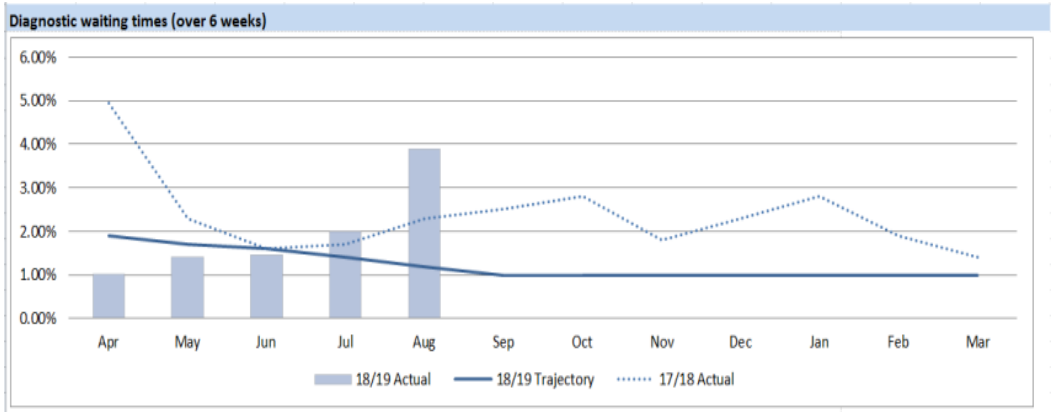
Monthly Waiting List

- August saw a further reduction in the waiting list following a peak in May. The peak was as a result of reduced activity due to Bank Holidays. The August waiting list was 28,818. This remains marginally above the end of March figure of 28,221 which is the target for the end of the year.

CANCELLATIONS AND DTC

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Aug-17	Aug-18	Var	2017/18	2018/19	Var		
Super Stranded (Census on last day of month)	M	136	99	-37					
Avg Daily Super Stranded Beddays (single month metric)	142	188	145	-43	218	171	-48	176	
Avg Daily Super Stranded Beddays (rolling 3 month avg NHSI metric)	142	203	153	-50					
Delayed transfer of care national standard	3.5%	4.0%	3.9%	-0.1%	5.6%	2.2%	-3.5%	2.2%	
Cancellations									
Urgent operations cancelled for a second time	0	0	1	1	1	4	3	0	
Proportion of last minute cancellations not rebooked within 28 days	0.0%	0.0%			0.0%	0.0%	0.0%	98.8%	



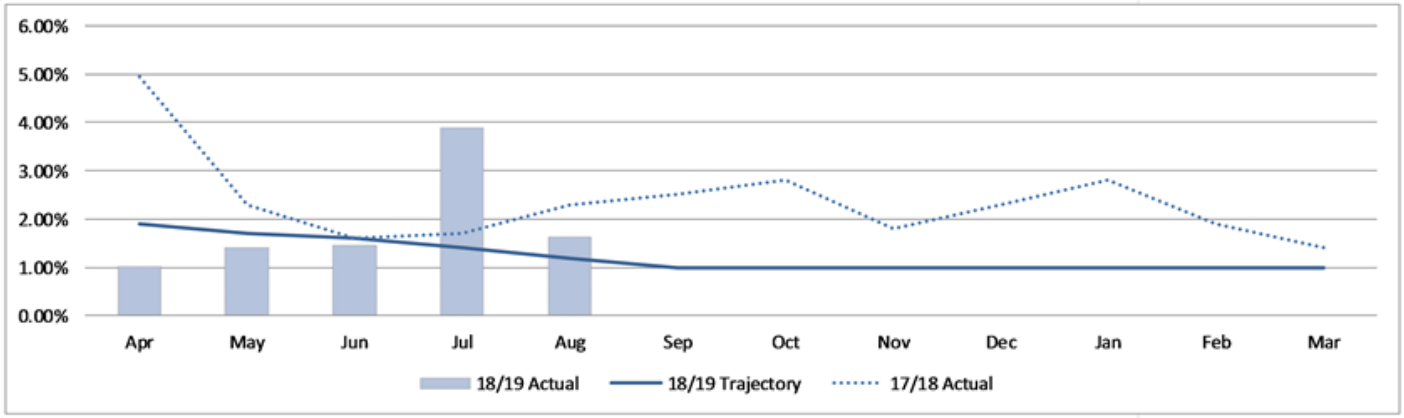
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	1.9%	1.7%	1.6%	1.4%	1.2%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
18/19 Actual	1.02%	1.42%	1.47%	2.0%	3.9%							
17/18 Actual	5.0%	2.3%	1.6%	1.7%	2.3%	2.5%	2.8%	1.8%	2.3%	2.8%	1.9%	1.4%

- DTC are currently at 3.9%, slightly about trajectory and the 3.5% target.
- Despite the increase in activity, non-elective bed days have reduced by 5.8% year to date versus last year
- Non Elective length of stay has reduced by 0.9 days from 5.5 to 4.6

Diagnostics

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Aug-17	Aug-18	Var	2017/18	2018/19	Var		
Diagnostic standard (% patients waiting more than 6 weeks)	1.0%	2.3%	1.6%	-0.6%	2.6%	1.9%	-0.7%	2.1%	

Diagnostic waiting times (over 6 weeks)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	1.9%	1.7%	1.6%	1.4%	1.2%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
18/19 Actual	1.02%	1.42%	1.47%	3.9%	1.6%							
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 56 breaches (5%) which contributed significantly to the overall position alongside the Non-Obstetric Ultrasound breaches 15. Performance is below the <1% target however this is anticipated to improve for September, ensuring sustainable delivery.

East Sussex Healthcare NHS
NHS Trust

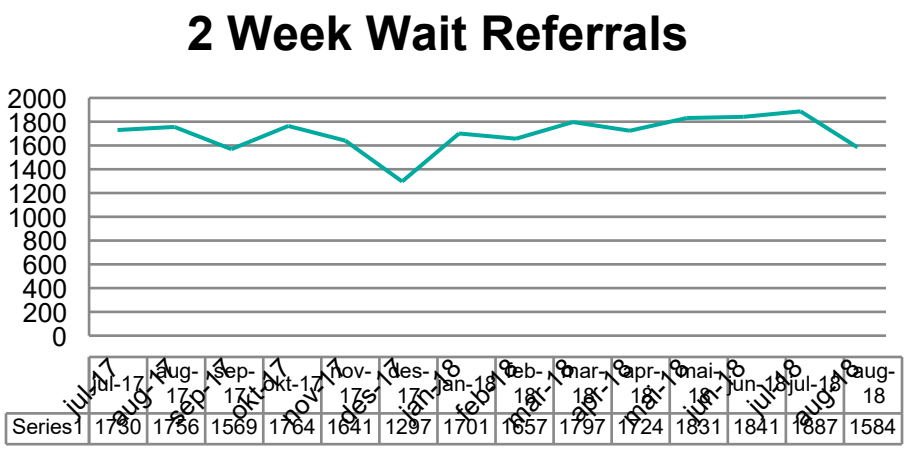
CANCER STANDARDS

Indicator Description	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
	Aug-17	Aug-18	Var	2017/18	2018/19	Var		
Cancer 2WW Standard	95.4%	96.0%	0.6%	95.8%	94.6%	-1.2%	95.7%	
Cancer 62 day urgent referral standard	74.7%	73.4%	-1.3%	75.7%	74.8%	-0.9%	75.6%	
Cancer 2WW Standard (breast symptoms)	96.8%	97.5%	0.6%	95.9%	94.9%	-1.0%	95.5%	
Cancer 31 day standard	95.3%	90.0%	-5.3%	97.3%	95.8%	-1.6%	96.7%	
Cancer 31 day subsequent drug treatment	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Cancer 31 day subsequent surgery	100.0%	90.0%	-10.0%	97.6%	95.3%	-2.3%	98.0%	
Cancer 62 day screening standard	55.6%	76.5%	20.9%	79.4%	46.2%	-33.2%	54.2%	

July 2018 – 62 Day

- As previously noted the June 2018 62 Day performance was an exceptional month reporting 157.5 treatments and 53 breaches, whereas the activity and data for July was reported closer to the levels of expected performance for the Trust generally.
- The 62 Day performance for July increased to 73.4% compared to June 2018 (66.3%).
- The Trust reported 133.5 62 Day treatments for July compared to 157.5 in June (24 fewer treatments) and 116 in May (17.5 more treatments).
- The total number of patients treated on a 62 day pathway in July was 167 individual patients.
- ESHT reported 11 shared treatments for July; 6 pathways were referred out of ESHT to the treating Trusts after Day 38. If the new day 38 reallocation rules were in place ESHT's performance would potentially decrease by 0.5% to 72.9%.

Cancer 2 Week Wait Referrals

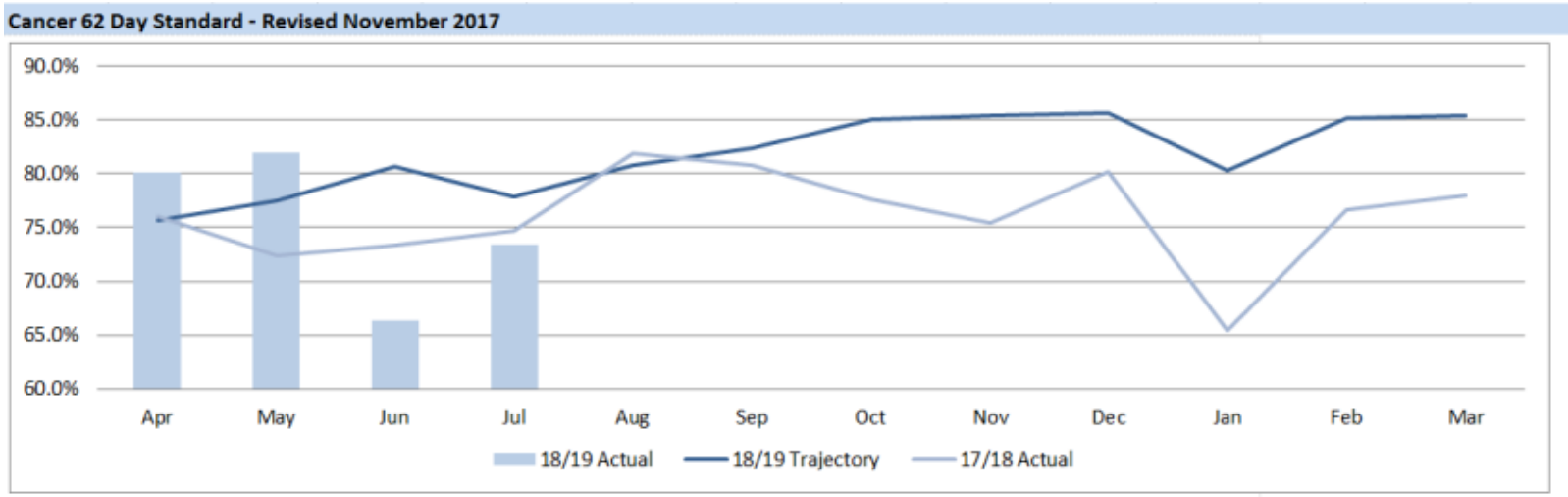


2 week wait referrals dropped in August after a steady increase over 2018. This increase has added further pressure into the system, although this reflects the seasonal trends and will be monitored through September.

The Urology campaign "Blood in Pee" started in July and is expected to impact further.

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%	66.3%	73.4%								
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, Colorectal, and lung are the highest breaching specialities this month.

Actions to deliver improvements include :

- Cancer Pathway Matrons now in place for surgical specialties
- Implementation of straight to test for colonoscopy in place from mid September
- Redesign of urology pathway

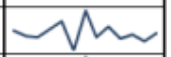
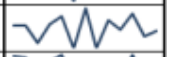
East Sussex Healthcare NHS
NHS Trust

Cancer Standards – 62 days (target 85%)

July 2018 Summary					
Standard	Total Seen /Treated	On Target	Breaches	Compliance	Target
Cancer Two Week Wait	1,699	1,631	68.0	96.0%	93%
Breast Symptom Two Week Wait	158.0	154.0	4.0	97.4%	93%
31 Day First Treatment (Tumour)	187.0	179.0	8.0	95.7%	96%
31 Day Subsequent Surgery	10.0	9.0	1.0	90.0%	94%
31 Day Subsequent Drug Treatments	11.0	11.0	0.0	100.0%	98%
31 Day Subsequent Palliative Treatments	4.0	4.0	0.0	100.0%	N/A
Cancer 62 Day Standard (Tumour)	133.5	98.0	35.5	73.4%	85%
62 Day Screening Standard (Tumour)	8.5	6.5	2.0	76.4%	90%
62 Day Upgrade Standard (Tumour)	3.5	15.0	18.5	81.1%	N/A

Community

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jul-17	Jul-18	Var	2017/18	2018/19	Var		
Community Nursing									
Community nursing referrals	M	4167	4085	-82	16472	16006	-466	4099	
Community nursing total contacts	M	35981	35313	-668	141540	143137	1597	35644	
Community Nursing face-to-face contacts	M	20425	19654	-771	80562	78128	-2434	19532	
Community nursing ALOS	M	22.1	7.3	-15	22.0	10.8	-11.2	16	
Waiting Times									
% SALT patients waiting less than 13 weeks	M	100.0%	83.0%	-17.0%	100.0%	90.9%	-9.1%	96.5%	
Total SALT patients waiting	M	107	151	44	547	650	103	151	
% 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	259	250	-9	1154	1272	118	257	
% Dietetics patients waiting less than 13 weeks	M	93.8%	100.0%	6.3%	97.6%	100.0%	2.4%	99.7%	
Total dietetics patients waiting	M	90	83	-7	327	429	102	72	
% MSK patients waiting less than 13 weeks	M	93.9%			92.1%			60.2%	
Total MSK patients waiting	M	1021	0	-1021	5041	0	-5041	519	

Activity

ACTIVITY

Activity Headlines

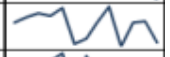
East Sussex Healthcare NHS
NHS Trust

- Year to date to the end of August shows non elective and follow ups on or up against plan. Day case, Electives and first outpatients remain below anticipated levels.
- Daycase: Year to date 0.2% **under** plan (42 cases under plan). Key under performance in Ophthalmology, Dermatology and Max-Fax.
- Elective: Year to date 7.3% **under** plan (225 cases). Decrease since last week. Under performance in General Surgery, T&O and Gynaecology.
- First: Year to date 3.7% **under** plan (1924), a decrease on last week. Under performance in ENT, Ophthalmology and Paediatrics.
- Follow up: Year to date 1.6% **up** on plan (2007 over plan) – under performance in a number of areas (predominantly DAS) off set by substantial over performance in cardiology.
- NEL: Year to date 9.5% **up** on plan (1977).

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
		Jul-17	Jul-18	Var	2017/18	2018/19	Var		
Emergency Department attendances	M	10596	11553	9.0%	40280	43577	8.2%	10179	
Ambulance conveyances	M	3219	3058	-5.0%	12815	12292	-4.1%	3184	
Admissions via A&E	M	27.6%	26.9%	-0.7%	26.7%	28.6%	2.0%	29.8%	
Elective spells	M	591	511	-13.5%	2453	2195	-10.5%	582	
Day Cases	M	3953	3998	1.1%	15821	15526	-1.9%	3885	
Elective Beddays	M	1850	1682	-9.1%	6747	6425	-4.8%	1605	
Total Non-Elective Spells	M	4163	4582	10.1%	15980	18184	13.8%	4440	
Number of Emergency spells	M	3534	4004	13.3%	13492	15871	17.6%	3841	
Number of Maternity spells (ante and post partem)	M	331	306	-7.6%	1339	1220	-8.9%	321	
Number of other non-elective spells (Births/Transfers from other hospitals)	M	298	272	-8.7%	1149	1093	-4.9%	278	
Non-Elective beddays	M	21342	20275	-5.0%	87240	81491	-6.6%	21461	
LOS									
Elective Average Length of Stay	M	3.1	3.3	0.2	2.8	2.9	0.2	2.8	
Non-Elective Average Length of Stay	M	5.0	4.4	-0.7	5.6	4.6	-1.0	4.9	
Inpatient Average Length of Stay at intermediate care units	M	28.6	24.0	-4.6	31.3	27.9	-3.4	27.3	

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

YTD (End August)	Actual 18/19	Actual 17/18	Plan 18/19	Variance to last year	Variance to plan
Daycase	19,307	19,714	19,571	-2%	-1%
Inpatient	2,709	3,081	3,023	-12%	10%
Elective (Total DC/IP)	22,016	22,795	22,594		
Non Elective	21,721	19,099	19,901	14%	9%
First OP	47,893	49,231	50,015	-3%	-4%
Follow Up OP	124,699	121,285	123,430	3%	1%

excludes well babies and neonatals

YTD (End August)	Year End Plan	Year end forecast	Variance to Year end forecast
Daycase	47,446	46,806	-1%
Inpatient	7,330	6,567	-10%
Elective (Total DC/IP)	54,776	53,373	
Non Elective	47,475	51,818	9%
First OP	121,261	116,108	-4%
Follow Up OP	299,247	302,311	1%

Leadership & Culture

LEADERSHIP & CULTURE

East Sussex Healthcare NHS
NHS Trust

TRUST OVERVIEW

TRUST														
WORKFORCE CAPACITY	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Trend line
Budgeted fte	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	7,031.1	6,941.3	
Total fte usage	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	6,755.4	6,667.0	
Variance	-152.3	-197.6	-95.3	-65.5	-26.5	29.2	-143.4	16.4	-149.5	-299.5	-286.0	-275.7	-274.3	
Permanent vacancies	706.4	745.9	647.0	622.0	609.9	577.7	537.1	527.6	644.6	605.2	651.3	663.5	641.2	
Fill rate	89.4%	89.0%	90.4%	90.8%	91.0%	91.4%	92.0%	92.2%	90.5%	91.0%	90.4%	90.3%	90.5%	
Bank fte usage (as % total fte usage)	9.3%	9.3%	9.3%	9.3%	9.7%	9.7%	6.7%	9.1%	10.1%	7.3%	8.1%	8.3%	7.8%	
Agency fte usage (as % total fte usage)	2.2%	2.2%	1.8%	2.1%	1.8%	2.0%	1.9%	1.9%	1.6%	1.9%	1.8%	1.7%	1.6%	
Turnover rate	11.2%	11.6%	11.3%	11.3%	11.3%	11.2%	11.1%	11.0%	10.9%	11.0%	10.9%	11.1%	11.0%	
Stability rate	91.7%	91.1%	91.6%	91.5%	92.1%	92.2%	91.9%	92.7%	92.1%	91.9%	89.5%	92.0%	92.0%	
SICKNESS ABSENCE														
Annual sickness rate	4.3%	4.3%	4.3%	4.3%	4.4%	4.4%	4.5%	4.5%	4.5%	4.5%	4.5%	4.4%	4.4%	
Monthly sickness rate (%)	4.2%	4.3%	4.8%	5.0%	5.3%	5.6%	4.6%	4.1%	3.6%	3.7%	3.5%	3.8%	3.9%	
Short term sickness (<28 days)	59.5%	63.4%	58.6%	61.6%	59.0%	65.4%	48.4%	57.5%	45.9%	44.3%	46.0%	41.2%	45.0%	
Monthly long term sickness (28 days+)	40.5%	36.6%	41.4%	38.4%	41.0%	34.6%	51.6%	42.5%	54.1%	55.7%	54.0%	58.8%	55.0%	
MANDATORY TRAINING & APPRAISALS														
Appraisal rate	81.6%	82.2%	82.3%	81.4%	81.3%	81.8%	81.3%	79.6%	79.5%	79.2%	78.1%	78.2%	79.7%	
Fire	85.9%	85.5%	85.8%	86.0%	85.8%	86.4%	86.5%	86.6%	86.2%	87.4%	87.1%	86.6%	87.6%	
Moving & Handling	90.2%	89.7%	89.1%	89.3%	89.4%	90.4%	90.3%	90.1%	89.4%	89.9%	89.8%	88.7%	89.2%	
Induction	95.0%	94.3%	91.9%	93.5%	92.5%	95.1%	95.1%	94.8%	94.4%	95.0%	94.3%	94.8%	96.2%	
Infec Control	89.6%	89.3%	88.8%	88.8%	88.7%	89.8%	89.9%	90.2%	89.9%	90.5%	90.1%	89.6%	90.0%	
Info Gov	85.3%	85.7%	85.0%	85.8%	84.6%	86.8%	86.5%	86.3%	85.8%	85.1%	83.8%	84.7%	84.0%	
Health & Safety	88.8%	88.1%	87.9%	88.8%	87.9%	88.0%	87.4%	88.0%	88.8%	89.1%	88.6%	89.4%	88.7%	
MCA	96.0%	95.8%	94.8%	94.8%	95.1%	95.0%	95.3%	95.8%	95.8%	96.1%	96.1%	96.5%	96.5%	
DoLs	97.6%	97.5%	95.5%	95.5%	95.8%	95.1%	96.3%	96.4%	96.4%	96.8%	96.9%	97.2%	96.7%	
Safeguarding Vulnerable Adults	90.1%	88.9%	88.0%	87.8%	87.4%	86.2%	85.2%	84.7%	84.2%	85.8%	86.0%	86.7%	86.6%	
Safeguarding Children Level 2	86.4%	86.1%	85.9%	86.0%	85.7%	85.0%	85.4%	85.3%	84.7%	86.4%	87.4%	87.6%	87.8%	

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

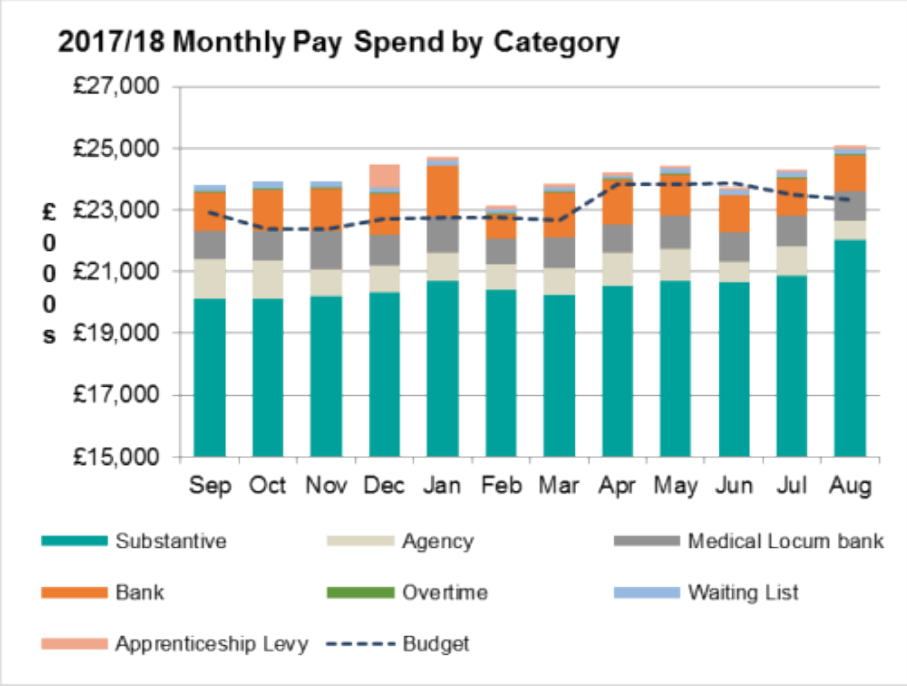
MONTHLY HEADLINES

HEADLINES – AUGUST 2018

- Actual workforce utilisation 6,667.0 fte, -274.3 fte below the budgeted establishment
- August '18 monthly budget £23,321k against monthly actual expenditure £25,085k (+£1,763k). n.b. this month included 3 months of pay award arrears
  - Substantive expenditure £22,044k
  - Temporary staff expenditure £2,933k (11.7% of total pay expenditure) as follows:
    - Bank expenditure £2,132k
    - Agency expenditure £604k
    - Overtime £41k
    - Waiting List payments £156K
- Vacancies in July have reduced to 641.2 fte (9.5%), this is a decrease of 22.3 ftes .
- Annual turnover reduced by -0.1% to 11.0%, which represents 638.1 fte leavers in the last year
- Annual sickness rate unchanged at 4.4%
- Monthly sickness increased by +0.1% against July to 3.9%.
- Mandatory Training rate and Appraisal rates:
  - Mandatory Training rate increased by +0.1% to 88.8%. Compliance increased for Fire, Moving & Handling, Infection Control, Trust Induction, Safeguarding Children Levels 2 & 3 and End of Life Care but decreased for Information Governance, Health & Safety, Deprivation of Liberties and Safeguarding Vulnerable Adults. Appraisal compliance increased by +1.5% to 79.7%

WORKFORCE EXPENDITURE

Actuals in Month (£000s)													
Category	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Trend line
Budget	£22,912	£22,390	£22,366	£22,726	£22,733	£22,733	£22,657	£23,830	£23,824	£23,875	£23,490	£23,321	
Substantive	**£20,126**	**£20,096**	**£20,189**	**£20,306**	**£20,679**	**£20,401**	**£20,228**	**£20,540**	**£20,683**	**£20,635**	**£20,873**	**£22,044**	
Apprenticeship Levy				£744	£123	£128	£126	£94	£100	£92	£99	£108	
Agency	£1,269	£1,269	£889	£907	£929	£848	£863	£1,053	£1,037	£697	£954	£604	
Medical Locum bank	£909	£968	£1,249	£976	£1,145	£796	£1,014	£911	£1,086	£923	£977	£960	
Bank	£1,268	£1,321	£1,347	£1,329	£1,663	£801	£1,448	£1,451	£1,343	£1,210	£1,229	£1,172	
Overtime	£45	£44	£32	£31	£31	£45	£34	£46	£28	£30	£43	£41	
Waiting List	£210	£235	£238	£195	£153	£108	£135	£110	£151	£128	£136	£156	
Total Temp Expenditure	**£3,701**	**£3,837**	**£3,755**	**£3,438**	**£3,921**	**£2,598**	**£3,494**	**£3,571**	**£3,645**	**£2,988**	**£3,339**	**£2,933**	
Total Spend	**£23.827**	**£23.933**	**£23.944**	**£24.488**	**£24.723**	**£23.127**	**£23.848**	**£24,205**	**£24,428**	**£23,715**	**£24,311**	**£25,085**	



- Budgeted establishment has reduced by 90 ftes due to reductions for ward reconfiguration, although wards have not yet closed due to continuing activity.
- The increase in substantive expenditure this month is mostly due to the payment of three months arrears from the pay award.
- **AGENCY** - Expenditure reduced by -£350K this month. The majority of this reduction was in Medicine where the agency stroke consultant has left, whilst medical agency was not used in Rheumatology due to holidays. In addition there were accounting adjustments for unused agency shifts. Elsewhere, an agency consultant in Microbiology has been replaced by a locum, whilst General & Breast Surgery clinics were cancelled this month and did not require agency cover. There was also a reduction in midwifery and gynae nursing agency due to substantive appointments
- **BANK -** Locum in Community Paediatrics has left and being replaced by new substantive staff.

***Source data**: Finance Ledger*

WORKFORCE - PLANNED V ACTUAL (fte)

- Planned substantive fte (Workforce Submission to NHSI refresh as of 20th June '18)
- Actual worked substantive ftes broadly in line with forecast, though Medical and Registered Nursing reduced this month

PLANNED WORKFORCE					
MONTH END	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Prof Scientific and Tech	163.0	163.0	163.0	163.0	163.0
Additional Clinical Services	1,869.1	1,868.1	1,842.6	1,842.6	1,842.6
Administrative and Clerical	641.2	643.2	640.9	640.9	640.9
Allied Health Professionals	383.0	383.0	383.0	383.0	387.2
Estates and Ancillary	511.6	510.6	510.6	510.6	510.6
Healthcare Scientists	132.5	132.5	132.5	132.5	132.5
Medical & Dental	594.9	596.9	599.9	600.9	603.9
Nursing & Midwifery Registered	1,799.9	1,802.0	1,790.2	1,793.4	1,793.4
Planned Substantive Staff	**6,095.2**	**6,099.3**	**6,062.7**	**6,066.9**	**6,074.1**

ACTUAL WORKFORCE					
BY STAFF GROUP IN POST	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Prof Scientific and Tech	165.2	160.4	160.4	160.7	156.5
Additional Clinical Services	1,882.2	1,866.2	1,851.4	1,864.7	1,855.2
Administrative and Clerical	643.0	642.9	646.7	645.8	642.9
Allied Health Professionals	384.0	381.6	387.3	395.4	397.6
Estates and Ancillary	516.0	519.5	513.9	512.2	518.1
Healthcare Scientists	137.6	136.0	135.4	132.2	132.9
Medical & Dental	582.8	582.9	575.9	583.3	569.8
Nursing & Midwifery Registered	1,788.9	1,778.2	1,774.2	1,783.9	1,766.9
Actual Staff in Post	**6,099.6**	**6,067.6**	**6,045.3**	**6,078.1**	**6,039.9**

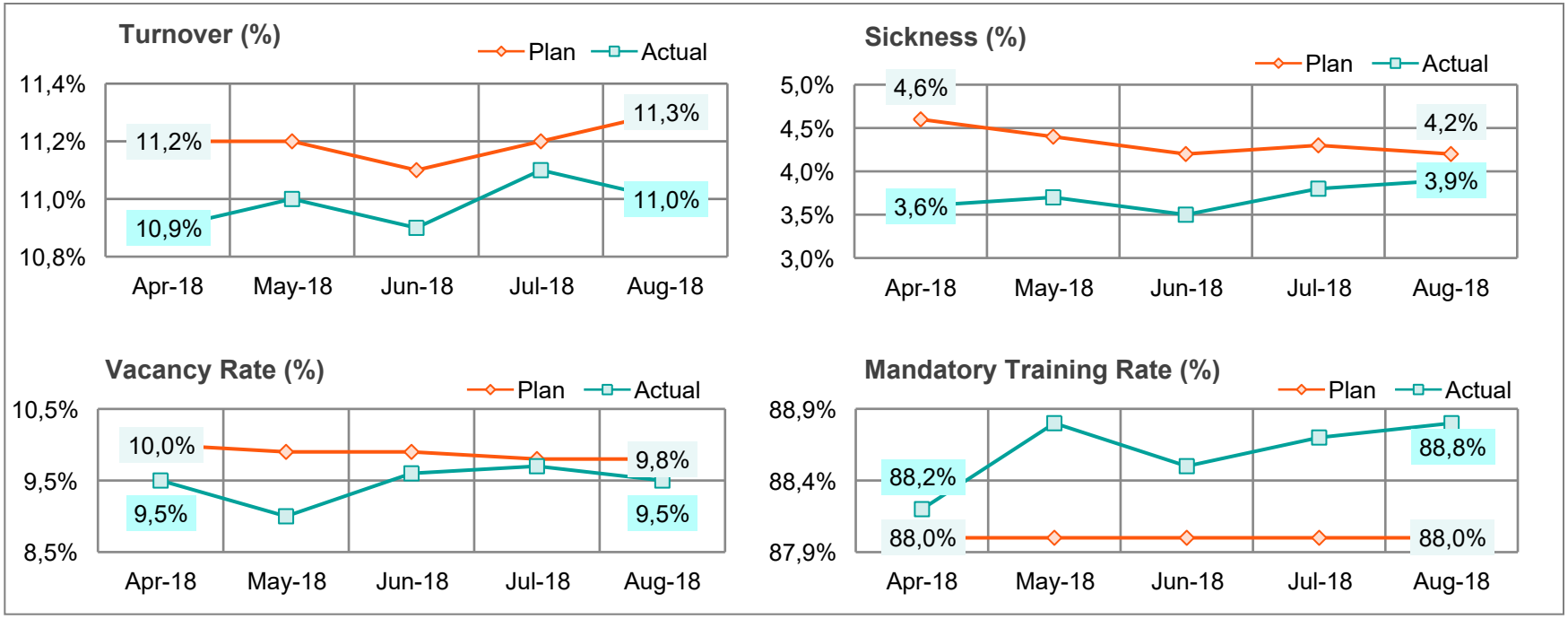
PLANNED V ACTUAL					
BY STAFF GROUP IN POST	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Prof Scientific and Tech	2.2	-2.6	-2.6	-2.3	-6.5
Additional Clinical Services	13.1	-1.9	8.8	22.1	12.6
Administrative and Clerical	1.8	-0.4	5.8	4.9	2.0
Allied Health Professionals	1.0	-1.4	4.3	12.4	10.4
Estates and Ancillary	4.4	8.9	3.3	1.6	7.5
Healthcare Scientists	5.1	3.5	2.9	-0.3	0.4
Medical & Dental	-12.1	-14.0	-24.0	-17.7	-34.1
Nursing & Midwifery Registered	-11.0	-23.8	-16.0	-9.5	-26.5
Planned v Actual +/-	**4.4**	**-31.7**	**-17.4**	**11.2**	**-34.2**

***Source data**: Finance Ledger*

NHSI KPI'S - PLANNED v ACTUAL

- The Trust is performing better than forecast on all 4 core workforce KPIs (compared to the NHSI Workforce submission)

Category	Plan/Actual	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Annual Turnover %	Planned	11.2%	11.2%	11.1%	11.2%	11.3%
	Actual	10.9%	11.0%	10.9%	11.1%	11.0%
Monthly Sickness %	Planned	4.6%	4.4%	4.2%	4.3%	4.2%
	Actual	3.6%	3.7%	3.5%	3.8%	3.9%
Vacancy Rate %	Planned	10.0%	9.9%	9.9%	9.8%	9.8%
	Actual	9.5%	9.0%	9.6%	9.7%	9.5%
Mandatory Training rate	Planned	88.0%	88.0%	88.0%	88.0%	88.0%
	Actual	88.2%	88.8%	88.5%	88.7%	88.8%

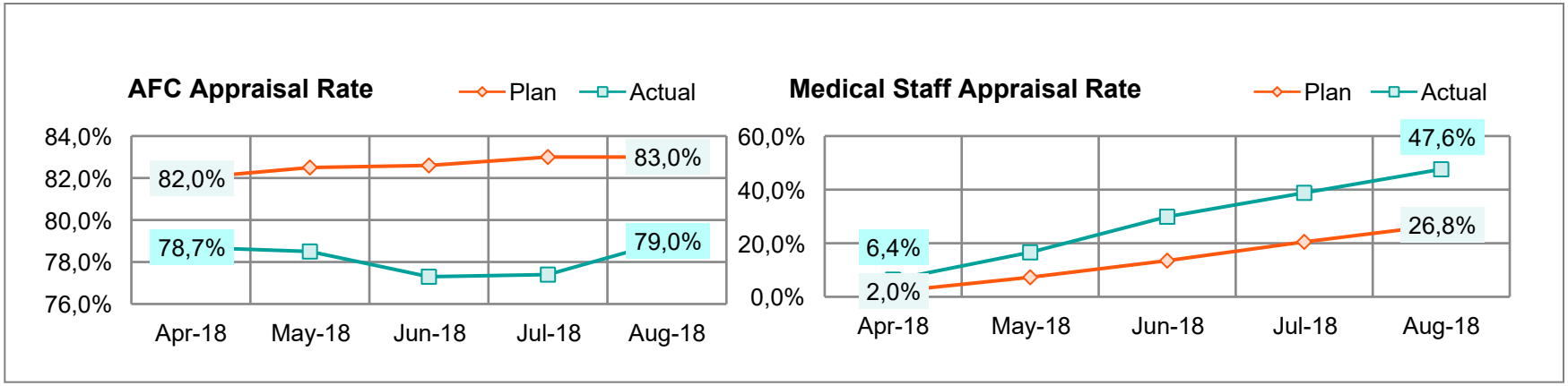


***Source data**: ESR & Finance Ledger*

NHSI KPI'S - PLANNED v ACTUAL (2)

- Agenda for Change appraisal rate % based on a rolling year whilst the Medical Staff Appraisal rate looks at year to date (as per Revalidation reports)
- Agenda for Change appraisal rate currently below forecast however has seen an improvement over the last two months

Category	Plan/Actual	Apr-18	May-18	Jun-18	Jul-18	Aug-18
AfC Appraisal Rate (rolling year)	Planned	82.0%	82.5%	82.6%	83.0%	83.0%
	Actual	78.7%	78.5%	77.3%	77.4%	79.0%
Medical Staff Appraisal Rate (Yr to date)	Planned	2.0%	7.3%	13.5%	20.5%	26.8%
	Actual	6.4%	16.6%	29.9%	38.8%	47.6%



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

East Sussex Healthcare NHS
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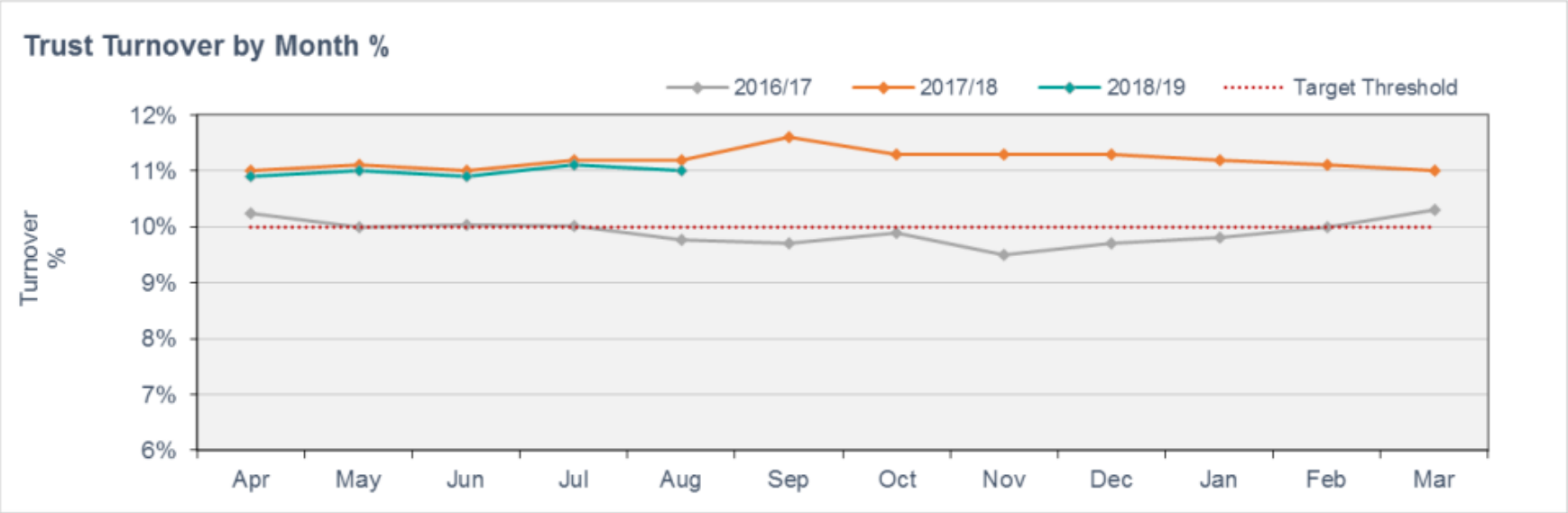
TURNOVER TREND – STAFF GROUP

- Turnover rate of 11.0% in August equates to 638.1fte leavers.
- There were 49.8 fte leavers in August (not including junior doctors rotation); 33.8 were voluntary resignations.

TRUST TURNOVER BY STAFF GROUP (%)

Year on Year	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Trend line
Additional Clinical Services	13.7%	13.9%	14.5%	13.8%	13.5%	13.5%	13.5%	13.4%	13.5%	13.4%	14.0%	13.5%	
Administrative and Clerical	11.5%	11.3%	10.8%	11.1%	11.4%	11.1%	11.3%	11.7%	12.5%	11.7%	11.8%	11.6%	
Allied Health Professionals	11.3%	11.0%	11.6%	12.7%	12.7%	12.9%	13.2%	12.1%	10.6%	10.0%	9.6%	9.6%	
Estates and Ancillary	11.0%	11.5%	11.4%	10.4%	10.7%	10.3%	9.9%	8.9%	8.6%	9.1%	9.9%	9.1%	
Healthcare Scientists	12.0%	11.8%	12.4%	11.0%	9.7%	10.9%	12.1%	11.8%	10.8%	12.3%	12.5%	12.1%	
Medical & Dental	11.4%	9.7%	9.4%	10.0%	9.1%	9.7%	10.8%	10.4%	11.1%	11.7%	11.8%	11.5%	
Nursing & Midwifery Registered	11.1%	10.3%	10.2%	10.4%	10.2%	10.0%	9.4%	9.2%	9.4%	9.3%	9.5%	9.9%	
Prof Scientific and Tech	6.7%	8.2%	8.8%	8.8%	8.3%	9.7%	8.8%	8.7%	8.6%	8.7%	9.3%	9.1%	
TOTAL TRUST TURNOVER	**11.6%**	**11.3%**	**11.3%**	**11.3%**	**11.2%**	**11.1%**	**11.0%**	**10.9%**	**11.0%**	**10.9%**	**11.1%**	**11.0%**	



***Source data**: ESR*

East Sussex Healthcare NHS
NHS Trust

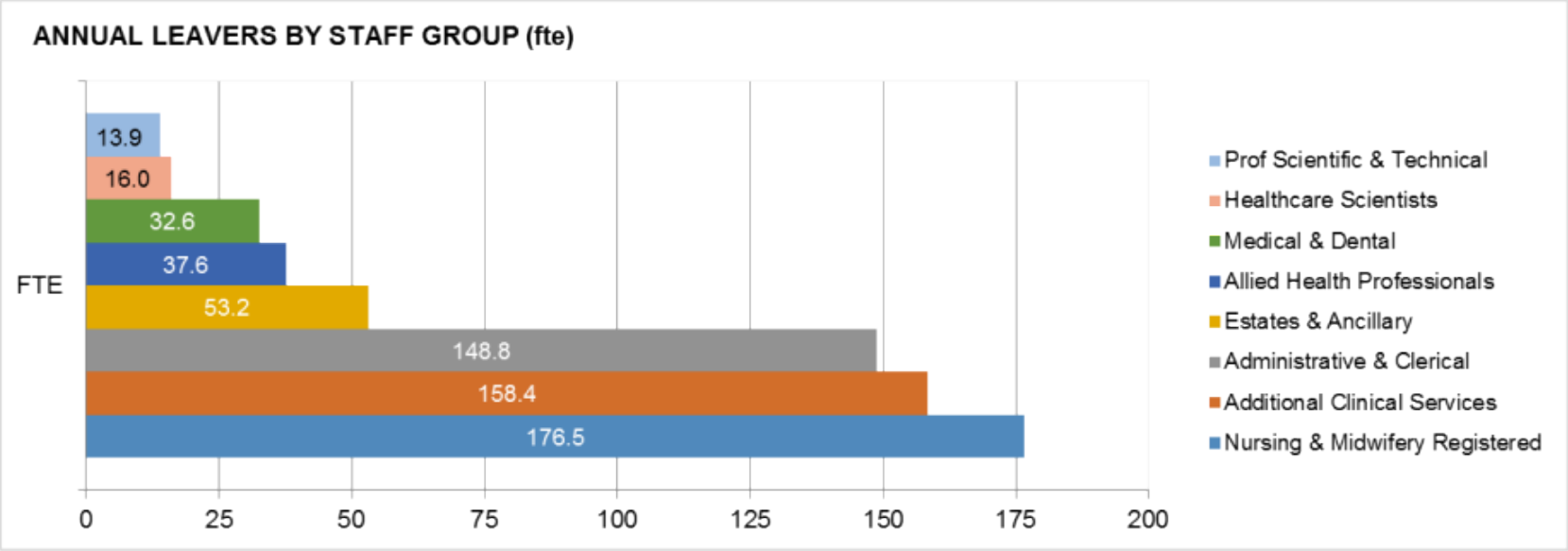
LEAVERS & STABILITY – STAFF GROUP

STAFF GROUPS	STABILITY > 1YR
Medical & Dental	91.5%
Prof Scientific & Technical	87.9%
Administrative & Clerical	93.2%
Nursing & Midwifery Registered	92.9%
Estates & Ancillary	94.9%
Additional Clinical Services	90.0%
Healthcare Scientists	90.1%
Allied Health Professionals	90.3%
TRUST	**92.0%**

Overview

- The Stability Rate measures the number of current staff who have more than 1 year's service with ESHT
- Nursing & Midwifery Registered staff remain the largest cohort of leavers with 176.5 ftes leaving in the last year. The next largest group is Additional Clinical Services (i.e. unregistered nurses and other clinical support)
- Medical & Dental leavers does not include junior doctor rotation, in line with common NHS practice.

Source: ESR August 2018

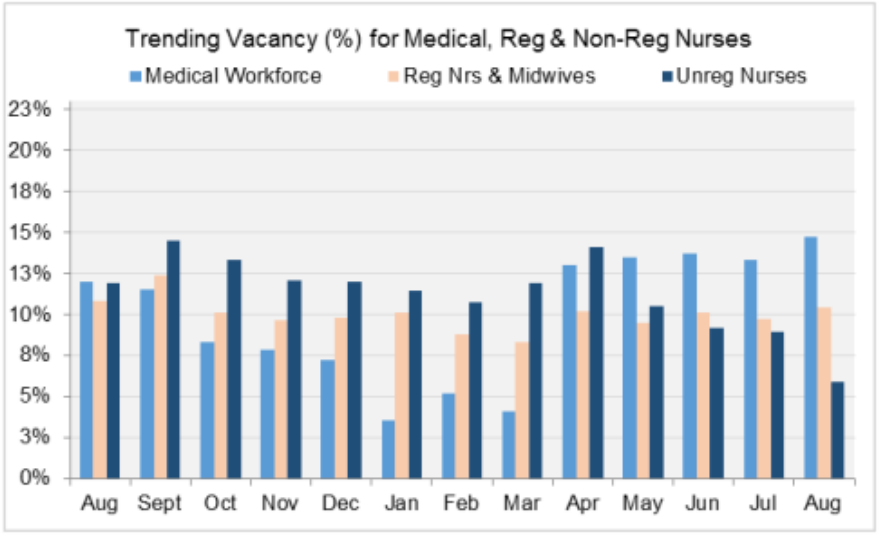


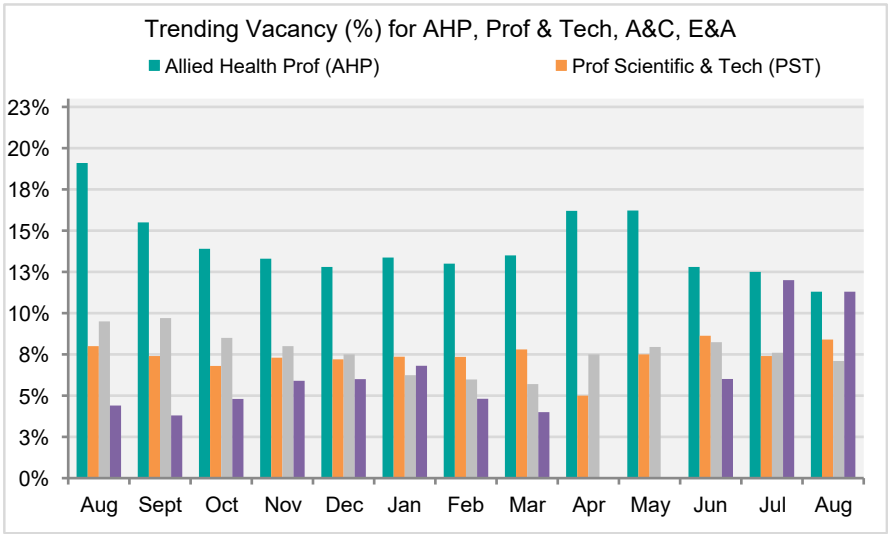
***Source data**: ESR*

RECRUITMENT – TRENDING NET VACANCIES BY STAFF GROUP (%)

- Vacancy rate has reduced by 0.2%. Total fte vacancies for the Trust is 641.2 fte
- Registered nursing & midwifery vacancy rates are below the national vacancy rate of 11.8% for June 2018 (NHSI Provider Sector first quarter report). Overall, the national vacancy rate for NHS Providers was 9.2% in June
- Medacs recruitment agency on site from 13th September with contract due to start from 1st October

AUG 2017 TO AUG 2018	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Trend line
Medical Workforce	12.0%	11.5%	8.3%	7.8%	7.2%	3.5%	5.2%	4.1%	13.0%	13.5%	13.7%	13.3%	14.7%	
Reg Nrs & Midwives	10.8%	12.4%	10.1%	9.6%	9.8%	10.1%	8.8%	8.3%	10.2%	9.5%	10.1%	9.7%	10.4%	
Unreg Nurses	11.9%	14.5%	13.3%	12.1%	12.0%	11.4%	10.7%	11.9%	14.1%	10.5%	9.2%	8.9%	5.9%	
Allied Health Prof (AHP)	19.1%	15.5%	13.9%	13.3%	12.8%	13.4%	13.0%	13.5%	16.2%	16.2%	12.8%	12.5%	11.3%	
Prof Scientific & Tech (PST)	8.0%	7.4%	6.8%	7.3%	7.2%	7.4%	7.4%	7.8%	5.0%	7.5%	8.6%	7.4%	8.4%	
Admin & Clerical	9.5%	9.7%	8.5%	8.0%	7.5%	6.2%	6.0%	5.7%	7.5%	8.0%	8.2%	7.6%	7.1%	
Estates & Ancillary (E&A)	4.4%	3.8%	4.8%	5.9%	6.0%	6.8%	4.8%	4.0%	-1.5%	-2.7%	6.0%	12.0%	11.3%	
TRUST	**10.6%**	**11.0%**	**9.6%**	**9.2%**	**9.0%**	**8.6%**	**8.0%**	**7.8%**	**9.5%**	**9.0%**	**9.6%**	**9.7%**	**9.5%**	





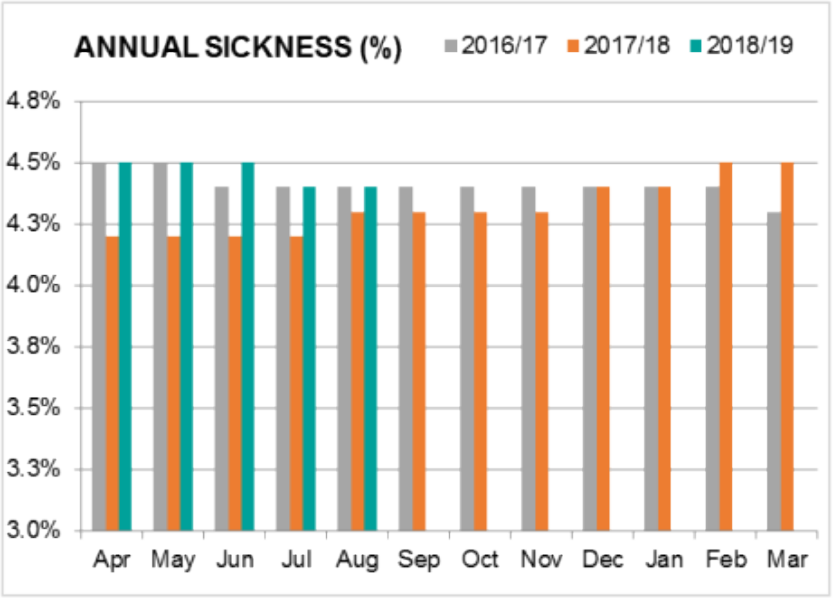
***Source data**: ESR & Finance Ledger*

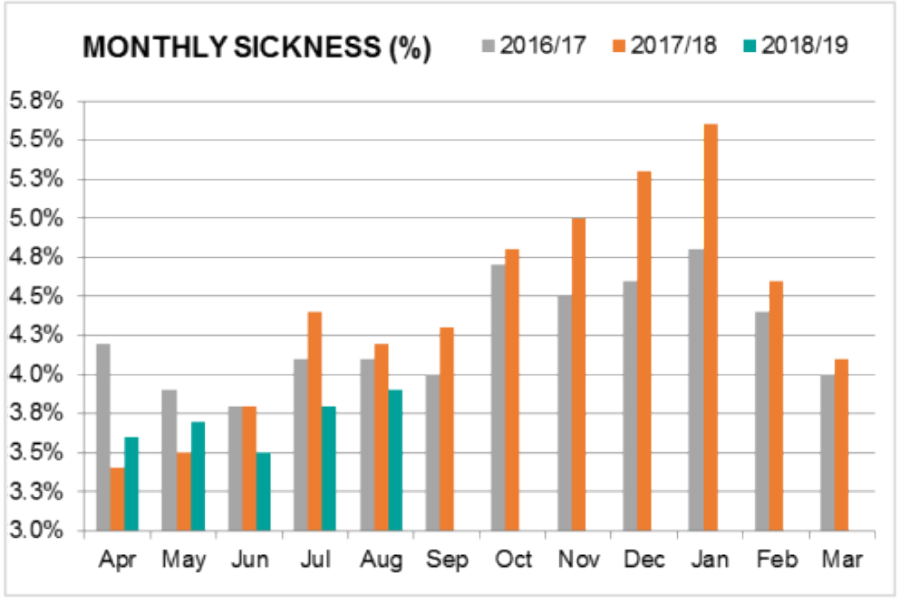
ABSENCE MANAGEMENT – SICKNESS RATES

- The monthly sickness rate increased by +0.1% to 3.9%, but is lower than the monthly rates for August 16 & August 17. The annual sickness rate is unchanged.
- Estates & Ancillary show highest monthly sickness rate at 5.4% (-0.4%) followed by Additional Clinical Services at 4.7% (-0.1%).

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%	4.4%	4.4%							

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%	3.8%	3.9%							



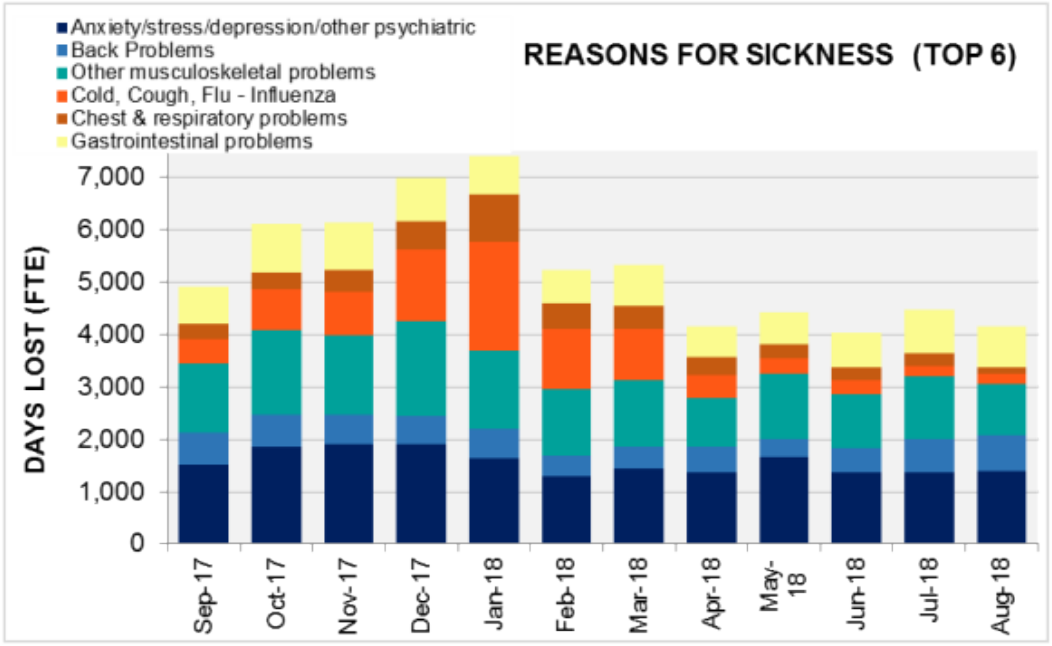


***Source data**: ESR*

ABSENCE MANAGEMENT – SICKNESS REASONS

- Fte days lost due to anxiety/stress and back problems have slightly increased by +22 and +62 days lost respectively but other musculoskeletal problems have reduced significantly by -236 days
- Fte days lost to sickness were 7,389 which equates to 238 fte staff off sick

TOP 6	Fte Days Lost by Month												
Reason for sickness	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Trend line
Anxiety/stress/depression/other psychiatric	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	1,369.6	1,391.9	
Back Problems	611.0	599.0	548.2	532.2	553.9	396.6	415.1	490.1	346.1	462.9	629.8	691.8	
Other musculoskeletal problems	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	1,212.7	977.0	
Cold, Cough, Flu - Influenza	472.3	789.5	829.0	1,360.5	2,070.4	1,139.0	990.8	442.9	313.0	275.3	189.2	185.8	
Chest & respiratory problems	299.4	325.2	409.5	555.1	920.1	499.6	438.6	353.0	264.0	235.8	244.2	132.8	
Gastrointestinal problems	699.8	930.7	895.1	831.8	723.1	647.3	777.1	587.5	604.9	657.3	825.8	782.7	



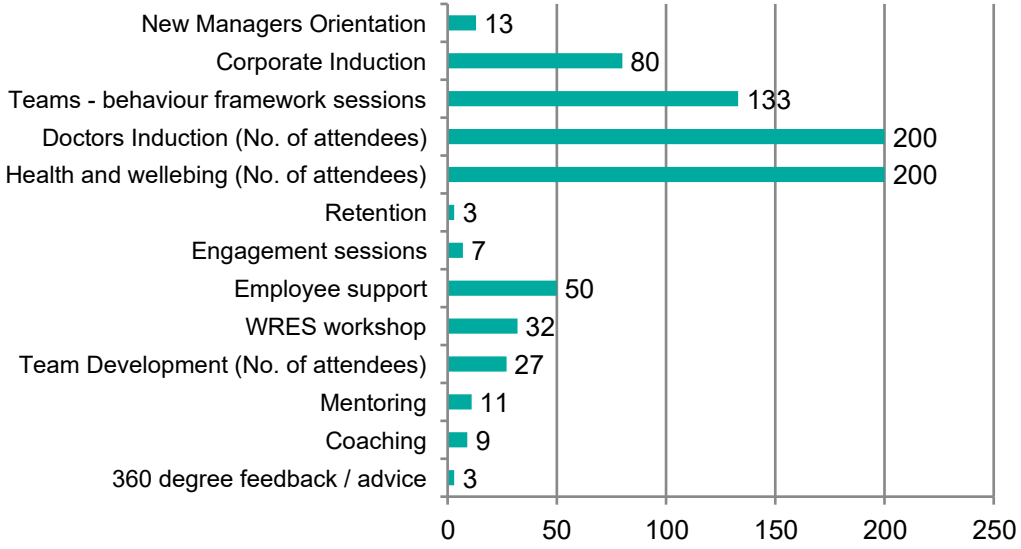
Aug 2018 - Top 10 in descending order (%)		%
1	Anxiety/stress/depression/other psychiatric illnesses	18.8%
2	Other musculoskeletal problems	13.2%
3	Gastrointestinal problems	10.6%
4	Back Problems	9.4%
5	Other known causes - not elsewhere classified	9.2%
6	Unknown causes / Not specified	7.8%
7	Injury, fracture	5.9%
8	Genitourinary & gynaecological disorders	3.8%
9	Benign and malignant tumours, cancers	3.0%
10	Headache / migraine	2.8%
	TOP 10 REASONS	**84.5%**

***Source data**: ESR*

WELLBEING & ENGAGEMENT

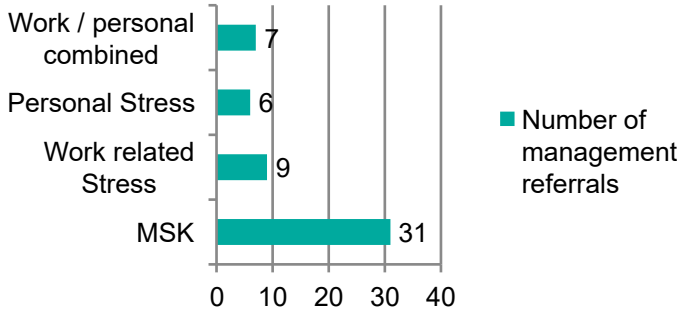
Development interventions

Number of people OD / SEWB worked with in August



Occupational Health

Number of management referrals (August)



- Additionally counselling and psychology accepted 24 referrals in August

The above interventions are delivered with the aim of improving the culture, reducing sickness, improving retention and building a resilient and sustainable leadership capacity across the Trust

East Sussex Healthcare NHS
NHS Trust

TRAINING & APPRAISAL COMPLIANCE BY DIVISION

MANDATORY TRAINING

- Overall mandatory training compliance increased by +0.1%
- Information Governance is continuing to show a decline in compliance following the move to eLearning. Departments will be offered help to address this; particularly areas who may experience difficulty accessing computers to offer laptop loans, facilitated eLearning sessions or additional support if required
- Additional Safeguarding Children Level 3 training sessions have been provided for Out of Hospital where this is a relatively newly identified requirement.
- Emphasis over the next few months will be to target those areas or staff who are continually low in compliance to ensure that they meet their mandatory training requirement .

APPRAISAL OVERVIEW

- The Trust appraisal rate has increased by +1.5% to 79.7%.

DIVISION	APPRAISAL COMPLIANCE	
	12 mth	16 mth
Urgent Care	79.4%	87.7%
Medicine	83.9%	92.0%
Out of Hospital	71.7%	85.6%
Diag/Anaes/Surg	84.3%	92.6%
Womens, Child, S/Health	74.9%	87.4%
Estates & Facilities	86.2%	91.7%
Corporate	75.8%	83.5%
TRUST	**79.7%**	**89.0%**

										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	76.7%	77.9%	96.4%	78.3%	73.5%	89.2%	93.5%	87.5%	16.6%	84.1%	87.4%	85.7%
Medicine	85.3%	86.7%	97.4%	87.5%	79.6%	87.6%	95.4%	94.3%	33.5%	86.6%	86.8%	N/A
Out of Hospital	86.6%	89.9%	98.2%	92.6%	78.3%	87.2%	97.7%	99.0%	28.0%	84.5%	83.0%	31.5%
Diag/Anaes/Surg	86.4%	88.9%	92.4%	88.1%	83.9%	84.3%	97.5%	97.3%	25.6%	88.5%	90.5%	N/A
Womens, Child, S/Health	86.8%	86.7%	91.5%	89.4%	84.9%	89.8%	95.7%	95.2%	1.0%	87.7%	91.3%	90.5%
Estates & Facilities	91.7%	89.4%	96.9%	93.5%	91.4%	93.0%	n/a	n/a	n/a	n/a	n/a	n/a
Corporate	94.5%	96.1%	98.9%	94.5%	93.0%	95.1%	98.9%	98.7%	5.7%	81.9%	86.4%	100.0%
TRUST	**87.6%**	**89.2%**	**96.2%**	**90.0%**	**84.0%**	**88.7%**	**96.7%**	**96.7%**	**25.0%**	**86.9%**	**87.8%**	**74.2%**

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

***Source data**: ESR*

May 2018

FINANCE

Jonathan Reid, Director of Finance

Finance Report Summary - Month 5

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**

Operational Deficit

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(18,099)	(19,518)	(20,106)	(588)
Year End Forecast	(68,422)	(45,000)	(45,000)	0

The Trust is £588k behind plan YTD at M5, a deterioration of £258k from the previous month. The in month run rate position has improved by £0.4m. However, CIP is £1.1m under delivered YTD. Pay is £3.4m overspent YTD which is mainly due to A/C wage award costs of £2.1m, which is offset within income. Overspends in medical pay, CIP delivery, waiting list initiative premium payments and nursing special observations £0.5m. Non pay underspends include non recurrent benefits from VAT and stock adjustments.

Agency Usage

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(6,824)	(4,482)	(4,345)	137
Year End Forecast	(13,799)	(9,305)	(9,305)	0

Agency spend has reduced 36% compared to the same period 2017/18. However, there is continued requirement for agency in difficult to recruit medical and AHP posts. Non clinical agency has significantly reduced from M3 and overall agency costs are within the NHSI ceiling for 2018/19.

Income

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	163,664	165,996	167,360	1,364
Year End Forecast	387,935	397,467	397,467	0

Under performance on elective and day case activity is partially offset by increased non-elective activity above plan. A&E activity is significantly above plan in month which is in line with national trends. £2.1m pay award income is above plan and offsetting increased pay costs.

Operating Costs

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(178,564)	(182,283)	(184,207)	(1,924)
Year End Forecast	(448,948)	(434,713)	(434,713)	0

Overall, costs are reporting £1.9m overspent against plan YTD. New A/C wage award national deal (£2.1m offset by additional funding in income), medical pay costs including agency (£1.5m) drugs overspend (£0.3m) and CIP under delivery are offset by non-recurrent benefits from stock adjustments and VAT.

Cost Improvement Programme

	Plan £k	Actual £k	Variance £k
Year to Date	6,794	5,691	(1,102)
Year End Forecast	23,516	23,516	0

CIP is £1.1m under delivered against plan YTD. The main reason is the delayed impact of patient flow bed modelling £927k (largely pay) with capacity continuing to be utilised in August due to an increase in activity, £102k endoscopy scope leases, £127k theatres (primarily gynae and urology). Waiting list initiative reductions £112k, partially offset by over delivery on pharmacy and vacancies in Emergency Care.

Cash

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Current Balance	2,100	2,100	3,166	1,066
Year End Forecast	2,100	2,100	2,100	0

Cash balance above minimum balance at month end.

Capital Plan

	Plan £k	Actual £k	Variance £k
Year to Date	7,952	5,225	2,727
Year End Forecast	23,856	13,049	10,807

Current CRL is £13m. To enable the Trust to deliver the planned spend significant external funding will need to be applied for, approved and delivered in year. Negotiations with East Sussex County Council are on-going.

BPPC

	Month Volume	Month Value	YTD Volume	YTD Value
Trade Invoices	75.86%	84.36%	60.09%	70.51%
NHS Invoices	96.25%	99.87%	82.48%	96.92%

75% of trade invoices were paid within 28 days which equates to 84% of the total value paid in month.

96% of NHS invoices were paid within contract or within 28 days of receipt which was 100% of the total NHS invoices paid.

Divisional Performance

Division	In the Month						Year to Date			Forecast Outturn		
	Plan FTE	Actual FTE	Variance FTE	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k
Diagnostics, Anaesthetics & Surgery	1,769.93	1,657.99	111.94	(289)	(1,369)	(1,079)	(2,528)	(4,790)	(2,262)	(3,446)	(3,446)	0
Medicine	1,421.17	1,399.53	21.64	2,858	2,820	(38)	14,075	12,704	(1,371)	33,226	33,226	0
Urgent Care	323.73	306.85	16.88	656	895	239	3,751	4,244	494	8,477	8,477	0
Out of Hospital Care	1,083.26	1,030.43	52.83	(757)	(711)	46	(3,076)	(3,260)	(183)	(6,707)	(6,707)	0
Women's, Children's & Sexual Health	696.59	653.72	42.87	1,078	868	(210)	5,418	4,959	(458)	13,203	13,203	0
Estates & Facilities	639.07	618.47	20.60	(2,181)	(2,524)	(343)	(10,136)	(10,904)	(768)	(23,711)	(23,711)	0
Corporate	1,007.53	999.99	7.54	(4,321)	(4,576)	(254)	(21,283)	(20,898)	384	(49,923)	(49,923)	0
Central	0.00	0.00	0.00	11	1,392	1,381	(5,739)	(2,162)	3,577	(16,120)	(16,120)	0
Total	**6,841.28**	**6,888.88**	**274.30**	**(2,848)**	**(3,204)**	**(268)**	**(18,618)**	**(20,106)**	**(588)**	**(46,000)**	**(46,000)**	**0**

Key Risks

Key Risk 1	Medical pay costs increased by 5% compared to M1-5 2017/18 (£1.5m overspend YTD)
Key Risk 2	Day case and Elective activity £1.6m below plan YTD (gynae, orthopaedics, ophthalmology and dermatology). Overall activity on day case and elective is 4% below 17/18 levels M1-5
Key Risk 3	Unidentified CIP and delivery of CIP YTD £1.1m behind plan
Key Risk 4	Special observations £0.7m cost YTD on wards against annual budget of £0.5m
Key Risk 5	Contract challenges (counting and coding, MRET, fines and penalties, CQUIN, HWLH NHSPS)

Mitigations

Mitigation 1	Recruitment to substantive medical posts wherever possible. Additional controls implemented on agency and locum spend including review of highest overspends in medical pay costs in ophthalmology, gastroenterology, radiology and respiratory. Medical agency costs in August have reduced £0.3m compared to July.
Mitigation 2	Review of elective and day case activity at specialty level to understand correlation with costs, waiting list and referral trends.
Mitigation 3	Divisions being held to account via Confirm and Challenge sessions and IPRs. Grip and control to be tightened across Trust. Capacity identified as bed modelling CIP remains open in M5 due to an increase in NEL activity.
Mitigation 4	Additional controls in place and number of shifts booked to cover special observations is reducing as DoN is reviewing process.
Mitigation 5	Ongoing discussions with CCGs, including an escalation process to DoF and CEO.

Income & Expenditure Summary - Month 5

	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	25.5	28.0	27.4	(0.5)	130.4	137.0	135.2	(1.8)	329.1	329.1	0.0
Tariff-Excluded Drugs & Devices	3.1	3.1	2.9	(0.1)	14.0	15.3	14.9	(0.4)	36.4	36.4	0.0
Private Patient / ICR	0.3	0.3	0.2	(0.0)	1.1	1.3	1.0	(0.2)	3.7	3.7	0.0
Other Non-Clinical Income	3.2	2.3	4.6	2.3	15.6	12.5	16.2	3.8	28.3	28.3	0.0
Total Income	**32.0**	**33.6**	**35.2**	**1.6**	**161.1**	**166.0**	**167.4**	**1.4**	**397.5**	**397.5**	**0.0**
Pay - Substantive	(20.2)	(20.8)	(22.3)	(1.5)	(100.1)	(103.7)	(106.1)	(2.4)	(250.2)	(250.2)	0.0
Pay - Bank	(2.1)	(1.8)	(2.1)	(0.4)	(9.5)	(10.2)	(11.3)	(1.1)	(22.8)	(22.8)	0.0
Pay - Agency	(1.0)	(0.7)	(0.6)	0.1	(6.8)	(4.5)	(4.3)	0.1	(9.3)	(9.3)	0.0
Total Pay	**(23.3)**	**(23.3)**	**(25.1)**	**(1.8)**	**(116.4)**	**(118.3)**	**(121.7)**	**(3.4)**	**(282.2)**	**(282.2)**	**0.0**
Drugs	(3.7)	(3.5)	(3.4)	0.1	(17.7)	(17.7)	(18.0)	(0.3)	(42.2)	(42.2)	0.0
Supplies & Services - Clinical	(2.8)	(2.9)	(3.1)	(0.2)	(14.3)	(14.7)	(14.8)	(0.1)	(35.3)	(35.3)	0.0
Supplies & Services - General	(0.2)	(0.4)	(0.3)	0.1	(1.8)	(2.0)	(2.0)	0.0	(4.8)	(4.8)	0.0
Purchase of Healthcare (non-NHS)	(0.4)	(0.5)	(0.5)	0.0	(2.1)	(2.3)	(2.3)	(0.0)	(5.8)	(5.8)	0.0
Services from Other NHS Bodies	(0.6)	(0.6)	(0.6)	0.1	(2.5)	(3.1)	(3.0)	0.1	(7.5)	(7.5)	0.0
Consultancy	(0.1)	(0.1)	(0.1)	(0.0)	(0.4)	(0.6)	(0.5)	0.1	(1.0)	(1.0)	0.0
Clinical Negligence	(1.2)	(0.9)	(0.9)	0.0	(6.1)	(4.4)	(4.4)	0.0	(10.3)	(10.3)	0.0
Premises	(1.0)	(1.1)	(1.8)	(0.7)	(5.5)	(5.7)	(6.6)	(0.9)	(14.6)	(14.6)	0.0
Depreciation	(1.1)	(1.0)	(1.0)	(0.1)	(5.3)	(6.0)	(5.2)	0.8	(12.9)	(12.9)	0.0
Other	(1.4)	(1.6)	(1.1)	0.5	(6.6)	(7.5)	(5.7)	1.8	(18.3)	(18.3)	0.0
Total Non-Pay	**(12.5)**	**(12.6)**	**(12.7)**	**(0.1)**	**(62.2)**	**(64.0)**	**(62.5)**	**1.5**	**(152.6)**	**(152.6)**	**0.0**
Total Operating Costs	**(35.7)**	**(35.9)**	**(37.8)**	**(1.9)**	**(178.6)**	**(182.3)**	**(184.2)**	**(1.9)**	**(434.8)**	**(434.8)**	**0.0**
Net Surplus/(Deficit) from Operations	**(3.7)**	**(2.3)**	**(2.6)**	**(0.3)**	**(17.5)**	**(16.3)**	**(16.8)**	**(0.5)**	**(37.4)**	**(37.4)**	**0.0**
Financing Costs	(0.7)	(0.6)	(0.6)	(0.0)	(3.2)	(3.2)	(3.2)	(0.0)	(7.6)	(7.6)	0.0
Total Non-Operating Costs	**(0.7)**	**(0.6)**	**(0.6)**	**(0.0)**	**(3.2)**	**(3.2)**	**(3.2)**	**(0.0)**	**(7.6)**	**(7.6)**	**0.0**
Total Costs	**(36.4)**	**(36.5)**	**(38.5)**	**(1.9)**	**(181.8)**	**(185.5)**	**(187.4)**	**(1.9)**	**(442.5)**	**(442.5)**	**0.0**
Net Surplus/(Deficit)	**(4.4)**	**(2.9)**	**(3.2)**	**(0.3)**	**(20.7)**	**(19.5)**	**(20.1)**	**(0.5)**	**(45.0)**	**(45.0)**	**0.0**
Donated Asset/Impairment Adjustment	0.0	0.0	0.0	0.0	0.1	0.0	(0.0)	(0.0)	0.0	0.0	0.0
Operational Surplus/(Deficit)	**(4.4)**	**(2.9)**	**(3.2)**	**(0.3)**	**(20.6)**	**(19.5)**	**(20.1)**	**(0.6)**	**(45.0)**	**(45.0)**	**0.0**
Sustainability & Transformation Fund	0.7	0.0	0.0	0.0	2.6	0.0	0.0	0.0	0.0	0.0	0.0
Net Surplus/(Deficit)	**(3.7)**	**(2.9)**	**(3.2)**	**(0.3)**	**(18.0)**	**(19.5)**	**(20.1)**	**(0.6)**	**(45.0)**	**(45.0)**	**0.0**

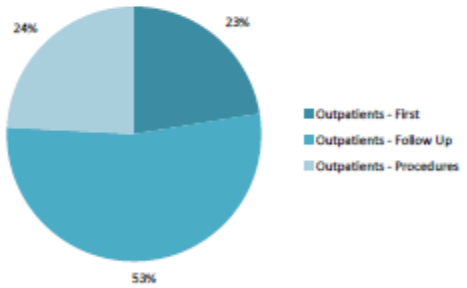
Summary & Next Steps

The Trust's YTD financial performance at M5 is behind plan (£588k). Run rate has improved from previous month (£0.4m). However, YTD CIP underperformance of £1.1m. Other non clinical income includes over performance on Pharmacy Manufacturing Unit £0.2m, central funding for the AfC wage award £2.1m and Education & Training income above plan. Drugs is reporting an overspend, partially linked to increased NEL activity and higher acuity of patients. Mitigating actions are being taken to recover overspends and bring back to plan by year end. £0.8m depreciation underspend is due to the original phasing of the plan on donated assets, which is offset by other non-clinical income over plan.

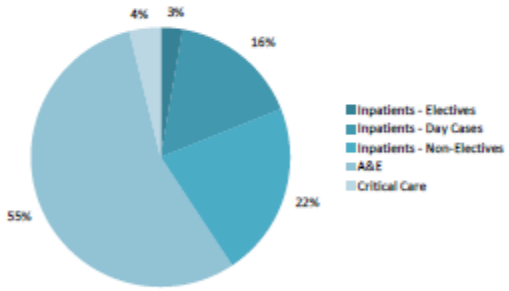
Income & Activity Summary - Month 5

	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	609	633	509	(124)	1,668	1,882	1,619	(263)	3,054	3,050	2,696	(354)	8,751	9,068	8,237	(831)	21,643	21,643	0
Inpatients - Day Cases	3,253	3,476	3,018	(458)	2,449	2,612	2,335	(277)	16,491	16,750	16,069	(681)	12,270	12,586	11,773	(814)	30,041	30,041	0
Inpatients - Non-Electives	3,901	4,173	4,454	281	8,190	8,784	9,356	571	18,504	20,595	21,562	967	38,553	43,354	44,784	1,430	103,427	103,427	0
Outpatients	33,136	35,427	33,777	(1,650)	3,493	3,786	3,630	(155)	163,330	170,676	170,713	37	17,182	18,237	17,828	(409)	43,539	43,539	0
A&E	10,513	10,381	11,123	742	1,398	1,395	1,543	148	51,018	51,234	54,888	3,654	6,779	6,885	7,512	628	16,424	16,424	0
CQUIN	0	0	0	0	533	605	619	14	0	0	0	0	2,611	2,953	3,026	72	7,100	7,100	0
Critical Care	618	750	828	78	630	823	1,037	214	3,641	3,701	3,828	127	3,871	4,061	4,215	155	9,687	9,687	0
Direct Access	9,062	9,031	8,105	(926)	349	364	292	(71)	44,175	43,512	42,218	(1,294)	1,751	1,751	1,578	(173)	4,180	4,180	0
ESBT	0	0	0	0	420	588	588	(0)	0	0	0	0	1,932	2,939	2,939	(0)	7,055	7,055	0
Excess Bed Days	1,395	1,503	158	(1,345)	341	366	273	(93)	8,934	7,408	3,929	(3,479)	2,139	1,803	1,143	(660)	4,301	4,301	0
Exclusions	0	0	0	0	3,122	3,094	2,946	(148)	0	0	0	0	14,013	15,269	14,876	(392)	36,426	36,426	0
IMSK	0	0	0	0	860	118	118	(0)	0	0	0	0	1,772	592	592	(0)	1,421	1,421	0
Maternity Pathway	584	582	560	(22)	622	593	557	(36)	2,823	2,805	2,825	20	2,878	2,858	2,936	77	6,822	6,822	0
Other	308,732	311,844	299,369	(12,476)	5,647	5,479	5,446	(33)	1,493,163	1,538,608	1,529,292	(9,316)	32,459	28,545	28,641	95	69,489	69,489	0
Contract Income Total	371,803	377,801	361,901	(15,900)	29,721	30,488	30,360	(128)	1,805,133	1,858,338	1,848,020	(10,318)	146,962	150,902	150,080	(822)	361,554	361,554	0
Divisional Income					3,446	3,099	4,845	1,746					16,692	15,094	17,280	2,186	35,913	35,913	0
Total Income	371,803	377,801	361,901	(15,900)	33,166	33,587	35,205	1,618	1,805,133	1,858,338	1,848,020	(10,318)	163,653	165,996	167,360	1,364	397,467	397,467	0

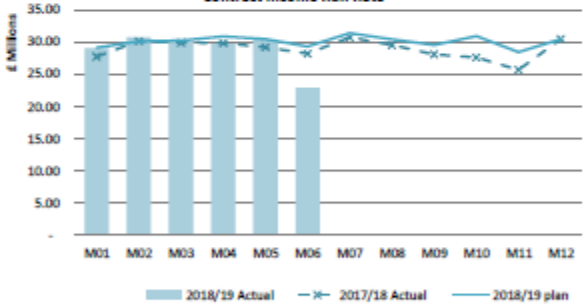
YTD Outpatients Activity by POD



YTD Inpatient & A&E Activity



Contract Income Run Rate



Summary & Next steps

Inpatients - Electives & Day Cases (YTD) £1,645k below plan -7.6%

Trauma and Orthopaedics have underperformed by £697k YTD against plan.
Ophthalmology (£433k) and Gynaecology (£321k) have underperformed YTD against plan.

Inpatients - Non-Electives (YTD) £1,430k above plan 3.3%

Overperformance of £1,809k YTD in General Medicine.

Outpatients (YTD) £409k below plan -2.2%

Trauma and Orthopaedics have overperformed by £244k YTD against plan, offset by underperformances in Ophthalmology (£264k) and Paediatrics (£169K).

A&E (YTD) £628k above plan 9.1%

Financial overperformance of £628k YTD. Reduction in activity of 4% from July to August 2018, however, in-month activity is 6% higher than August 2017.

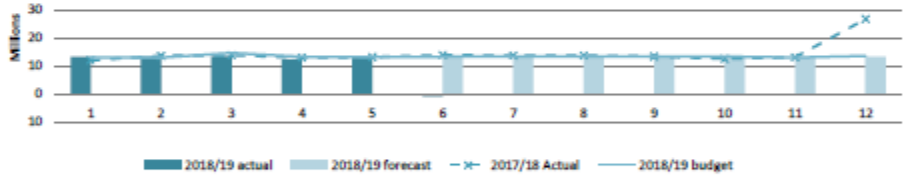
Financial Risks (YTD) £4,454k

£4,454k of risk relating to Winter, CQUIN, MRET, GP Streaming, and counting and coding challenges has not been included in YTD contract income figures.

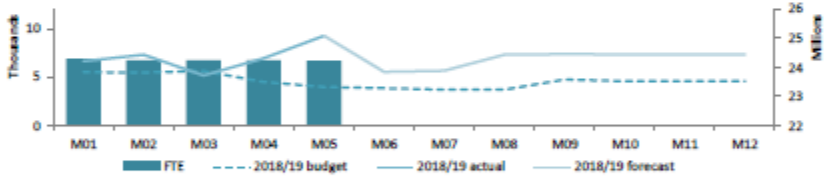
Operating Expenditure & Workforce Summary - Month 5

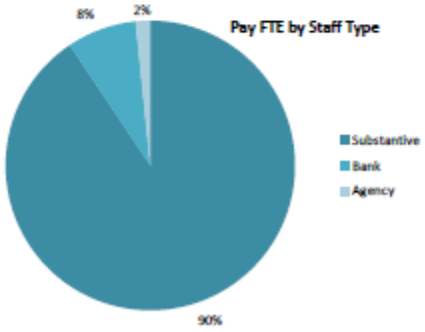
Cost Element	In Month								Year to Date				Forecast Outturn		
	17/18 WTE Actual	18/19 WTE Plan	18/19 WTE Actual	WTE Variance	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	18/19 Expenditure Variance (£k)	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	18/19 Expenditure Variance (£k)	18/19 Plan (£k)	18/19 FOT (£k)	Variance (£k)
Administrative & Management	1355	1387	1336	51	3,675	4,085	4,053	32	17,776	18,996	18,556	439	45,680	45,680	0
Ancillary	664	706	677	29	1,381	1,879	1,806	72	7,043	7,710	7,573	137	18,494	18,494	0
Medical	649	710	659	51	5,374	5,587	5,830	(243)	28,110	27,965	29,462	(1,498)	66,537	66,537	0
Nursing & Midwifery	3051	3086	3013	74	9,473	10,013	10,279	(266)	47,279	48,074	48,790	(716)	114,544	114,544	0
Prof, Scientific & Tech	544	530	522	8	1,914	1,840	1,902	(62)	8,899	8,521	8,861	(339)	20,339	20,339	0
Professions Allied to Medicine	421	523	461	61	1,445	1,928	1,707	220	7,194	8,872	7,785	1,088	21,112	21,112	0
Other	0	0	0	0	13	(2,010)	(493)	(1,517)	62	(1,798)	717	(2,515)	(4,479)	(4,479)	0
Total Pay	**6884**	**6841**	**6887**	**275**	**23,274**	**23,321**	**26,085**	**(1,763)**	**118,386**	**118,340**	**121,743**	**(3,403)**	**282,227**	**282,227**	**0**
Services from Other NHS Bodies					588	627	576	51	2,508	3,135	3,029	106	7,454	7,454	0
Clinical Negligence Premium					1,218	877	869	8	6,090	4,387	4,379	8	10,270	10,270	0
Consultancy					80	62	66	(4)	354	556	491	65	1,036	1,036	0
Drugs					1,051	629	684	(55)	5,095	3,893	4,330	(437)	9,105	9,105	0
Drugs - Tariff Excluded					2,689	2,908	2,707	201	12,576	13,792	13,696	97	32,902	32,902	0
Education and Training					70	132	81	52	438	646	372	275	1,572	1,572	0
Establishment Expenses					638	639	737	(98)	3,087	3,193	3,119	75	7,645	7,645	0
Premises					1,044	1,132	1,818	(686)	5,518	5,731	6,571	(841)	14,531	14,531	0
Purchase of Healthcare from Non NHS Bodies					397	503	495	8	2,077	2,334	2,326	7	5,841	5,841	0
Supplies and Services - Clinical					2,767	2,734	3,104	(370)	14,320	14,402	14,780	(378)	34,040	34,040	0
Supplies and Services - General					188	336	302	34	1,759	1,684	1,968	(284)	4,032	4,032	0
Other Non-Pay					11,894	2,000	1,287	713	8,378	10,222	7,404	2,818	24,185	24,185	0
Total Non-Pay					**22,823**	**12,679**	**12,727**	**(147)**	**82,199**	**83,976**	**82,483**	**1,511**	**162,814**	**162,814**	**0**
Total Expenditure	**6884**	**6841**	**6887**	**275**	**46,097**	**36,001**	**37,811**	**(1,911)**	**178,584**	**182,316**	**184,207**	**(1,892)**	**434,841**	**434,841**	**0**

Non-Pay Monthly Run rate



Pay Monthly Run Rate vs FTE





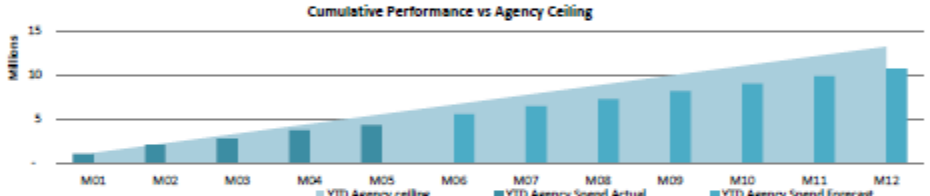
Summary & Next Steps

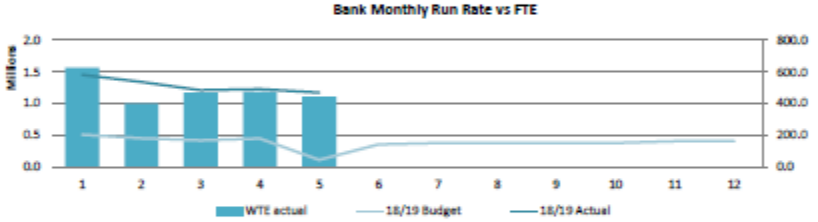
The arrears for AfC national pay award have been paid to eligible staff in M5. £2,050k income was received to offset the additional pay increase M1-5. Variances in Other Pay is attributable to unidentified CIP and increases as a result of the new deal AfC pay award. Medical pay is £1,498k overspent YTD and costs have increased by 4.8% (£1,352k) compared to the same period last year, however medical agency costs have reduced in the month by £343k.

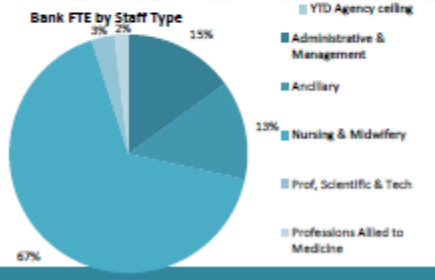
Drugs spend is showing £437k overspend due to inflationary pressures and increase in non-elective activity, this has been largely offset by a stock adjustment in month. Tariff excluded drugs are underspent by £97k YTD, which is offset by income. A number of non-recurrent stock adjustments and capitalisation of grouped assets have improved YTD performance in clinical supplies, establishment expenses and premises costs. Due to an external review of VAT treatment in July, the Trust has been recovered £547k of VAT relating to the 2017/18 financial year.

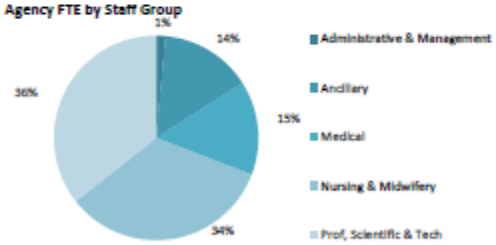
Temporary Workforce Summary - Month 5

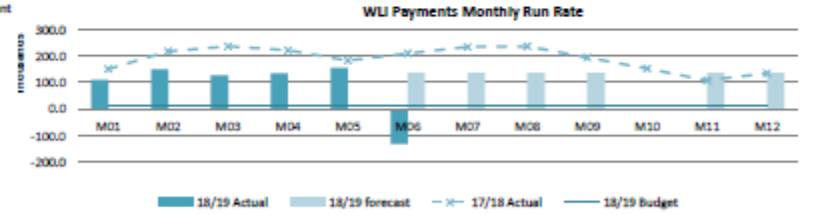
Cost Element	In Month								Year to Date				Forecast Outturn			
	17/18 WTE Actual	18/19 WTE Plan	18/19 WTE Actual	WTE Variance	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	Expenditure Variance (£k)	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	Expenditure Variance (£k)	18/19 Plan (£k)	18/19 FOT (£k)	Variance (£k)	
Agency																
Administrative & Management	11	1	2	-1	161	69	29	39	491	393	315	77	872	872	0	
Ancillary	12	0	16	-16	26	69	93	(25)	261	393	339	53	872	872	0	
Medical	30	11	16	-5	263	324	100	224	3,415	1,662	1,572	90	3,580	3,580	0	
Nursing & Midwifery	50	0	36	-36	291	101	167	(66)	1,293	875	1,018	(143)	1,582	1,582	0	
Prof, Scientific & Tech	48	0	39	-38	301	177	215	(38)	1,365	1,160	1,101	59	2,399	2,399	0	
Total Agency	**161**	**12**	**108**	**-98**	**1,043**	**739**	**604**	**135**	**6,824**	**4,482**	**4,345**	**137**	**9,305**	**9,305**	**0**	
Bank																
Administrative & Management	100	4	67	-63	189	305	139	166	863	1,525	676	849	3,510	3,510	0	
Ancillary	83	22	60	-38	163	0	129	(129)	801	0	661	(661)	0	0	0	
Nursing & Midwifery	336	92	295	-203	926	789	826	(37)	4,644	4,916	4,702	214	11,763	11,763	0	
Prof, Scientific & Tech	11	0	14	-14	39	58	47	11	162	290	210	80	696	696	0	
Professions Allied to Medicine	4	0	8	-8	15	33	31	2	62	165	156	9	436	436	0	
Total Bank	**536**	**118**	**443**	**-325**	**1,332**	**1,185**	**1,172**	**13**	**6,631**	**6,898**	**6,404**	**482**	**16,406**	**16,406**	**0**	
Total Locum	**84**	**18**	**74**	**-58**	**746**	**574**	**960**	**(388)**	**2,843**	**3,288**	**4,855**	**(1,567)**	**8,381**	**8,381**	**0**	
Total Waiting List Initiative	**13**	**0**	**10**	**-10**	**184**	**14**	**158**	**(142)**	**1,012**	**88**	**881**	**(813)**	**183**	**183**	**0**	
Total Temporary Workforce	**782**	**148**	**638**	**-487**	**3,303**	**2,512**	**2,892**	**(381)**	**17,310**	**14,714**	**16,288**	**(1,571)**	**32,234**	**32,234**	**0**	











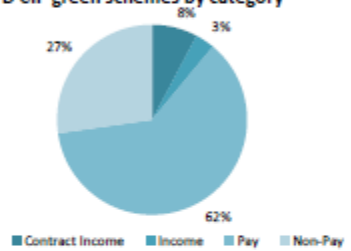
Summary & Next steps

Medical agency usage has fallen in month to £0.1m. Specialties which are heavily reliant on agency are neurology, rheumatology, pathology, general surgery, radiology and A&E. There is a shift from prior year towards utilisation of bank and locum resource opposed to agency and some progress is being made with recruitment to locum or substantive posts but continued focus needed on hard to fill vacancies to look at alternative staffing models. Non clinical agency has reduced and plans are in place to further reduce non clinical agency from M7. Overall agency is £135k below plan YTD and has seen a significant reduction compared to the previous financial year. Total temporary staffing costs have fallen by 6% compared to the previous year (£1,024k lower).

Cost Improvement Programme Summary - Month 5

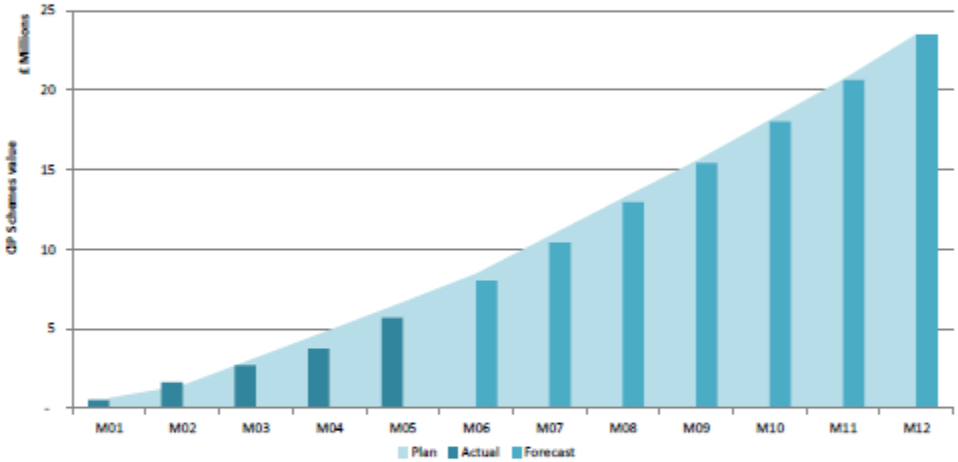
Category	In Month			Year to Date			Forecast Outturn			YTD Rec (£k)	YTD Non-Rec (£k)
	Plan (£k)	Actual (£k)	Variance (£k)	Plan (£k)	Actual (£k)	Variance (£k)	Plan (£k)	Actual (£k)	Variance (£k)		
Contract Income	134	150	16	614	557	-58	1,889	1,789	-100	269	287
Income	73	64	-9	306	278	-28	1,151	1,116	-35	225	53
Pay	1,367	1,192	-174	3,975	3,063	-912	9,977	8,488	-1,489	1,801	1,262
Non-Pay	454	527	73	1,898	1,794	-105	5,784	5,285	-499	1,691	102
Total 'Green' schemes	2,027	1,933	-95	6,794	5,691	-1,102	18,801	16,678	-2,123	3,986	1,705
Pipeline/Unidentified	0	0	0	0	0	0	4,715	6,838	2,123	70%	30%
Total	2,027	1,933	-95	6,794	5,691	-1,102	23,516	23,516	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 5 by £1.1m. This is mainly due to the delayed impact of patient flow bed modelling (£927k), slippage in month 1 and 2 on endoscopy scopes (£102k), waiting list initiative reductions in DAS £112k, theatre productivity £127k, the underperformance is partially offset with over delivery on pharmacy drugs and vacancies in Emergency Care.

The variance on contract income associated with cardiology echo and COPD activity continues as a result of unsuccessful recruitment, this has been mitigated in the month due to overperformance on adult audiology activity.

The underperformance in pay is largely associated with bed modelling, which has a later start date than was assumed in the financial plan, this was expected to deliver from August however activity has prevented this from happening. The waiting list initiative reduction and theatre productivity also form part of this variance.

The non-pay overspend is due to endoscopy scopes (£102k) as well as the later start date of bed modelling (£140k), plus some smaller schemes which have not delivered, the over-performance on pharmacy reduces the impact of these variances.

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

Finance Report Divisional Summaries - Month 5

Divisional Performance

Division	In the Month						Year to Date			Summary
	Plan FTE	Actual FTE	Variance FTE	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	
Diagnostics, Anaesthetics & Surgery										
Contract Income				9,116	8,509	(607)	44,383	42,872	(1,512)	Contract income under performance and unidentified CIP are key drivers of underperformance. Medical agency and locum increase in microbiology due to backfill has also contributed. Theatres agency increased vs run rate average. Division recovery plans are in progress for pathology, radiology, opthalmology and urology.
Divisional Income				386	372	(14)	1,920	1,853	(67)	
Pay	1,769.93	1,657.99	111.94	(7,225)	(7,457)	(232)	(35,742)	(36,267)	(525)	
Non-Pay				(2,567)	(2,793)	(227)	(13,090)	(13,248)	(158)	
Overall	**1,769.93**	**1,657.99**	**111.94**	**(288)**	**(1,388)**	**(1,079)**	**(2,628)**	**(4,790)**	**(2,282)**	
Medicine										
Contract Income				8,413	8,956	543	41,185	41,807	622	Key drivers of divisional underperformance are special observations, medical pay and CIP under delivery causing overspends on ward nursing pay. Over performance on non-elective activity is largely offset by underperformance in day cases and elective spells.
Divisional Income				98	81	(18)	549	592	43	
Pay	1,421.17	1,399.53	21.64	(4,999)	(5,453)	(454)	(24,149)	(26,075)	(1,926)	
Non-Pay				(654)	(764)	(110)	(3,510)	(3,620)	(111)	
Overall	**1,421.17**	**1,399.53**	**21.64**	**2,858**	**2,820**	**(38)**	**14,075**	**12,704**	**(1,371)**	
Urgent Care										
Contract Income				2,163	2,382	219	10,684	11,419	735	A&E activity is above plan, in line with a national increase in month. Continued agency, arrears and recruitment and retention payments to medical staff have deteriorated the pay position YTD. Overspends on discharge and site team continue on trend.
Divisional Income				23	31	8	137	159	22	
Pay	323.73	306.85	16.88	(1,466)	(1,444)	22	(6,771)	(6,928)	(157)	
Non-Pay				(63)	(74)	(11)	(299)	(406)	(106)	
Overall	**323.73**	**306.85**	**16.88**	**658**	**895**	**238**	**3,751**	**4,244**	**494**	
Out of Hospital Care										
Contract Income				3,030	3,032	2	16,384	16,413	28	Drugs overspend £250k YTD. Pharmacy Manufacturing Unit staff awaiting redeployment and therefore this continues to be a stranded cost which is offset by vacancies across therapies and district nursing.
Divisional Income				589	585	(4)	1,585	1,688	103	
Pay	1,083.26	1,030.43	52.83	(3,560)	(3,428)	132	(16,003)	(15,819)	184	
Non-Pay				(816)	(900)	(83)	(5,042)	(5,542)	(500)	
Overall	**1,083.26**	**1,030.43**	**52.83**	**(757)**	**(711)**	**46**	**(3,076)**	**(3,260)**	**(183)**	
Women's, Children's & Sexual Health										
Contract Income				4,023	3,896	(127)	19,812	19,230	(582)	Under delivery of activity in Paediatrics (non-elective) and Gynaecology (day case/elective) in month. Continued vacancies in Sexual Health offset increased agency usage in midwifery unit and agency medical in month.
Divisional Income				55	66	11	303	398	95	
Pay	696.59	653.72	42.87	(2,726)	(2,776)	(50)	(13,286)	(13,077)	208	
Non-Pay				(274)	(317)	(43)	(1,412)	(1,592)	(180)	
Overall	**696.59**	**653.72**	**42.87**	**1,078**	**868**	**(210)**	**5,418**	**4,958**	**(468)**	
Estates & Facilities										
Divisional Income				714	708	(6)	3,553	3,529	(24)	CIP under delivery against target, utilities costs and catering provisions overspend YTD are the key drivers of overspends. Housekeeping agency and spend is to be reviewed in line with performance against quality indicators.
Pay	639.07	618.47	20.60	(1,679)	(1,752)	(73)	(7,265)	(7,332)	(67)	
Non-Pay				(1,217)	(1,481)	(264)	(6,424)	(7,101)	(677)	
Overall	**639.07**	**618.47**	**20.60**	**(2,181)**	**(2,524)**	**(343)**	**(10,136)**	**(10,904)**	**(768)**	
Corporate										
Divisional Income				1,147	1,276	129	5,666	6,166	500	Training and education income is above plan although correction to LDA income to be reflected M6. Corporate agency use continues to decline with plans to cease agency usage in clinical coding. Unidentified CIP in pay and non pay.
Pay	1,007.53	999.99	7.54	(3,407)	(3,501)	(94)	(16,195)	(16,208)	(13)	
Non-Pay				(2,061)	(2,351)	(290)	(10,754)	(10,857)	(103)	
Overall	**1,007.53**	**999.99**	**7.54**	**(4,321)**	**(4,576)**	**(254)**	**(21,283)**	**(20,898)**	**384**	
Central										
Contract Income				3,742	3,584	(158)	18,453	18,339	(115)	YTD divisional income includes national pay deal £2.0m which offsets increased pay costs in divisions. Tariff exclusions income is below plan and contra underspend on non-pay costs. Identification of CIP in operational divisions has led to balancing and phasing adjustments between Income, Pay and Non Pay in this division in order to to ensure alignment of Trust budgets to NHSI plan.
Divisional Income				87	1,726	1,639	1,380	2,893	1,513	
Pay	0.00	0.00	0.00	1,741	727	(1,014)	1,070	(37)	(1,106)	
Non-Pay				(5,559)	(4,688)	871	(26,643)	(23,315)	3,328	
Overall	**0.00**	**0.00**	**0.00**	**11**	**1,348**	**1,337**	**(6,739)**	**(2,119)**	**3,620**	
Donated assets adjustment				**0**	**44**	**44**	**0**	**(42)**	**(42)**	
Total	**6,941.28**	**6,666.88**	**274.30**	**(2,848)**	**(3,204)**	**(268)**	**(18,618)**	**(20,106)**	**(688)**	

Statement of Financial Position - Month 5

	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	216.0	0.3	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**	**219.2**	**0.2**	**219.0**	**219.0**		**0.0**
Inventories	7.3	7.3	7.3	0.0	7.3	7.3		0.0
Trade and Other Receivables	35.3	26.0	28.8	2.7	26.0	26.0		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**	**39.3**	**3.8**	**35.4**	**35.4**		**0.0**
Trade and Other Payables	(37.7)	(28.6)	(32.3)	(3.7)	(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)	(2.6)	(0.9)	(1.7)	(1.7)		0.0
Current Liabilities	**(75.7)**	**(31.3)**	**(71.2)**	**(39.9)**	**(31.3)**	**(31.3)**		**0.0**
Borrowings	(121.5)	(201.6)	(141.0)	60.6	(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**	**44.1**	**(19.0)**	**19.2**	**19.2**		**0.0**
Public Dividend Capital	156	156	156	0	156	156		0
Income & Expenditure Reserve	(187)	(232)	(207)	25	(232)	(232)		0
Revaluation Reserve	94	94	94	(0)	94	94		0
Total Tax Payers Equity	**64.2**	**19.2**	**44.1**	**24.9**	**19.2**	**19.2**		**0.0**

Summary & Next Steps

M5 cash balance above minimum cash balance of £2.1m at month end and borrowing in line.

Cashflow & Borrowing Summary - Month 5

Short Term (13 week) Cashflow Forecast

Week Ending (Friday)	Actual (£k)				Forecast (£k)								
	03-Aug	10-Aug	17-Aug	24-Aug	31-Aug	07-Sep	14-Sep	21-Sep	28-Sep	05-Oct	12-Oct	19-Oct	26-Oct
Balance Brought Forward	9,322	6,353	5,152	35,889	8,852	3,151	4,174	28,582	19,933	4,813	2,964	980	21,038
Receipts													
WGA Income	746	511	29,366	64	88	966	27,513	410	0	0	0	30,525	0
Other Income	329	1,841	532	304	123	632	1,103	660	364	731	424	1,921	427
External Financing	0	0	4,835	0	0	0	0	4,345	0	0	0	2,122	0
Payments													
Pay	(264)	(320)	(290)	(23,578)	(235)	(400)	(245)	(10,759)	(13,394)	(270)	(270)	(10,170)	(15,301)
Non-Pay	(3,660)	(2,651)	(3,598)	(3,154)	(5,600)	(175)	(3,396)	(2,097)	(2,090)	(2,310)	(2,138)	(4,174)	(3,090)
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	(121)	(381)	(109)	(672)	(77)	(0)	(567)	(1,209)	0	0	0	(166)	0
Total Payments	(4,045)	(3,553)	(3,997)	(27,404)	(5,912)	(576)	(4,208)	(14,064)	(15,484)	(2,580)	(2,408)	(14,510)	(18,391)
Net Cash Movement	(2,969)	(1,201)	30,737	(27,037)	(5,702)	1,023	24,409	(8,649)	(15,120)	(1,849)	(1,984)	20,058	(17,964)
Balance Carried Forward	6,353	5,152	35,889	8,852	3,151	4,174	28,582	19,933	4,813	2,964	980	21,038	3,074

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

Loans

Description	Draw Value £k	Date Drawn	Term	Interest Rate	Value £k	Annual Interest £k
Prior Years						
Capital Loan 1 -Decontamination Cer	1,500	Dec 08	10	3.50%	151	4
Capital Loan 2 - Endoscopy Develop	2,000	Dec 09	20	4.00%	1,167	45
Capital Loan 3 - Endoscopy Develop	2,000	Jun 10	20	3.90%	1,200	46
Capital Loan 4 - Health Records	428	Mar 15	10	1.40%	300	4
Capital Loan 5 - Health Records	441	Mar 15	10	1.40%	309	4
Capital Loan 6 - Ambulatory Care	800	Feb 18	20	1.60%	800	13
Revolving Working Capital	31,300		5	3.50%	31,300	1,096
Interim Loan Agreement	35,218		3	1.50%	35,218	527
2016/17 Loans	23,144	Dec 16 - Mar 17	3	6.00%	22,619	1,356
2017/18 Loans	13,755	Apr 17 - Jul 17	3	6.00%	13,755	827
2017/18 Loans	50,393	Aug 17 - Mar 18	3	3.50%	50,393	1,761
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
Loan July 2018	3,080	Jul 18	3	3.50%	3,080	55
Loan August 2018	4,835	Aug 18	3	3.50%	4,835	88
Current Year Total	19,519				19,519	352
Total Loans	180,498				176,731	6,055

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. Payment run for week ending 7 September credited early on 31 August.

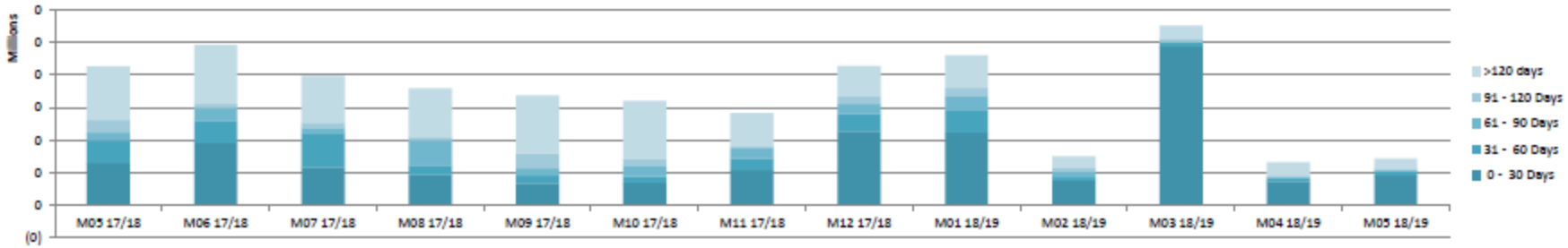
4. Planning assumption is to draw cash equivalent to deficit during 2018/19.

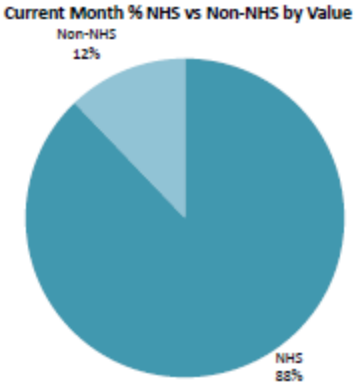
5. All existing loans listed in the table on the left.

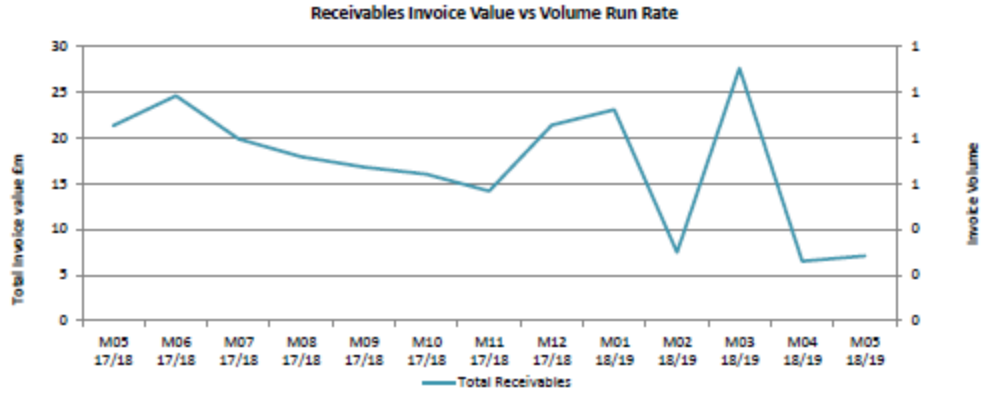
6. The "Interim Loan Agreement" for £35.2m is due to be repaid in February 2019. Discussions are currently underway with NHSI about repayment and the interest rate to be charged on any future loan.

Receivables Summary - Month 5

Receivables Aging Run rate (£k)													
Aging Profile	M05 17/18	M06 17/18	M07 17/18	M08 17/18	M09 17/18	M10 17/18	M11 17/18	M12 17/18	M01 18/19	M02 18/19	M03 18/19	M04 18/19	M05 18/19
0 - 30 Days	6,448	9,548	5,737	4,648	3,269	3,418	5,379	11,332	11,164	3,753	24,337	3,630	4,559
31 - 60 Days	3,461	3,411	5,217	1,450	1,286	960	1,745	2,686	3,335	448	696	566	685
61 - 90 Days	1,248	1,938	941	3,850	1,099	1,588	1,573	1,467	2,189	968	(44)	273	161
91 - 120 Days	1,920	643	782	583	2,331	1,133	470	1,214	1,316	518	618	(71)	100
>120 days	8,233	9,036	7,179	7,372	8,809	8,897	4,997	4,685	5,048	1,775	1,963	2,111	1,586
Total Receivables	21,309	24,576	19,856	17,903	16,794	15,996	14,164	21,384	23,053	7,461	27,572	6,508	7,091







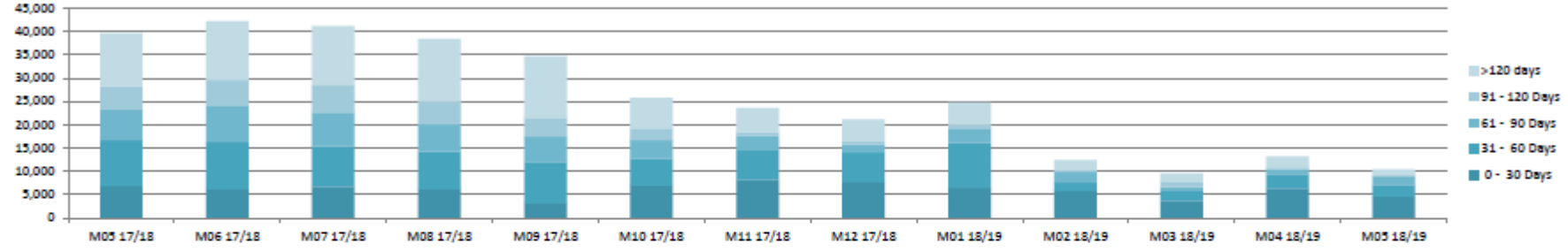
Summary & Next Steps

1. Internal plan for August was to reduce aged receivables to £2.5m and the Trust achieved this target.
2. Reduction in over 90 day debt of £354k.
3. Current debtor days is 28 days (26 days in July).

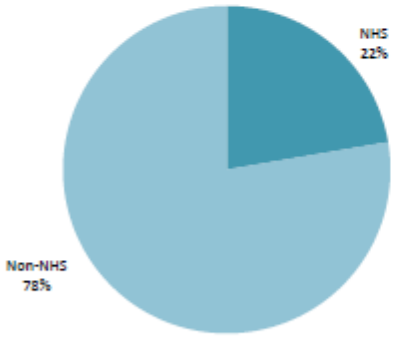
Payables Summary - Month 5

Payables Aging Run rate (£k)

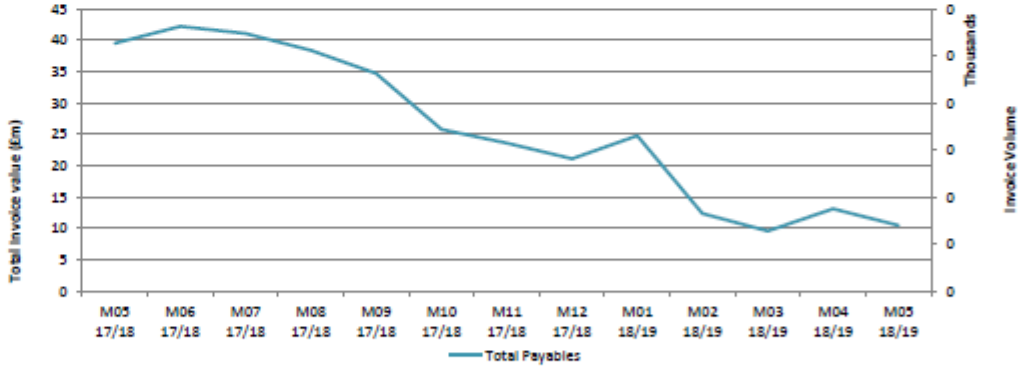
Aging Profile	M05 17/18	M06 17/18	M07 17/18	M08 17/18	M09 17/18	M10 17/18	M11 17/18	M12 17/18	M01 18/19	M02 18/19	M03 18/19	M04 18/19	M05 18/19
0 - 30 Days	6,799	6,188	6,726	6,227	3,130	6,872	8,184	7,668	6,423	5,752	3,711	6,387	4,552
31 - 60 Days	9,861	10,094	8,620	7,924	8,902	5,760	6,341	6,360	9,679	1,843	2,117	3,002	2,547
61 - 90 Days	6,737	7,883	7,267	5,929	5,430	4,064	3,128	1,681	2,969	2,267	766	1,039	1,703
91 - 120 Days	4,792	5,402	5,851	4,875	4,025	2,521	729	655	932	367	1,148	452	366
>120 days	11,353	12,638	12,599	13,449	13,202	6,556	5,220	4,753	4,762	2,135	1,854	2,249	1,315
Total Payables	**39,542**	**42,204**	**41,063**	**38,405**	**34,688**	**25,773**	**23,602**	**21,118**	**24,765**	**12,363**	**9,596**	**13,129**	**10,484**



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. Creditor days at 85 (88 in July)
3. Internal KPI's to eliminate invoices > 120 days and creditor days < 60.

Capital Programme Summary - Month 5

YTD Capital Programme Performance	TOTAL PLAN ADJUSTED £000	CRG COMMITTED £000	ACTUAL EXPENDITURE £000	FORECAST EXPENDITURE £000	SYSTEM COMMITTED £000
Brought Forward	**500**	**992**	**932**	**932**	**717**
External Funding	3,709	250	51	250	20
2018/19 Business Cases	2,370	100	53	1,800	56
Medical Equipment	2,200	362	245	2,200	8
Digital	2,072	1,643	916	2,050	231
Estates	11,005	10,306	2,161	12,802	2,050
Finance	2,000	1,657	867	1,657	64
Total Owned	**23,856**	**15,310**	**5,225**	**21,691**	**3,146**
Donated	0	0	0	0	0
Less donated Income	0	0	0	0	0
Total	**23,856**	**15,310**	**5,225**	**21,691**	**3,146**

Capital Resource Limit	Source	£k
Opening Capital Resource Limit		13,049
Closing Capital Resource Limit		13,049

Summary & Next steps

1. The Capital Resource Group has committed £15.3m of this year's Capital Resource Limit (CRL) of £13m.
2. External funding and bids to increase CRL are being processed for fire, MRI and medical devices via NHSI.
3. The MRI Finance Sub-Group meets weekly and reports in to the MRI Programme Board who are responsible for delivery of the project within the agreed budget.
4. The Capital Programme will deliver the CRL target at year end.

Sustainability and Strategy

SUSTAINABILITY

ESHT – Long-term

The Trust submitted the first iteration of a medium to long term sustainability and financial recovery plan (3+2) to our regulator NHSI at the beginning of the month. Further work is being undertaken to further develop this and to facilitate alignment of the Trust and CCG plans moving forward. We will be engaging with stakeholders, including our staff ,patients, public and the HOSC to outline the key parts of the sustainability plan and to discuss how we can ensure that we involve stakeholders in any redesign of services as we move forward.

We continue to work closely with other Acute providers locally to ensure that together we can explore areas of mutual benefit such as closer working with BSUH on our ENT services and with MTW on Urology provision. We continue to explore wider network opportunities in areas such as pathology.

The annual planning cycle has started with first iteration of divisional and corporate plans being prepared and we will have the opportunity to review these as a Board in February 2018.


WHAT
MATTERS
TO YOU
MATTERS
TO US
ALL

ESHT Elective Performance Assurance Submissions to NHSI

Meeting information:			
Date of Meeting:	2nd October 2018	Agenda Item:	10
Meeting:	Trust Board	Reporting Officer:	Joe Chadwick-Bell

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

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

RTT

On 22nd August 2018, NHSI formally approached all Trusts and CCGs to seek assurance regarding the delivery of elective care. In particular assurance was sought that:

- Elective care performance and activity levels alongside emergency care and finance is recognised by your trust's senior leadership and given sufficient scrutiny at Board level
- Reducing the number of 52 week waiters
- A review of the forecast plan and performance commitments to deliver agreed trajectory and maintain waiting list at March 2018 level (28,218)
- To work with your commissioners to determine how any gaps will be closed through use of capacity in other trusts and/or the independent sector.

The Trust and CCG prepared a joint response which is attached below. In summary ESHT's position is:

- No 52 week waiters in July 2018 as planned in the Trust's 18/19 trajectory shared with NHSI April 2018.
- In line with our agreed plan the trajectory is aimed to deliver 90% and maintain waiting list at March 2018 levels as requested by NHSE/I.
- The waiting list increased in line with the seasonal trend in April and May, but has reduced through June and July and is 800 above the Trusts baseline position of 28,218.
- Elective activity is below the submitted plan in seven specialties (deep dives have taken place)
- There have been a number of influencing factors including an unprecedented increase in 2 week wait referrals since March 2018, a recent increase in DNA rates and a limited clinical workforce in Gynaecology, ENT, Neurology and Orthopaedics (knee and spinal modalities)

Cancer 62 days

NHSI wrote to Trusts on 18th July 2018, seeking assurance that cancer performance was being managed as a Trust priority and that the Board had oversight, there was a named Executive lead and that we were able to demonstrate compliance with the High Impact Actions. The summary is attached below:

High Impact Action	Response	High Impact Action	Response
Executive Lead	Joe Chadwick-Bell	RCA reviews completed for each pathway not meeting the standard, reviewing the last ten patient breaches and near misses (within 48hrs of breaching)	Yes, post treatment
62 day tumour specific performance visible to board	Included in Board Performance Pack	Capacity and demand analysis carried out for pathways	2 ww capacity and reviewed, although due to increases of up to 30% in some areas, if sustained at this level, will require further review and business case development for sustainable capacity. Full pathway C&D review in place for urology. Will undertake further review using NHSI C&D cancer toolkit and discussed with NHSI local performance team access to support using the C&D tool for the service managers..
Cancer operational policy ratified by the Trust Board?	Currently in place, to return to Trust Board for Annual Review October 2018	Pathway improvement plans for pathways not meeting the standard, based on breach analysis, capacity and demand modelling defining recovery trajectory and plan.	Detailed recovery plan by speciality in place.
Timed pathway. Trust maintains and publishes a timed pathway, agreed by commissioners and any other providers involved in the pathway?	In place but being reviewed for all pathways, due to on-going performance challenges. Dedicated support in place to implement prostate 28 day pathway. Will review lung and colorectal 28 day pathways for implementation over next quarter. Straight to test being implemented for lower GI from Sep 18. Pathways to be shared with commissioners through dedicated local performance meeting.	National guidance on reporting methodology consistently applied	Yes with external assurance received by NHSI and NHS Elect

Weekly PTL review: valid cancer specific PTL that is weekly reviewed for all tumour pathways?	Yes	Clinical review of excess waits been undertaken? Eliminate >104 days breaches	Yes, summary of breaches will be shared through the Trusts weekly safety meeting as an enhancement for treated patients. List of patients with ongoing pathways to be shared at weekly Executive meetings.

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

NHSI have sought assurance that the Trust Board has had sight of the submitted returns.

RTT - The attached letter has been submitted in conjunctions with the CCGs with regard to RTT assurance.

Cancer High Impact Actions reviewed at the Cancer Operational and Clinical Boards and have subsequently been submitted to NHSI.

Further detailed regarding performance delivery will be addressed through the Integrated Performance Review agenda item.

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

It is important to recognise that the agreed trajectory and plan falls short of the constitutional standard for elective activity, 92%, but was deemed to be a realistic and achievable plan for 2018/19.

Through continuous monitoring, improvement and maximising efficiency & productivity ESHT aim to exceed this plan and where possible deliver 92%.

NHS Hastings and Rother Clinical Commissioning Group
Chair – Dr David Warden Chief Officer – Amanda Philpott

NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Group
Chair – Dr Martin Writer Chief Officer – Amanda Philpott

Sent via email

Ian Dalton
CBE Chief Executive, NHS Improvement

Matthew Swindells
National Director: Operations and Information, NHS England

Anne Eden
Regional Director, NHS England (South East Region)

Bexhill Hospital
Holliers Hill
Bexhill-On-Sea
TN40 2DZ

Tel: 01424 735600
Email: HRCCG.enquiries@nhs.net

5 September 2018

Dear Ian, Matthew and Anne,

Re: Elective Care Expectations

Thank you for your recent letters addressed to both CCGs and acute trusts setting out your expectations in relation to Elective Care. This is a joint response between Hastings & Rother, Eastbourne, Hailsham & Seaford CCGs and East Sussex Healthcare NHS Trust. Firstly, we would like to reassure you that both the Trust and CCGs fully recognise the imperative of managing the waiting list and RTT within agreed trajectories and we are committed to working together to achieve this. You have sought a number of actions and assurances from both our organisations, which we will address in turn below.

1. Causes driving elective activity and performance

The Trust has been delivering RTT in excess of 90% since the beginning of the financial year; we note that elective activity is below the submitted plan in 7 specialties. The waiting list increased in line with the seasonal trend in April and May, but has reduced through June and July and is 800 above the Trusts baseline position of 28,218.

The key issues are summarised below:

- An unprecedented increase in 2 week wait referrals since March 18 have impacted on capacity to treat routine patients. This is showing an 8% increase of the previous year, but up to a 32% increase in some tumour sites, specifically lower GI, breast and urology.

- Clinical workforce availability in Gynaecology, ENT, Neurology and Orthopaedics (knee and spinal modalities)
- Recent increase in DNA rates (0.5 – 1%). Data would suggest that this correlates with the paper switch off for eRS
- Waiting list increased in months 1 & 2 and has decreased in months 3 & 4 following similar trajectory to previous years
- In 17/18, in line with CCG and Trust financial agreement there has been restriction of outsourcing of elective activity, with the greatest impact in Ophthalmology.

2. Reducing 52-week waits by at least 50% by 31st March 2019

We acknowledge the specific focus on over 52-week waiters and can advise you the Trust has zero 52 week waiters in July 2018 as planned in the Trust's 18/19 trajectory shared with NHSi April 2018.

The CCGs face a continued challenge of managing a small number of patients waiting 52 weeks with out of area providers. These are predominantly waiting for specialist treatments with London providers. At a CCG level, we have struggled engage with London providers in order to hold them to account and improve the position. To address this, we are currently investigating a joint STP-level approach to reduce the overall number of patients waiting over 52 weeks for treatment with London providers.

3. 18 Week Trajectories

	Variance from Planed Trajectory at M3		Forecast Variance at Year End		Additional Activity Identified by Trust	Remaining Variance	
	Activity	% Var	Activity	% Var		Activity	% Var
Referrals	-999	-3.00%	-	-	-	-	-
Day Case	-15	-0.20%	-547	-1.40%	566	19	0.05%
Ordinary Elective	-213	-11.60%	-725	-10.20%	21	-704	-9.90%
Total Elective (DC + IP)	**-228**	**-1.90%**	**-1272**	**-2.70%**	**587**	**-685**	**-1.40%**
Outpatient First Attendances	-2210	-7.10%	-5004	-4.10%	1468	-3536	-2.90%
Outpatient Folow Up Attendances	163	0.30%	635	0.30%	2787	3422	1.60%
Total Outpatient	**-2047**	**-2.40%**	**-4369**	**-1.30%**	**4255**	**-114**	**-0.03%**

In line with our agreed planning assumptions the trajectory above is aimed to deliver 90% and maintain waiting list at March 2018 levels as requested by NHSE/I. This will be supported by the actions detailed below:

- An Outpatient Improvement Plan in place targeting efficiency and modernisation (supported by PA Consulting for cost savings) including:

- Daily scrutiny of planned utilisation
- Call reminder service review & improved patient data collection
- Refresh of Access Policy & awareness
- Virtual clinics & non face-to-face clinical review of FU/ patients & diagnostics
- Redesign of pathways e.g. straight to test in Colorectal
- Action Plans to address outliers in N:FU ratio/variation in clinic templates
- Target of 6.5% DNA including overbooking where clinically acceptable
- Clinical & administrative validation of waiting list
- Relaunch of eRS A&G functionality, planned for September to December 2018

- Deep Dives by the Trust's COO in underperforming specialties week commencing 10th September 2018, reviewing recovery plans in line with the above initiatives and theatre productivity
- Review approach to outsourcing where cost effective
- Capacity released through outpatient and theatre productivity (see no. 4) to be re-utilised to meet waiting list demand.

Both parties will be closely monitoring performance to this trajectory and agreeing any additional remedial actions should they prove necessary.

4. CCG Governing Body /Acute Trust Board oversight of RTT

Both the CCGs and Trust have robust reporting arrangements in place in relation to all RTT standards and specifically to 52-week waiters, which are subject to monthly review by the relevant oversight committees:

- For CCGs this is the Performance & Delivery Committee and also Governing Bodies
- For the Trust this is the monthly Divisional IPR meetings, Weekly PTL meeting and Trust Board

To ensure that we have an accurate view of who is waiting for treatment, the CCGs and Trust have agreed that the Trust will conduct regular validation of the waiting list.

5. Managing Variation in Referrals

The CCGs have a number of initiatives underway to reduce variation in referrals including:

- A system wide initiative re referral variation and difference at GP Practice level - 5% reduction referral; in month 1 but not yet embedded.

- Reaffirmed our commitment to promoting the Advice and Guidance service available to our GPs.
- As part of the Clinically Effective Commissioning Programme, all Sussex CCGs have now ratified Tranches 0-2 policies and acute trusts have been formally asked to implement starting 14th September 2018. Monitoring arrangements are already in place within the CCG and we will be watching closely to understand how these policies are impacting on demand and on RTT.

6. Contingency Planning/Further Assurance

Assurance requested	**ESHT feedback**
Delivering planned activity and RTT treatment	See above for recovery plan
Booking patients in (clinically appropriate) chronological order	Yes – however, an increase in the 2ww activity means that waits for routine appointments are negatively impacted. Urology – complete service re-design, including capacity and demand review to achieve RTT and cancer pathways
Clear about what is driving elective underperformance	This is understood at speciality level by the divisions and the COO, recovery plans in place.
Ensuring there are zero 52 week waiters on non-admitted day case pathways	ESHT has a zero tolerance approach (one 52 week wait in Spring 2017 that related to human error). Our processes have and continue to be reviewed to avoid the risk of this recurring

Theatre Productivity	ESHT has undertaken an internal & NHSI Theatre Improvement Programme, with support from FourEyes Insight consultancy. Through more robust scrutiny and management of productivity ESHT has improved from a 19% efficiency opportunity to 10% YTD in terms of sessions run (allows 5% tolerance for on the day cancellations). In addition on the day cancellations have reduced to 4.2% in July 18. There is further opportunity for improving cases per list.
Reporting and reviewing progress as a board each month until assured (over 40 and 52 weeks waits by specialty, by admitted/non-admitted pathway, with and without TCI dates)	Yes – as a Trust total. But also reported in detail through the monthly divisional IPRs chaired by the Chief Executive. In addition, all over 40 week patients are reviewed, validated and reported each week.
By early September review 2018/19 Board approved plan and forecast. Where no longer able to meet the activity and performance work with your commissioners to determine how these gaps will be closed through use of capacity in other trusts and/or the independent sector.	Where capacity gaps remain following the planned deep dives in underperforming specialties, plans will be developed to identify how gaps will be managed and this will include the exploration of outsourcing opportunities.
Demand and capacity planning and management	The Trust has developed a production planning methodology to support daily monitoring of activity against plan and future forecast based on booked activity. This enables a more proactive approach to service delivery and performance management.

Minimising impact of non - elective activity	As part of East Sussex Better Together, supported by NHSI, a robust system plan is in place to reduce non elective activity and deliver A&E performance above 90%. There is a current surge in activity that creates additional risk however the improved length of stay is offsetting this surge and there is no impact on elective activity. This is further evidenced by the minimal cancellations of elective activity throughout winter 17/18.

We hope this joint letter will assure you that the Trust and CCGs are working closely together to ensure we meet and exceed NHS England and NHS Improvement expectation in relation to elective care.

Yours sincerely,

Amanda Philpott
Chief Officer
Hastings & Rother CCG and
Eastbourne, Hailsham & Seaford CCG

Adrian Bull
Chief Executive
East Sussex Healthcare NHS Trust

Mortality Report – Learning from Deaths 1st April 2017 to March 31st 2018

Meeting information:			
Date of Meeting:	2nd October 2018	Agenda Item:	11
Meeting:	Trust Board	Reporting Officer: David Walker	

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

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

Summary:

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

The requirements set out in the Care Quality Commission Learning from Deaths review have been incorporated into Trust policy. The mortality database has been updated to reflect the new review process and now includes a record of all plaudits and care concerns raised by family or carers of the deceased.
This report details the April 2017 – March 2018 deaths recorded and reviewed on the Mortality database.
The importance of reviewing deaths within the 3 month timescale is critical to ensure reporting is accurate and provides a useful overview of the number of deaths that were actually or potentially avoidable. This is the only risk remaining with the learning from deaths process changes. Consultants have been reminded (again) of the importance of timely review and accuracy of grading the avoidability of deaths. The Mortality Review Audit Group review the deaths with a much higher likelihood of avoidability on a quarterly basis, to ensure accuracy in reporting.

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

N/A

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

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

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

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

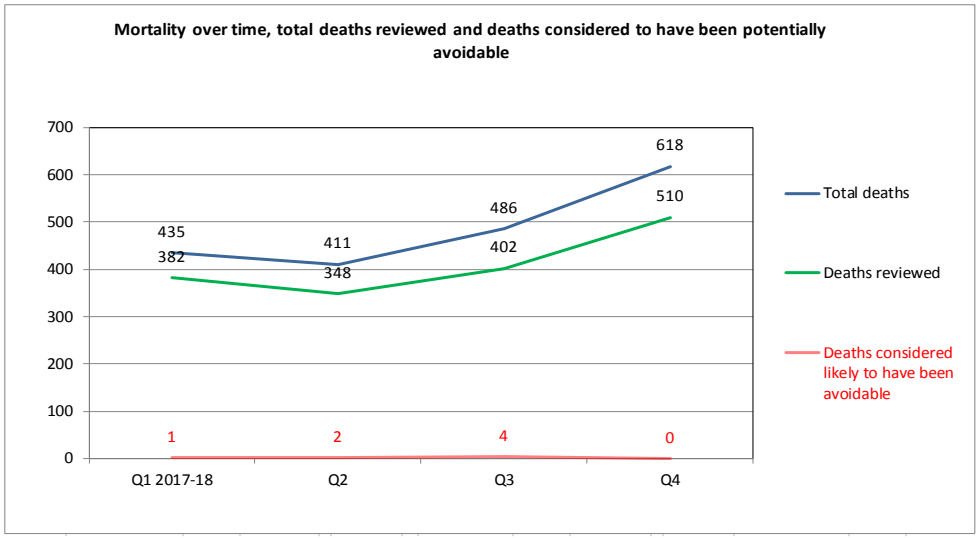
Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 06/09/2018)

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

Time Series:	Start date	2017-18	Q1

End date	2017-18	Q4

Total number of deaths in scope		Total deaths reviewed		Total number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
211	183	174	149	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
618	486	510	402	0	4
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1950	N/A	1642	N/A	7	N/A



Total deaths reviewed by RCP methodology score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	100.0%	This Month	0	0.0%	This Month	0	0.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	5	83.3%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	16.7%
This Year (YTD)	0	0.0%	This Year (YTD)	2	8.3%	This Year (YTD)	5	20.8%	This Year (YTD)	9	37.5%	This Year (YTD)	2	8.3%	This Year (YTD)	6	25.0%

Data shown above is as at 06/09/2018 and does not include patients with identified learning disabilities.
Family/carer concerns - There were 14 care concerns expressed to the Trust Bereavement team relating to Q4 deaths, 1 of which was subsequently raised as a complaint (mortality review overall care rating - 4 good).
Complaints - Of the complaints relating to 'bereavement' which were partially or fully upheld during Q4, none had reviews on the Mortality database which concluded poor or very poor care.
Serious incidents - One severity 5 incident reported in Q4. This was fully investigated as a serious incident and the death was also reviewed at the Mortality Review Audit Group in August 2018. Further review of this death, pending inquest outcome, will be carried over to the next Mortality Review Audit Group to establish the correct avoidability rating.
As at 06/09/2018 there were 308 April 2017 - March 2018 deaths still outstanding for review on the Mortality database.

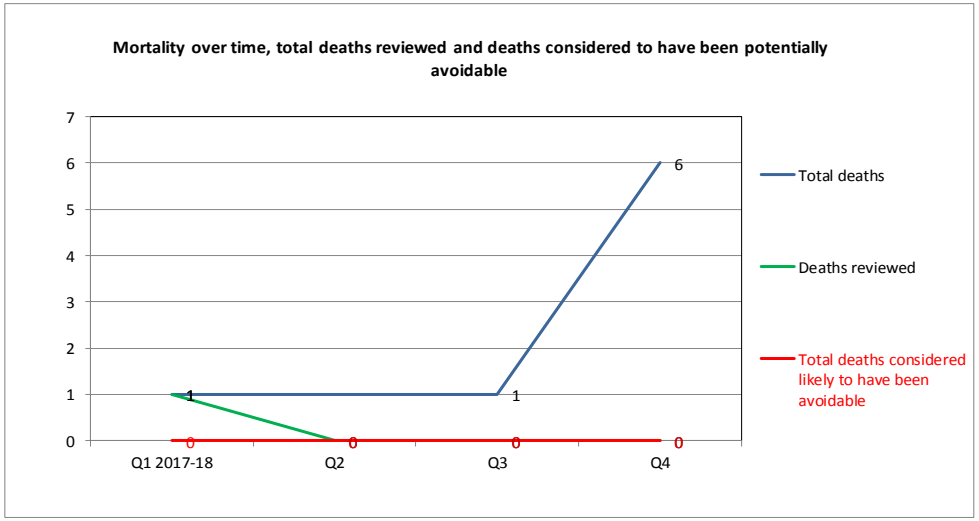
Summary of total number of learning disability deaths and total number reviewed (Data as at 06/09/2018)

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

Time Series:	Start date	2017-18	Q1

End date	2017-18	Q4

Total number of deaths in scope		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	2	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
6	1	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
8	N/A	1	N/A	0	N/A



Prior to the national requirement to review Learning disability deaths using the new national LeDeR (learning disability mortality review) methodology, the deaths were reviewed by the Learning disability nurse and Head of nursing for safeguarding, who entered their review findings on the Mortality database.
The LeDeR programme is now in place and the Learning disability deaths are being reviewed against the new criteria externally. Feedback from these external reviews will be received by the Trust in due course.

5 year Sustainability Strategy and Financial Recovery Plan

Meeting information:			
Date of Meeting:	2nd October 2018	Agenda Item:	12
Meeting:	Trust Board	Reporting Officer:	Jonathan Reid

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

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

Summary:

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

The Trust has developed a 5 year Sustainability Strategy and Financial Recovery Plan.

The strategy examines what we must prioritise as a Trust and as a system to create a sustainable model for services over the next 5 years (and beyond). Our 6 sustainability programmes address these priorities. Since 'Sustainability' includes both financial and clinical with the financial recovery being a central component of the 6 programmes. Our long term financial plan and projections are driven by the programmes included in both these components; they are not distinct.

A further submission, for the implementation phase, will need to be made to NHSI by 3 October.

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

Executive Team
Finance & Investment Committee (previous meetings)
Senior Leaders Forum

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

The Board is asked to note and approve the contents.

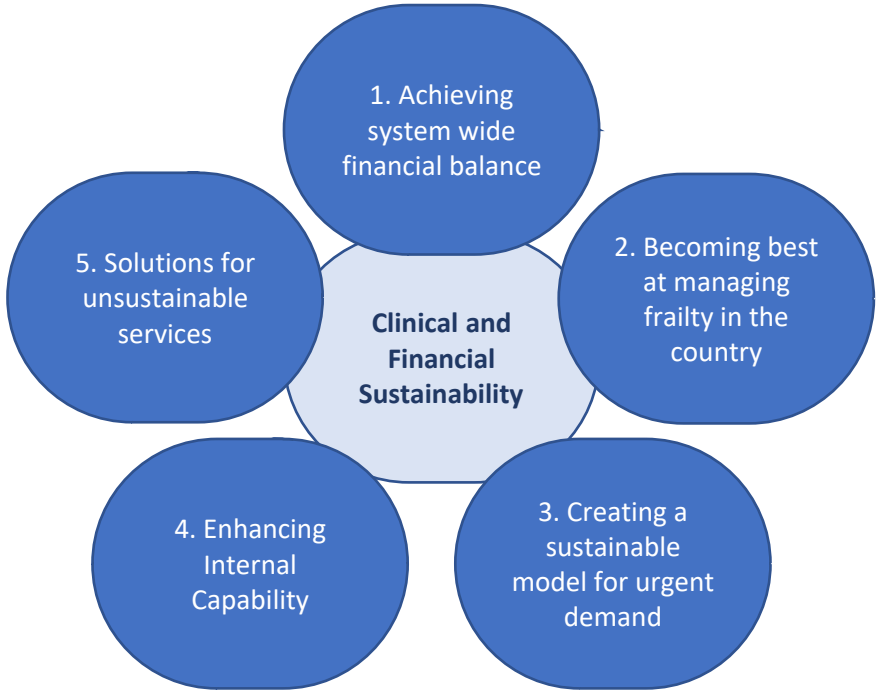
East Sussex Healthcare NHS Trust

5 Year Sustainability Plan

East Sussex Healthcare NHS Trust

September 2018

(Note: this document is subject to system-wide alignment processes and may therefore change)



Aims of this document

- **This document sets out our longer term 'Sustainability Strategy' that will make East Sussex Healthcare NHS Trust ('ESHT' or 'the Trust') a safe, high-quality integrated healthcare provider that is able to meet the demands of the future, provide modern healthcare and do so within the resources available to us**
  - Achieving sustainability means arranging our services so we can offer the best quality, using modern approaches to improve our capacity and productivity, having the right staff to deliver those services and minimising the use of agency staff, working with other NHS organisations where that is the best way to offer high quality and being in financial balance. We must do that in a way our system can afford
  - These are not separate things, and one without the other will not deliver a sustainable ESHT or system
  - The Board has set a challenging plan that recognises both the need and opportunity for the Trust to deliver the maximum internal efficiency as the first step towards financial recovery
- **The Trust is also committed to developing a joint system plan and this document sets out the work to date to achieve this, as well as the key next steps and timescales for completion. This plan is therefore subject to change as we work through those steps**
  - Sustainability for ESHT also requires a sustainable system and the Trust also acknowledges the need for a long-term, sustainable, system-wide solution and is working with system partners to achieve this. The East Sussex Healthcare system faces a number of challenges now and in the future:
    - Our population is using healthcare resources more and more – particularly acute hospital resources
    - The demand for services may grow even more rapidly in future as the proportion of people over 75 increases more rapidly than it has done over the last 5 years
    - Primary care is under significant pressure
    - The right, permanent specialist staff are in short supply
    - We are already facing financial pressures. Our system as a whole is over spent, not just East Sussex Healthcare Trust
      - This year (2018/19) ESHT aims to reduce its deficit to £45m and our main Clinical Commissioning Groups (CCGs)* are aiming to limit their combined deficit to £32m – achieving that plan though requires us to make efficiencies despite continuing to see growth in demand for services

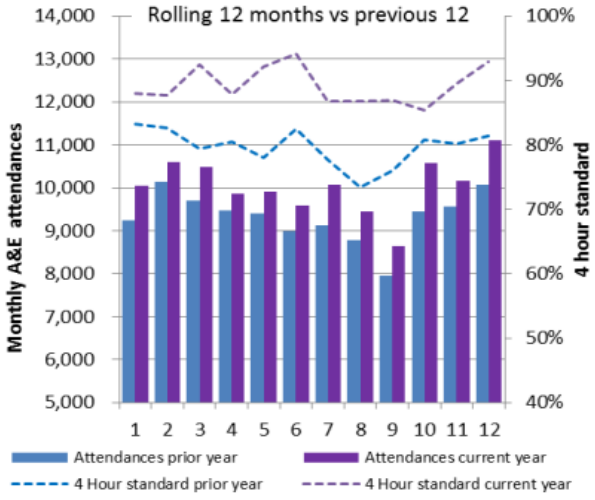
**(CCGs are NHS bodies that pay for most of the healthcare services in East Sussex on behalf of the population of East Sussex. Our CCGs are: NHS Eastbourne, Hailsham and Seaford; and NHS Hastings and Rother. They are governed by a group of GPs, Lay members and professional healthcare commissioners and managers. Most of our income at ESHT comes from those two CCGs)*

ESHT's focus is on providing high quality care sustainably – both clinically and financially

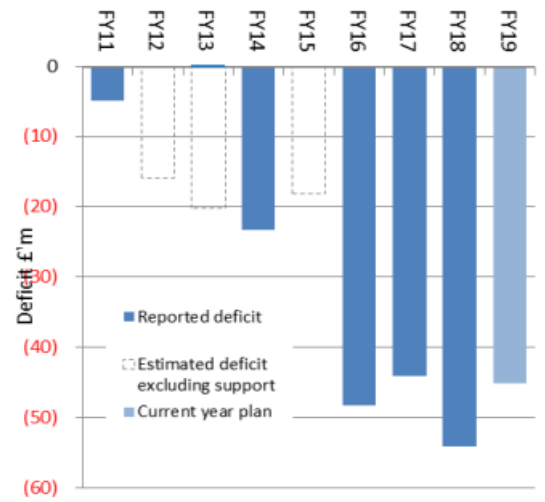
- **ESHT was formed by merging Eastbourne District General Hospital and Conquest Hospital (Hastings) in 2002. It is the main acute provider for the East Sussex population and provides a range of community services**
  - We provide our services at two district general hospitals, Conquest Hospital and Eastbourne District General Hospital, at community hospitals in Bexhill, Uckfield, and Rye, at a number of clinics and GP surgeries, and in people's homes
- **Financial performance has been an issue for ESHT in recent years, and now also for our CCGs - so far no *sustained* solution has been found**
  - ESHT has been in underlying deficit since 2010/11 – and required additional support to achieve balance in 2011/12, 2012/13 & 2014/15. From 2015/16 to 2017/18 the deficit worsened materially
    - The Trust went through a turnaround programme in 2014/15 and with additional support achieved balance but this was not sustained in 2015/16
    - The Trust was put into Quality Special Measures by the CQC in 2015, shortly after the Turnaround process, and then Financial Special Measures in 2016 as the financial performance was worsening
- **Against this backdrop leadership has changed significantly; the current executive team has been built since April 2016. The new leadership at the Trust has delivered some successes in moving the trust toward a more sustainable state:**
  - Significant work has been carried out to re-engage with staff and improve culture as morale had suffered over the preceding years. Staff are now much better engaged with the Trust again, proud of the improvements made so far and better understand the need to become a sustainable organisation
    - The Trust was moved out of quality special measures and very nearly received a 'Good' rating from the CQC (it was rated as good across all services that were inspected)
  - The 4 hr wait performance in A&E has been one of the most improved in the country, which has been noted nationally
  - Waiting time have significantly improved, serious incidents and complaints have decreased and plaudits have increased
- **These improvements and better staff engagement put ESHT into a much better position in terms of quality but there is still a great deal to do to become sustainable**
  - We must respond to longer term population trends – if we do not factor those into our plans now, we will not be able to manage demand long term. East Sussex Better Together ("ESBT") has been set up to help address these issues together as a system
  - We also have to address system challenges (our system as a whole is now in deficit) and the changes planned for our wider health and social care environment, such as Brighton and Sussex University Hospitals' ("BSUH") 3T's investment and changes expected in East and West Kent which border our catchment
    - Alignment is a major task and challenge for all of the health, social and voluntary sector partners in our health economy

Whilst we have made significant operational and quality improvements, ESHT needs to address its financial performance

A&E Performance 2016/17 vs 2017/18

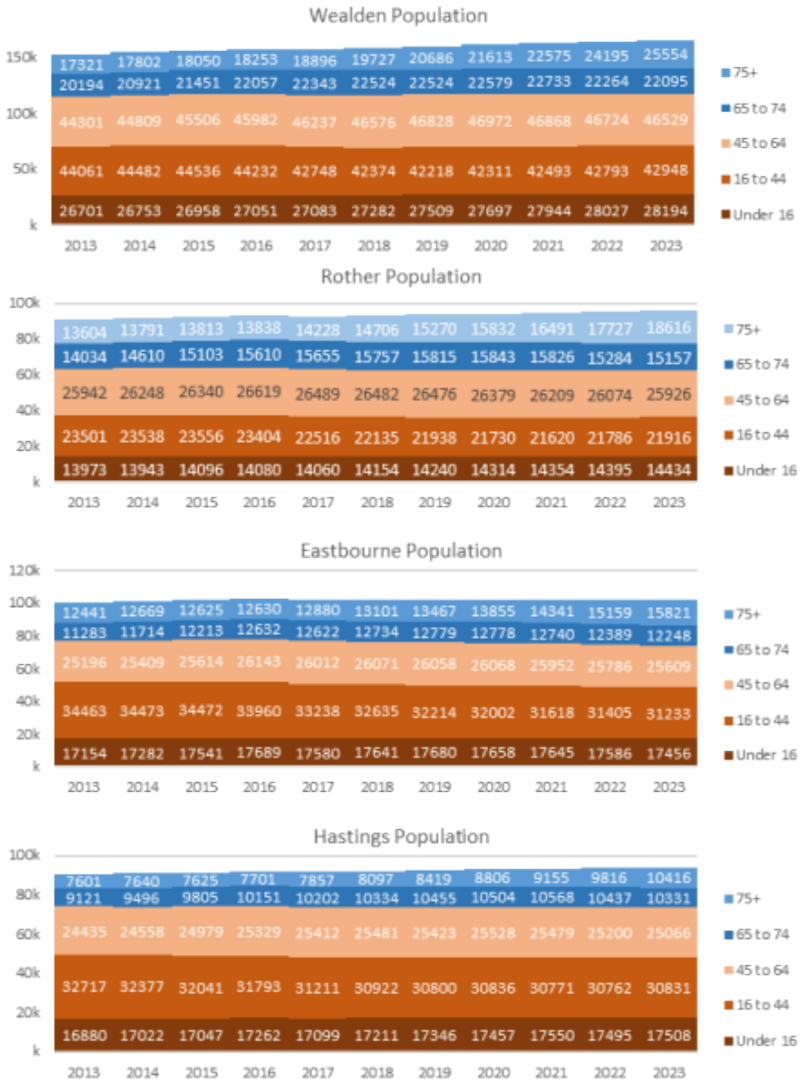


ESHT Deficit 2010/11 to 2018/19 (plan)



- **The leadership team at ESHT has changed almost completely since 2016/17 with a new Chief Executive and Executive team. Since that time a number of improvements have been made including:**
  - Improvements in mortality, serious incidents fell
  - Complaints fell from 658 to 559, plaudits rose from 27,500 to 36,400
  - One of the most improved A&E performances in the country despite higher than usual growth in attendances (see chart)
- **ESHT had been placed in 'Quality Special Measures' in 2015, however as a result of so much improvement the Care Quality Commission recommended that those special measures be lifted in 2018**
- **These improvements coupled with better staff engagement and cultural change create a much stronger platform for ESHT to address its financial challenges**
  - ESHT has been in underlying deficit since 2010/11
- **Since 2014/15 a number of factors have made the financial situation significantly more challenging and as a result the Trust was put into Financial Special Measures (FSM) in 2016**
  - 2015/16 saw ESHT's financial performance worsen significantly – driven by a range of factors, but in particular an increase in temporary staffing spend and a fall in our income
  - In 2017/18 the Trust was on track to deliver a better financial performance (albeit still a significant deficit) but an adverse contract arbitration resulted in £11m less income than planned
  - The whole East Sussex Healthcare system is facing financial pressures as our CCGs are also over spent and as a result were put under legal directions in July 2018
- **Sustainability for ESHT requires a sustainable system. It is crucial that both our plans and those of our CCGs work in concert**
  - The East Sussex system now has a joint NHS England and NHSI System Improvement Director to help that happen
  - The process to 'align' our 5 year plans has begun but at the time of writing is still a work in progress – which means that our plan may yet still need to change in the coming months

Our catchment population is one of the most elderly in the country – and is projected to age more quickly going forward



- **The population ESHT services is relatively elderly (East Sussex has a relatively low birth rate, high inward migration amongst elderly age groups)**
- **Demographic trends in East Sussex indicate that pressure on health and social care services may increase more quickly in the future:**
  - In the last 5 years the highest rate of growth was in the 65 to 74 year old age group (at 2.3% per annum), but over the next 5 years the highest rate of growth is projected to be in the over 75s (at 4.4% per annum)
  - Our over 85 population is also projected to grow at 3.5% per annum in future
- **In populations over 75 (and more so in those over 85) certain factors tend to increase their need for Hospital or community based healthcare markedly**
  - More people will be living with 'frailty' – 'Frailty' is a formal term used for a collection of factors that mean people are more likely to need hospital treatment after seemingly 'minor' events (like a urinary tract infection) or more likely to have an injury from a fall that requires an admission. Many of the signs of frailty relate to mobility (e.g. finding it harder to get out of a chair, slowing walking pace, worsening balance).
  - Older people are also more likely to have multiple, ongoing health problems (like high blood pressure, angina, diabetes, emphysema and so on) which means that they are more likely to become ill and need hospital attention
  - To make matters worse, it is well established now that time spent immobile or with reduced mobility in a hospital bed increases 'frailty' as well
  - So we need to make the 'acute' phase of someone's illness as short as possible, address frailty and the risks of frailty outside hospital and manage ongoing health conditions as well as possible
- **Our ability to manage this trend as a Trust and as a system – in particular the impact of an increase in those living with frailty – will be a key priority over the next 5 to 10 years to create a sustainable system**

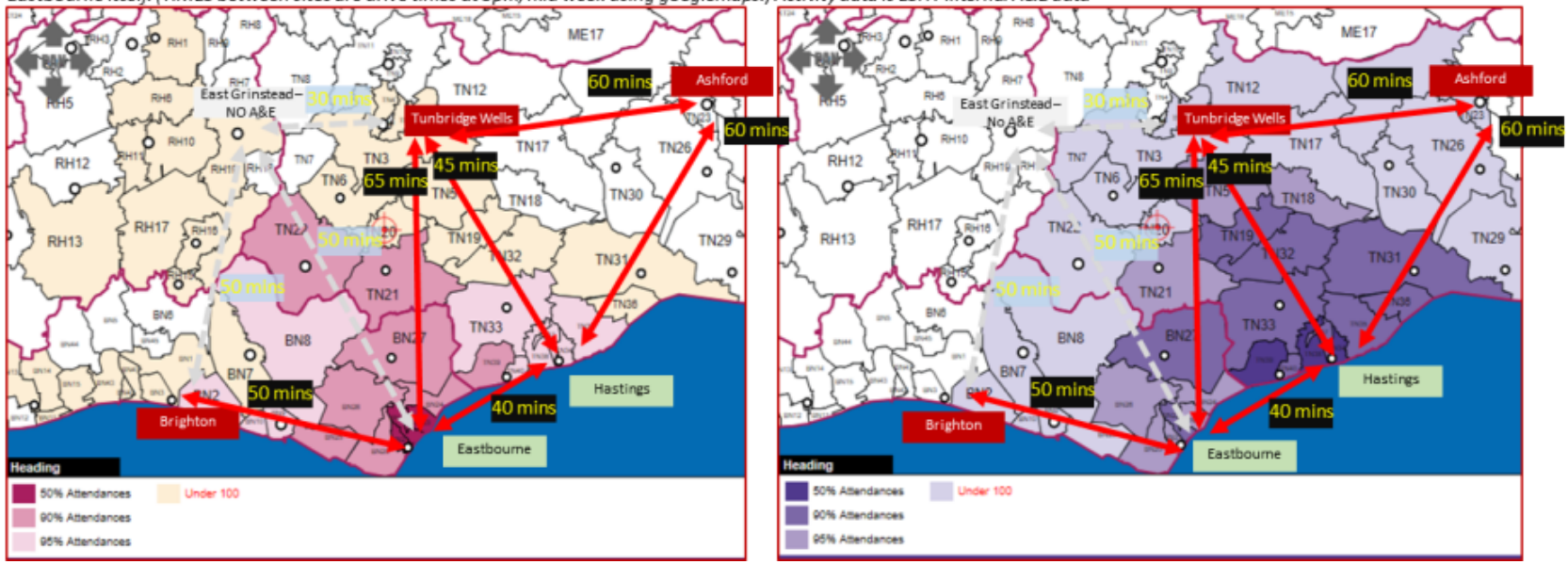
Sources: ESCC Population Analysis, East Sussex JSNA, British Geriatric Society

ESHT operates two main acute hospitals (Eastbourne District General "EDGH" and Conquest in Hastings) and community services for East Sussex

EDGH A&E Attendances

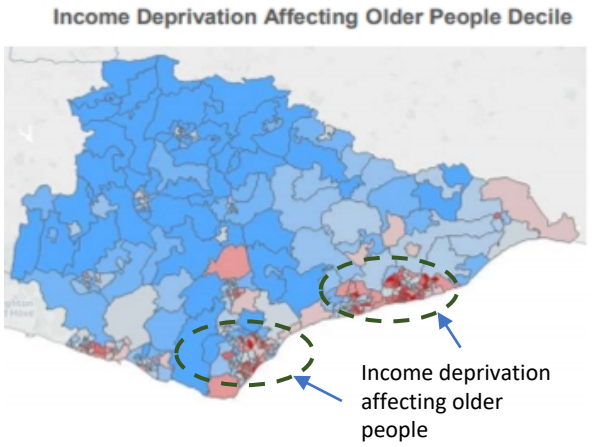
Conquest A&E Attendances

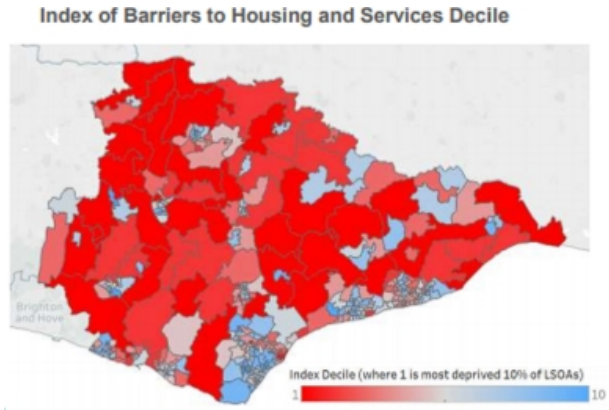
These maps show postcode districts and the proportion of each A&E's total activity that comes from that district – e.g. 50% of EDGH attendees come from the 3 districts in Eastbourne itself. (TIMES between sites are drive times at 3pm, mid week using googlemaps.) Activity data is ESHT internal A&E data



- **ESHT runs two hospitals. Both have A&E departments – with similar numbers of attendances (c.58,000 and c.60,000 each year)**
  - In a national context these are quite small A&Es but they are growing
  - About 50% of each A&E's attendees come from its urban centre (i.e. Eastbourne for EDGH's A&E and Hastings for Conquest's A&E). The next 40% from the immediate surrounding areas and for about 90% of attendees ESHT offers the closest A&E to their home district
  - For practical operational reasons and to make the right levels of quality possible some of the more specialist emergency requirements are centred at Conquest (e.g. our Trauma Unit) – so Conquest has a more 'acute' service mix and a wider catchment
  - As we explain in the next two slides below – parts of our elderly population experience transport issues and some difficulty accessing public services. We also have high levels of both deprivation in our urban centres.
- **For these reasons, if the A&Es *can* be delivered sustainably long term (i.e. we can staff them and deliver the right quality) it would be better to retain both, but we will need to examine different ways to deliver urgent care to do that**
  - In any case, based on current activity (attendances and subsequent admissions) and projected demand growth there is no prospect of 'fitting' one hospital's Urgent Care activity into the other without large scale capital investment (to build enough capacity on a single site) – which is unlikely to become available in the short term

The general ageing trend in our population combines with a number of other factors that may increase demand growth in the future

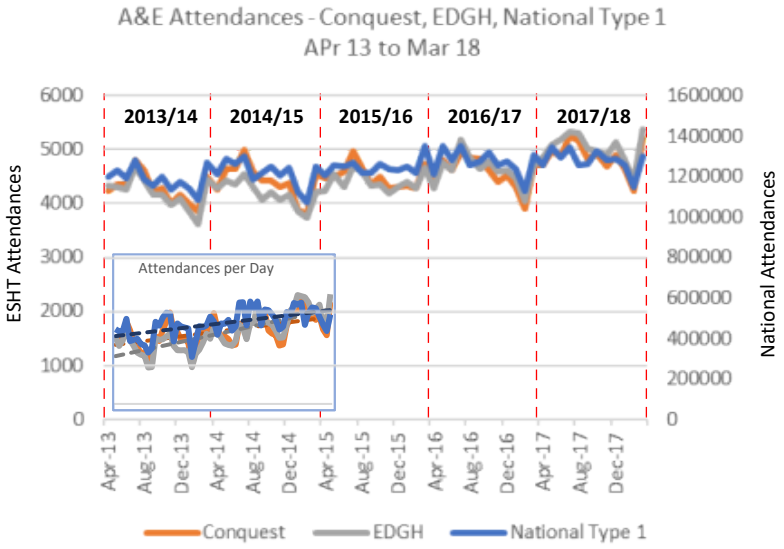


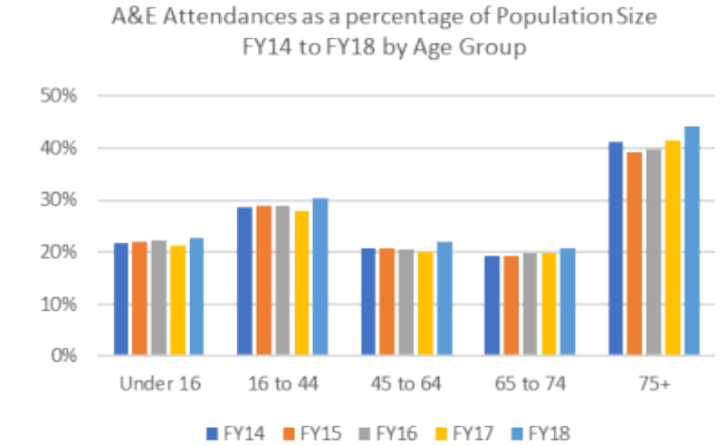


Sources: PwC Population Analysis Tool, East Sussex JSNA, British Geriatric Society

- **Currently 24,000 people are estimated to be 'living with frailty' – this number will grow more quickly with higher growth in the over 75 and over 85 age groups**
  - The proportion of those living with frailty increases rapidly above the age of 75 and in particular above 85 years (some sources estimate 25 to 50% over those over 85 have frailty)
  - 'Difficulty with Daily Activities' accelerates quickly once people pass 75 years of age
- **Other factors, projected to increase, also tend to drive up demand for services**
  - The number of over 75s living alone is projected to increase (11,000 more by 2025)
  - More people living with limiting long term illness (up by c.9% by 2021)
  - An estimated 10,600 people have dementia locally – the JSNA indicates this will grow by c.5,000 over the next 5 years - Age specific rates of admission grow *very* rapidly for those over 75 with dementia
- **Ageing is expected to drive up need resulting from heart failure, new cancers, stroke, bone health, eye disease among others (JSNA)**
  - Increased obesity in older people is also driving up other co-morbidities, such as diabetes (c.4,000 more by 2025)
  - Multiple co-morbidity is expected to increase *as a proportion* in England – e.g. 15% of over 85s in 2015, to 40% of over 85s by 2025 predicted to have 4 or more conditions
- **Outside the urban areas transport links are a challenge for the elderly (36% do not have a car or van) in our catchment**
  - This drives up demand for ambulances (we have a high conveyance rate), tends to push up admission rates and increases community demand
  - PwC's 'Barriers to Housing and Services Decile' includes 'access to Primary care' amongst other measures
- **We also see high rates of income deprivation affecting older people in the areas immediately surrounding our main hospital sites**
- **We will need, as a whole system, to work together to address all these factors if we are to meet the urgent and planned care needs of our population in future – within the resources available to us (i.e. funding)**

Growth in A&E attendances and the resulting inpatient activity poses the biggest affordability challenge to our system as a whole



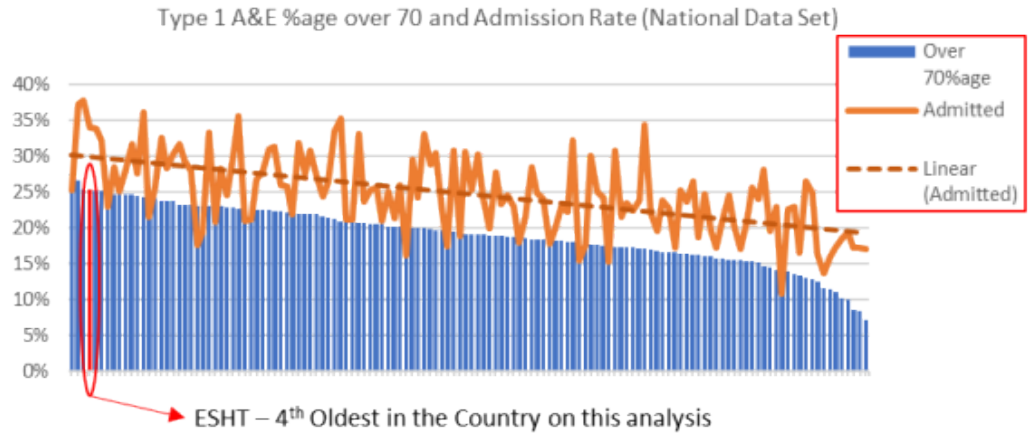


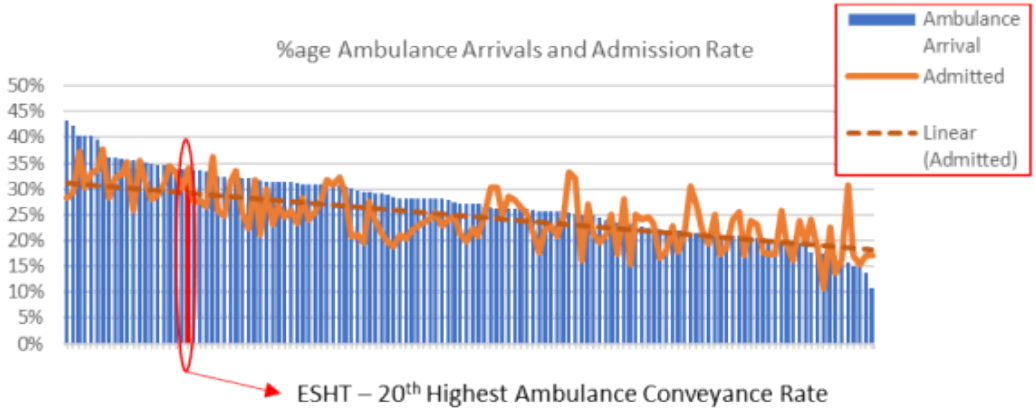
- **A&E attendance growth at ESHT follows a similar pattern to the national trend**
  - Attendances peak in summer months; the affect is more pronounced for ESHT
  - Attendances have grown well ahead of population growth overall (0.8 % per annum over population growth - but 2.3% per annum and 3.2% per annum growth at Conquest A&E and Eastbourne A&E respectively
  - Over 75 year olds use A&E at the highest rate
- **From 2016/17 to 2017/18 attendances increased more quickly at both Conquest and Eastbourne A&Es (6.2% and 8.8% respectively vs 0.8% nationally)**
  - The change in growth coincided with changes in primary care capacity locally which might be a factor; primary care is under significant pressure
  - It could also be due to the ageing of the population
- **In our projections for A&E activity we have assumed demand will continue to grow faster than the overall population growth – as people use A&E more and as the average population age continues to increase**
  - The impact of growth in A&E and the resulting admissions is driving up system spending faster than funding is growing
- **Other factors and changes to our they way our local system delivers urgent care services may impact demand in future**
  - We do not yet have detailed changes planned but a joint programme is in development to examine better ways to meet urgent need and this may mean our projections will need to be reviewed

Source: ESHT Internal A&E Data, National A&E Data (NHS Digital) and ESCC Population Data and Projections

**Note – this is simply A&E attendances by age band divided by population size, by age band for Wealden, Rother, Eastbourne and Hastings combined. So the rate does not indicate how many individuals of that age group attend A&E specifically just how the two relate – i.e. over 75s use A&E more (whether that's individuals using A&E multiple times or more individuals, in reality a mix of both is likely)*

By working together the system needs to address urgent demand differently in future to reduce reliance on hospital beds and ambulances





- **ESHT has the 4th oldest age mix in the country (based on the percentage of attendees at A&E who are over 70)**
  - This means we are likely to admit people from A&E more often
- **However, ESHT's admission rate (historically) has been higher than a number of peers serving similarly elderly populations at A&E**
  - Western Sussex Hospitals (St Richard's Hospital in Chichester and Worthing Hospital) is a useful local comparator as it also serves an elderly population
  - Western Sussex admits people attending A&E at a rate of about 28% whereas ESHT admits at a rate of about 34%
  - ESHT also has a higher proportion of arrivals via ambulance
- **In our view – if we can remodel our approach to Urgent Care and become much better as a Trust and as a system at managing frailty we should be able to lower our admission rate to that of the better performing comparator Trusts**
  - This is about a combination of ensuring the right services are available outside the hospital, that there are alternative settings to hospital beds available and that we manage our A&E differently in future
  - The system's Urgent Care Programme Board is working on this at the moment

Source: NHS Digital Data (note admission have been adjusted for East Sussex actual admission data as the NHS Digital source appeared to have admission levels for only 1 of the ESHT sites)

Our System also faces a number of structural challenges and changes that impact ESHT

- **Primary care is under significant pressure**
  - Changes have occurred to practices in areas where we have both deprivation and an elderly population, which in turn builds pressure on acute, community and social services
  - This coincided with increased attendances at our A&Es in 2017/18
- **MSK has had a material impact on T&O activity at ESHT – we understand this provides a financial benefit for the system and potentially a quality benefit for patients. The loss in activity at ESHT however creates a risk to clinical sustainability**
  - A system wide review of MSK services has been initiated
- **The Urgent Treatment Centre competitive procurement outcome could create risk to ESHT A&E sustainability – financially and clinically**
  - If ESHT is not selected to provide the service, sustaining A&E staffing will be at risk and we would expect A&E financial performance to deteriorate
  - Equally if ESHT is selected then there is a risk that the agreed contract values or tariffs put further pressure on ESHT finances
- **Sustainability and Transformation Plans and Local System recovery plans create risks for ESHT – we do not yet know the implications for activity or our services**
  - Concurrent development makes alignment a challenge – both ESHT and the CCG are developing plans in a tight timeframe leaving little room for alignment. If there are significant differences in assumptions these will take time to resolve
  - The system as a whole is in deficit which can create tension as we all need financial recovery and it limits scope for investment
- **Social services budgets are constrained**
  - Historically ESCC has a high ratio of care home beds per '100 people over 75 yrs old' (13.2 vs 10.3 nationally) – and we are better at keeping older people at home than the national average but sustaining this will get harder as the population gets older and frailer
- **Outside the urban areas, transport and access (including to primary care) is poor for the elderly (36% do not have a car or van)**
  - This drives up demand for ambulances (we have a high conveyance rate), tends to push up admission rates and increases community demand. As the population ages, and informal carers age, this pressure could increase
- **These issues create additional challenges for ESHT and our system partners – at a time when demand growth is set to increase**

Our analysis of the system indicates 5 priorities for ESHT and the CCGs to work on together to create a sustainable system for East Sussex

1. Becoming best at managing frailty in the country

- **Innovative management to support those with frailty (working as a system)**
  - Improve quality of life and help people live well and safely at home or in the most appropriate environment
  - Integrate the way we work to share information better, reduce 'hand overs' from one part of the system to another and make it easier for professionals to address the risks of frailty together and for our population to access support
- **Examine and develop the way community based services (i.e. services outside the hospital) work to identify and support those who have frailty, multiple long term conditions or have urgent needs**
  - Understand and implement changes that help community teams work seamlessly with acute hospital teams

2. Creating a sustainable model for urgent demand

- **Urgent care operating model**
  - We need to be able to address urgent needs more quickly either at A&E or a more appropriate setting – in a way that reduces the need for inappropriate or unnecessary admissions to hospital beds
  - This requires a review of not only how we staff A&E and address attendances there – but also work with the system to change the overall approach to meeting urgent need with out of hours, primary care and community based services
  - Working on solutions collectively would improve services for patients, but also help our primary care colleagues and the system overall by ensuring that the care is provided more efficiently overall

3. Internal Capability

- **We will need to enhance our ability to deliver change and measure progress, successes and failures**
  - ESHT has improved quality and operations significantly in the last 2 years – it needs to combine those skills with enhanced change, productivity and commercial capabilities for sustainable financial performance as well

4. Address Service Sustainability Risks

- **Some services may become difficult for ESHT to sustain alone (e.g. because of sub-specialisation or scale).**
  - Where this is the case ESHT may need to find alternative ways to deliver those services – for example some may be better delivered only on one site, others may be better delivered in partnership with other NHS Trusts

5. Achieving financial balance

- **We must achieve financial balance again so have the financial capacity to make the right investments and changes**
  - This means we will need to control our spending more effectively and improve how efficiently our services run

As well as these priorities our Board has set out key strategic "fixed points" about the way ESHT should aim to deliver services in the future

The strategy assumes we aspire to become an integrated provider operating within an integrated system – with a series of fixed points:

1. **If it can be done sustainably we should continue to operate two acute sites**
   - As long as quality can be maintained and we can make services affordable the two sites offer better access for our population, but we will need to examine how services are configured across the two
   - In any case we believe that at there is not enough capital available for a new, larger, single hospital to replace our two current acute sites

2. **Obstetrician-led maternity will be delivered by ESHT and because of clinical interdependencies will remain at Conquest**
   - Wider maternity services are a core proposition for the community. Therefore if Obstetrics at Conquest is a fixed point, the future of wider maternity services is strategically important for ESHT

3. **We will offer appropriate Urgent Care at both EDGH and Conquest sites**

4. **The system will need to retain a Trauma Unit at Conquest**
   - Providing a Trauma Unit creates significant interdependencies – and therefore fixes some of the wider service requirements at Conquest (e.g. emergency general surgery)

5. **We need to retain clinical oncology delivery at both ESHT sites to ensure the population can access treatment**
   - Currently we are supported by Brighton and Sussex University Hospitals in the west and Maidstone and Tunbridge Wells in the east.

6. **Being an integrated Trust – (i.e. acute with community services) – is a fixed strategic ambition for ESHT as we believe an integrated solution is the best way for us to help the system deliver sustainable services for an elderly population**

7. **We must achieve financial balance**
   - It is an essential for a sustainable future

…and as we deliver the Sustainability Plan our vision, mission, values and overall objectives remain the same

Patients come first at ESHT. Our aim is to be an outstanding organisation by 2020, which provides excellent healthcare for the people of East Sussex, and that people are happy and proud to work at ESHT

Our Vision	Our strategic objectives
• To integrate community and hospital services to provide safe, compassionate, and high quality care to improve the health and wellbeing of the people of East Sussex.	• Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.
	• All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.
	• We will work closely with commissioners, local authority, and other partners to plan and deliver services that meet the needs of our local population in conjunction with other care services.
	• We will operate efficiently and effectively, diagnosing and treating patients in timely fashion and expediting their return to health.
	• We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable.

We have developed 6 primary programmes to address these priorities and support the system in moving to a more sustainable position

ESHT core sustainability programmes are:

1. Productive planned care	• To make our planned services like outpatients and planned surgery as high quality and as efficient as possible
2. Becoming the best at managing frailty	• To help those who have frailty stay well for longer, with better quality of life, and reduce their need for hospital services
3. Creating a sustainable model for urgent care	• To meet urgent demand more quickly and with the most efficient resources
4. Integrating community services	• To make sure our out of hospital an in hospital services and teams can work seamlessly, sharing information and practices
5. Implementing sustainable service Models	• To find the right configuration across our sites or the right partners to ensure all our services are high quality and sustainable
6. Business processes and cost control	• To ensure our corporate functions are fully equipped to help our services manage themselves efficiently and effectively and deliver the changes needed for the future

We expect each programme to improve capacity and quality as well as deliver financial improvements

Table of the financial improvements assumed in our Long Term Financial Model

Movement	FY19	FY20	FY21	FY22	FY23
Divisional CIPs	9.5	11.0	10.9	10.9	11.1
Sustainable Urgent Care	2.1	2.2	2.4	0.0	0.0
Productive Planned Care	2.0	1.7	1.4	0.0	0.0
Best at managing Frailty	2.1	-1.4	2.9	1.9	0.4
Integrating Community Services		0.0	1.5	1.0	0.0
Sustainable Service Models		1.0	1.7	1.2	0.5
Business Processes and Cost Control 1 (Grip & Control)	3.5	6.5	2.1	1.8	1.5
Business Processes and Cost Control 2 (Backoffice)		0.3	0.5	0.5	0.3
Business Processes and Cost Control 3 (Income correction)		4.8	6.5	0.0	0.0
TOTAL CIPs	**19.2**	**26.1**	**30.0**	**17.2**	**13.7**
Business Processes and Cost Control 4 (PSF)		0.0	15.0	0.0	0.0
Impact of Growth	1.2	1.0	1.3	1.7	2.1
Cost pressures	-4.5	-9.3	-10.1	-10.3	-10.6
Impact of Inflation	-4.0	-3.0	-2.9	-2.9	-3.0
Capital charges	-0.8	-1.3	-1.2	-0.3	-0.6
Other changes	1.3	0.0	0.0	0.0	0.0
Total movement	12.5	13.4	32.1	5.4	1.5
NHS REPORTED I&E Surplus / (Deficit)	-45.1	-31.7	0.4	5.8	7.3

- **Over the next three years, 2018/19 to 2022/23, the Trust needs to make a total of £75.3m of financial improvements to achieve financial balance (assuming our income grows as projected)**
- **All the various pieces of work that inform us about where financial improvement opportunities might have been pulled together (such as benchmarking with Model Hospital and the Drivers of the Deficit work carried out by PwC)**
- **As further work has been carried out we have worked through the process of understanding what the financial benefit of each of the 6 key programmes is from 2019/20 to 2022/23**
  - As implementation planning progresses these are likely to change to some degree as the details behind our plans become more specific
- **The resulting assumptions deliver financial balance in 2020/21**
  - Work on system alignment is progressing, as this firms up it is possible that if CCG plans or the wider NHS makes material changes to the contracting process, tariff or system funding allocations that there may need to be material changes to this plan

Source: ESHT Long Term Financial Model

The plan also assumes demand driven income and activity growth

- **The Trust anticipates a demand driven increase in overall income over the next five years – with the impact of Provider Sustainability Funding (formerly Sustainability and Transformation Funding) and an £11.3m income correction in addition to this demand increase**
  - However the Trust recognises that the income assumptions will be unaffordable for the East Sussex system within current projected funding allocations for our CCGs
  - Detailed work is underway with system partners to secure robust and deliverable plans for both the Trust and the system to reduce demand for acute services by investing and developing services outside the hospital. Working in an integrated way, we can design an affordable and sustainable system that meets the needs of the population we serve

£000	2015/16	2016/17	2017/18		2018/19	2019/20	2020/21	2021/22	2022/23
Income & Expenditure	**Actual**	**Actual**	**Actual**		**Plan**	**Forecast**	**Forecast**	**Forecast**	**Forecast**
Contract income	322,561	342,265	343,928		362,463	376,836	397,940	412,889	429,838
Other income	33,591	37,042	40,473		34,066	33,310	33,375	33,439	33,504
STF/PSF	-	-	3,534		-	-	15,000	15,000	15,000
Income total	**356,152**	**379,307**	**387,935**		**396,530**	**410,146**	**446,315**	**461,328**	**478,343**
Pay	(258,138)	(269,641)	(284,256)		(285,641)	(286,319)	(287,838)	(294,545)	(305,056)
Non pay	(125,779)	(134,739)	(137,584)		(134,249)	(133,293)	(134,604)	(137,249)	(141,669)
EBITDA	**(27,765)**	**(25,073)**	**(33,905)**		**(23,361)**	**(9,466)**	**23,873**	**29,534**	**31,618**
NHS REPORTED Surplus / (Deficit)	**(47,997)**	**(43,900)**	**(54,982)**		**(45,076)**	**(31,683)**	**448**	**5,819**	**7,314**

We are enhancing our governance processes to support delivery of the plan

- **The Trust Board, Executive Team and divisional teams are focused on both achieving our 2019 business plan and both clinical and financial sustainability in the longer term including**
  - Financial improvement through a clear accountability framework and fully resourced plans with the right capability and capacity to drive actions through to delivery
  - The Trust Board, the Executive Team and senior clinical and management staff all understand the need for a financially sustainable organisation and the necessity of effectively communicating this key message to all staff and stakeholders
  - Reporting of progress will be timely and relevant enabling corrective action to be taken to ensure delivery of financial sustainability
  - Key delivery metrics are in place to track delivery and provide early warnings of slippage of the FRP including critical success factors
- **Following appointment of our Recovery Director in July 2018, the Trust has put in place an approach to recovery which aims to deliver the financial improvement that the Trust recognises is necessary to continue to provide safe and high quality care but in a financially sustainable environment**
- **The existing governance structures have been reviewed and further enhanced by our Recovery Director. The approach seeks to co-ordinate activities across each of the areas of concern which are:**
  - Financial recovery
  - Specialty reviews, deep dives and redesign
  - Sustainability and Transformation Partnership (STP) alignment
  - Quality improvement
  - Other major projects
  - Strategic CIPs
- **A single improvement plan has been implemented which gives the Trust Board oversight and assurance of progress on the delivery of the range of improvement activities in place, led primarily by Divisions and supported by the Trust's Programme Support Office**
- **To support the recovery approach the Trust is strengthening its Programme Support Office, with additional recruitment, which will assure oversight, ensure control, provide challenge and support and ensure accountability**
- **The CEO is the Senior Responsible Officer for the overall Financial Recovery Plan and leads the process supported by named Executive Directors and delegated authorities appointed as Executive Sponsors**
- **Delivery is strengthened with the appointment of a joint System Improvement Director to enable and drive alignment**
- **A system PMO has been proposed**

There are several risks to delivering our programmes successfully – the most important risk relates to achieving system alignment

There are several key risks to delivering this plan – but the most important risk to mitigate is a lack of system alignment, in particular between ESHT and the CCGs. All risks are actively being addressed.

Risk	Impact	Likelihood	Possible Causes	Mitigations
Lack of system alignment	• Programmes not fully supported by the system • Benefits realisation is held back by negotiations or disagreements	High – (some programmes more likely to be affected than others)	• Conflicting aspirations and/or conflicting benefits required • Differing views on what is possible • Lack of shared objectives across the system	• Work to achieve alignment – overseen by the System Improvement Director • Alignment from NHSI and NHSE on system plans • Closer working between ESHT and CCGs
Loss of services essential to programme success	• Loss of services currently delivered by ESHT	Medium – we understand both are potentially at risk	• Commissioners see greater value in separating services currently delivered by ESHT as an integrated acute/community provider	• Work to achieve system alignment – with NHSI and NHSE support • Making the case for programmes to commissioners so they are able to support them
Insufficient delivery resources	• Phasing of benefits is delayed • Fewer programmes complete or all programmes are held back	Medium – requirements are inherently uncertain	• Unclear what sufficient resource looks like • The right skill-sets may not be available	• Close working with NHSI • Test as large an assumption as we can in the modelling • Look for system wide support where programmes clearly offer a system wide benefit
Failure to realise benefits	• Key benefits do not materialise – particularly financial ones • Programmes are revised, abandoned or changed for the wrong reasons • Patients and the wider population, and clinical staff, do not experience key benefits	Medium	• Benefits realisation – particularly financial benefits – can be a challenge for NHS systems. This is more pronounced if organisations are fragmented, but the changes needed to release system benefits need to be shared or cut across organisations	• System alignment and an agreed, shared benefits realisation and recognition processes • Effect arrangements to share risk evenly and/or proportionately – especially where organisations are fragmented and / or statutory duties or regulatory pressure appear to conflict
Ineffective measurement	• Lose the ability to recognise successes and failures therefore either adapt programmes inappropriately or under-realise benefits	Medium	• Lack of a shared and agreed baseline against which to identify changes • Inaccurate or incomplete information • Clumsy and / or siloed analysis rather than careful, coherent and comprehensive system wide analysis	• Develop a system-wide baseline that is agreed by all and detailed • Develop a system-wide programme to create a clear informatics capability, agreed by all

We are still working through a process of aligning our plans with those of the CCGs to create a joint system recovery plan

- **The Trust and the CCG are seeking to develop a shared understanding of the financial challenge, and the actions to address this challenge**
  - The Trust commissioned a drivers of the deficit review, and the CCG are considering elements of the deficit drivers in its commissioned review. The Trust has held a PwC supported a system financial workshop in August to develop a shared understanding of the key financial issues and the system response. As this work develops, the Trust financial plans will be refreshed
- **A new delivery governance for the East Sussex system has been put in place, both for the statutory bodies and for the regulators**
  - A single regulatory team is overseeing developments within the locality, with a single System Improvement Director appointed to both organisations by NHS England and NHS Improvement. The System Improvement Director is supported by a joint team from both regulators, with monthly regulatory oversight undertaken through a single meeting between the Trust, the CCG and the regulators
- **The Trust and the CCG, alongside the local authority, use the monthly System Financial Recovery Board (SFRB) to track performance and to make shared decisions**
  - This is chaired by the STP Executive Chair to facilitate effective performance and includes key stakeholders from the ESBT system
- **We are working towards a full alignment of the CCGs and ESHT plans so that this informs our medium term system plan in readiness for submission in September 2018**
  - Focus has been on testing the impact of CCG 'Quality Innovation Productivity and Prevention' (QIPP) plans on the Trust and the impact of ESHT CIP plans on the CCG spend in order to make sure these are aligned and can be delivered
  - We are also working to make sure that outside of the QIPP and CIP, our activity assumptions are not only aligned, but are profiled across the year in the same way
- **A number of key actions are in train to address the emerging system financial risks, supported by the 'East Sussex Better Together' Chief Financial Officers and through the ESBT System FRB:**
  - Updates are provided to the SFRB
  - All partners are working closely with NHSI/E delivery team to strengthen the pipeline
  - Both organisations are working with each other to establish opportunities for improved delivery
  - The Trust has held a PwC supported workshop to review drivers of the deficit and aligned opportunities for improvement, and the Trust/CCG/LA is planning a system workshop to address the same issues at system level
  - A number of reviews are in train to support strengthened financial governance at each organisation (Deloitte), strengthened CIP development and delivery (PwC) and a shared understanding of the future plans for community investments (CF). These are tracked through the SFRB
  - The key next step is to develop a shared forecast for the acute contract to support the development of a shared view of the financial challenge for the remainder of the year, and to support the agreed recovery actions for overperformance

Whilst the system alignment process progresses ESHT will also need to focus on delivering our 2018/19 plan and setting up our key programmes

There are three main steps we are focusing on as next steps which are

1. **Implementing financial recovery plan actions for 2018/19 (this year)**
   - Implementing key actions to delivery our 2019/20 CIP target – and aiming for the stretch target of £23.5m
   - Initiating 'T3' grip and control
   - Initiating 2019/20 business planning and CIP pipeline – within the 6 programme framework
2. **Progressing alignment of our Financial Recovery Plan with the CCG's to create a single, shared, system plan**
   - Inflation has already been agreed
   - Activity growth – ESHT has much more detailed activity modelling and projections – we can work with the CCG to align them (pre-QIPP) by end of September along with any provider price changes
   - The impact of CCG QIPP on ESHT is the largest difference between our FRP's currently. Joint working on system initiatives and implementation will bring these closer together and a number of actions are being undertaken to enable that:
     - We are carrying out a baseline review
     - A joint review of Community Services will be commissioned
     - We are developing the NHSI/E supported joint programmes with the CCG for Front Door/Frailty, Musculoskeletal Services (MSK) and Out of Hospital/Primary Care. A 12 week planning process has been defined, SROs are agreed and PIDs prepared
3. **Implementation Planning**
   - Internal implementation planning is underway – we will submit our implementation plans at the end of September
     - Milestones and actions for the programmes – detailed for 2018/19 and 2019/20
     - More detailed benefits phasing
     - Leadership and team arrangements for the programmes
     - Governance adjustments if required
     - Agreeing and developing delivery resources – over and above those already planned for the PSO
   - Internal planning must align with CCG plans – this will progress further over the next month and complete over the next 2 to 3 months (we will use the key joint programmes and their 12 week planning process as a vehicle for doing this)
   - We will agree system PMO arrangements and implement as a system

Glossary of Terms

Term	Meaning
BSUH	Brighton and Sussex University Hospitals NHS Trust
CCG	Clinical Commissioning Group
CHC	Continuing Health Care - funding for out of hospital support in specific circumstances
CIP	Cost Improvement Plan
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation - Income for providers with improvement or quality conditions attached
CSU	Commissioning Support Unit
EBITDA	Earnings before Interest Tax Depreciation or Amortisation
ESBT	East Sussex Better Together – a non-statutory board for leaders across the system to create sustainability initiatives
ESCC	East Sussex County Council
ESHT	East Sussex Healthcare NHS Trust
F&I	Finance and Investment Committee
FISC	Financial Improvement Scrutiny Committee
FRP	Financial Recovery Plan – the components of our 5 year plan that deliver financial improvements. This is an integral part of our sustainability Strategy
FSM	Financial Special Measures
FTE or WTE	Full Time Equivalent or Whole Time Equivalent – used interchangeably
FY (e.g. FY19)	Full Year (referring to the 12 months of a financial year as opposed to a calendar year, e.g. FY19 is the 12 months from April 2018 to March 2019)
GIRFT	Getting if Right First Time
HRG	Healthcare Resource Group
JSNA	Joint Strategic Needs Assessment
LoS or AvLoS	Length of Stay or Average Length of Stay
MRET	Marginal Rate Emergency Tariff (a lower tariff for emergency admissions above an agreed threshold)
MSK	Musculo-Skeletal - usually referring to services addressing conditions with the musculo-skeletal system
NHSE	NHS England
NHSI	NHS Improvement
P.A	Per annum
PID	Project or Programme Initiation Document
PSF	Provider Sustainability Fund
PSO	Programme Support Office
PwC	PricewaterhouseCoopers
QIA	Quality Impact Assessment
QSM	Quality Special Measures
SLR	Service Line Reporting
SSSG	Sustainable Services Steering Group
STP	Sustainability and Transformation Programme
STT	Scientific and Technical staff
Sustainability Strategy	The components of our 5 year plan that deliver sustainable models for delivering health and social care services – both clinically and financially. These are an integral part of our financial recovery
T&O	Trauma and Orthopaedics
UTC	Urgent Treatment Centre
WAU	Weighted Activity Unit -designed to normalise activity measures for the cost of associated resources. This enables more straightforward comparison (provided the WAU is a accurate enough)
WTE or FTE	Whole Time Equivalent or Full Time Equivalent

Winter Preparedness 2018/19

Meeting information:			
Date of Meeting:	2 October 2018	Agenda Item:	13
Meeting:	Trust Board	Reporting Officer:	Joe Chadwick-Bell

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

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☐
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:			
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 East Sussex Local Health Economy (LHE) has developed a winter plan, which is supported by the East Sussex Systems Surge and Capacity Plan. Both plans provide an input from all of the partners in the East Sussex Health and Social Care economy. The Surge and Capacity Plan describes the way in which East Sussex Health and Social Care Economy will respond to the additional demands of Easter and peak pressures throughout the year. A copy of the plan can be found in Appendix 1 of the attached Winter Plan document. This document (August 18) has been submitted to NHSI for review and assurance and will remain under continuous review.

The objectives of the plan are as follows:

- To maintain patient safety at all time;
- To achieve an acute bed occupancy of no more than 85% by Monday 24th December and to maintain bed occupancy below 95% throughout Winter;
- To ensure that all community bed and service capacity is fully utilised;
- To avoid ambulance delays of over 30 minutes;
- To deliver the 90% 4 hour standard and as a minimum deliver the agreed system performance trajectory of 95% by March;
- To ensure the system delivers and sustains the national reducing long length of stay (super stranded) ambition;
- To ensure system DTOCs are no greater than 3.50%.

<u>Managing Non-Elective Demand</u>

Non-Elective demand and bed availability remain the most significant risks, although these have been mitigated in the attached plan. In additional there are two key workstreams in place across the system focusing on demand management and reducing length of stay for the frailty patients.

Out of Hospital and Primary Care

- Increasing the use of the 'home first' principle from pre-admission to post discharge
- Optimising use of the integrated locality teams and crisis response teams
- Development of 5 key pathways, which the highest linked admissions
    - UTI and catheter
    - Flu and pneumonia
    - Non-injury falls
    - Cellulitis
    - Respiratory
- Primary Care out of hours service and supporting the interface between out of hospital and front door

Front Door and Frailty

- Ambulatory (same day emergency care) and acute medical units, optimisation and extension of the service
- Developing a clear pathway for patients and development of a multi-disciplinary team

Trust Level Delivery

At Trust level a winter delivery team comprising the senior clinical and operational team has been established to ensure delivery of the actions, and any further recommendations from NHSE. Focus continues on improving length of stay beyond the already met targets and reducing the patients with long lengths of stay.

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

Local A&E Delivery Board

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

For Assurance

Emergency Preparedness, Resilience & Response (EPRR) Assurance 2018

Meeting information:			
Date of Meeting:	2nd October 2018	Agenda Item:	14
Meeting:	Trust Board Seminar	Reporting Officer:	Joe Chadwick-Bell

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

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

Summary:

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

- ESHT has legal obligations to meet 'Emergency Preparedness, Resilience & Response' standards and requirements.
- In 2017 the Trust were assessed as partially compliant
- Additional EPRR provision has been put in place and a large program of work has been undertaken to improve ESHT performance.
- A substantial work program is on-going, with a lot having been achieved. However there is much still to do including training of staff at various levels for EPRR-related roles, and in reviewing service and division-level business Continuity plans.
- As part of this program a number of risks have been identified (as detailed below).
- The increased commitment provided by the ESHT EPRR program has resulted in significant improvement against core standards across the last 12 months and is likely to be agreed as having moved from 'Partially compliant' in 2017 to 'Substantially Compliant' in 2018.

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

EPRR steering group / Audit Committee

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

The Board are asked to receive assurance and note the improvements made to raise the level of compliance against the NHS England 'Core Standards for EPRR', with a view to the Trust achieving substantial compliance in Autumn 2018, and working towards full compliance in 2019.

Emergency Preparedness, Resilience & Response (EPRR) Assurance 2018

1. Introduction

This report provides a briefing on ESHT Emergency Preparedness Resilience & Response (EPRR) requirements and capabilities, and updates the June 2017 Board report on progress towards being 'fully compliant' with the NHS England EPRR Core Standards audit.

The Trust acknowledges its duties as a 'Category 1 responder' under the Civil Contingencies Act 2004, and the requirements of the NHS EPRR Framework 2015. These require ESHT to:

- Assess the risk of emergencies occurring and use this to inform planning;
- Put in place emergency plans (for external incidents);
- Put in place Business Continuity Management arrangements (for internal incidents);
- Put in place arrangements to warn and inform the public about civil protection matters which impact on the organisation;
- Share information and co-operate with other local responders.

NHS England (NHSE) maintains an EPRR Framework, which places similar duties to the above on all NHS-funded organisations. The performance of each Trust is audited against the EPRR framework annually in September / October, via the NHSE Core Standards for EPRR. This process is managed in Sussex by NHSE South (South-East), with assistance (in our case) from East Sussex CCGs. The CCGs co-ordinate the local health response on our behalf and we have worked closely with both the CCG and NHSE through the year to ensure ESHT is able to prepare and respond effectively. The assurance process involves assessment and grading against approximately 64 separate core standards (see below). As reported to the Board in November 2017 the Trust's compliance with the Core Standards, in Autumn 206 and 2017 was assessed as being 'Partially' compliant.

Fig. 1 Compliance Scoring

The level of compliance against the core standards for 2018 is assessed as:

	Total Core Standards <u>not</u> complied with
Full	0
Substantial	1-8 (99 – 89 %)
Partial	9-15 (77 – 88 %)
Non-compliant	16+ (76 % or less)

NHSE require assurance that the Board considers and engages in promoting full compliance with the EPRR Core Standards and is aware of the current level of compliance together with the action plan to achieve full compliance. It was accepted by the Board that work was needed to improve the ability of the Trust to prepare for and to respond to both 'business continuity' and 'major' incidents.

2. Work-plan and Progress 2018/19

The key full areas of non-compliance as at November 2017 (together with summarised progress against each area and showing outstanding actions), are shown in Appendix A, ESHT EPRR Core Standards Action Plan. This has been reviewed monthly and reported through the EPRR steering group. It can be seen that this has progressed significantly from October 2017, and since the Board last received an EPRR report, in June 2018.

The EPRR team had been operating for some time with one EPRR Officer in a part time capacity. In February 2018 an experienced practitioner was appointed as Head of EPRR (Kevin Claxton) and following the recent resignation of the original Officer a full time EPRR Officer has been appointed (Luke Blackwell). The COO is the designated executive officer responsible for EPRR and the team is now line managed by the ADO Operational Improvement/Performance. Further project and administration support has been provided from internal resources.

Together, the team has been working hard to raise the Trust's level of general preparedness ensuring that EPRR becomes embedded in our culture, and raising its profile across the Trust. With two full-time practitioners in post, and with the support of the Chief Operating Officer and a Board-level Non-Executive Director, a large program of work has been commenced with the aim is to ensure that the Trust is resilient; 24 hours per day, 365 days per year.

2a. Review of planned work

Planned next steps reported to the Board in June 2018 included:

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

2b. Policies & Plans

In recent months, significant progress has been made: The Trust's EPRR policy and its key plans have all been reviewed and implemented:

- Incident Response Plan (including Command and Control Framework)
- Major Incident Plan for number of casualties and mass Casualties
- Corporate Business Continuity Plans
- A number of further risk-based plans

A further key piece of work has been to raise the ESHT engagement in EPRR, and also raising the profile of EPRR across the organisation:

- The EPRR Steering Group has been re-invigorated and it's working practices have been reviewed. The group meets bi-monthly with good support from services and divisions. It has agreed and closed actions resulting from lessons identified from both the 'Birling Gap' incident and internal business Continuity incidents. The group reports to the Audit Committee.
- The ESHT EPRR Extranet page has been revamped with updated details and plans. A page has also been created on the external ESHT internet page.
- The EPRR team is active on Social media. The Head of EPRR is engaging with various staff forums, and items have been included in Trust-wide corporate communications.
- Board reports are now 6-monthly, and a NED has responsibility for EPRR.

In addition, the Trust values its engagement with both the (multi-agency) Sussex Resilience Forum (SRF) and the Local health Resilience Partnership (LHRP), as required by legislation. It has participated in incidents and exercises at and is represented across the range of SRF working groups, and event 'Safety Advisory Groups' organised by East Sussex local authorities.

3. Risks

A significant piece of work has been to ensure that risks highlighted under the SRF's 'Community Risk Register' and the LHRP risk register are for the first time, fully reflected in ESHT risk register.

4. Training

Training and exercising was an areas for specific review and development. A training needs analysis has now been completed, and a training programme developed. Training courses have been prioritised and the content of most has been agreed. Delivery of key parts of EPRR training has re-commenced.

A table top 'Emergo' exercise is being run in November in conjunction with the Sussex Trauma Network and other Sussex Trusts to test our key plan including Major Incident Plan and Mass Casualty plan.

5. Current EPRR Audit and Summary

The 2018 annual EPRR Core Standards Audit is currently underway with the East Sussex CCGs and NHSE. A self-assessment for ESHT has been undertaken against each of the 2018 Core Standards requirements, as follows:

Compliance Level	Definition
Not compliant	Not compliant with the Core Standard: In line with the EPRR work Programme, compliance will not be reached within the next 12 months
Partially compliant	Not Compliant with the Core Standard: The organisatiosn EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months
Fully Compliant	Fully compliant with the core standard

The ESHT EPRR self-assessment for 2018 is that of 'Substantially Compliant', which was our target for this year. This compliance level has been accepted by the CCGs, and will be confirmed at the LHRP strategic meeting on 8th October, and later reported to the Trust Board.

- Going forward, the EPRR work-plan (current version attached at Appendix B), will include:
- Continuing to deliver the role-out of the training program to staff in numbers of roles
- Testing plans & exercises to ensure that arrangements work. (ESHT has committed to a Sussex Major Trauma Network exercise on 28th Nov which will involve 50 key staff representing emergency departments & Incident Control Centres at both acute sites.)
- A key in-depth audit and upgrade of service & divisional business continuity plans.
- Any other work required by NHS England so as to comply with all Core Standards for EPRR

6. Conclusion

The EPRR team is committed to ensuring that the work program results in greater understanding of and commitment to 'emergency preparedness' arrangements across all sites. Significant progress has been made in 2018 and ongoing work will lead to improved Trust resilience, and full compliance with RPRR standards by the end of 2019.

Prepared by Kevin Claxton, Head of EPRR on behalf of Joe Chadwick-Bell, Chief Operating Officer East Sussex Healthcare NHS Trust.

Winter Flu Self-Assessment

Meeting information:	
Date of Meeting: 2nd October 2018	Agenda Item: 15
Meeting: Trust Board	Reporting Officer: Monica Green

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: Public Health England			
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? Not necessary – outlined within the paper	

Summary:

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

1.1 Seasonal Influenza

Flu is a very common, highly infectious illness most prevalent over the winter months. It can develop into more serious illnesses, such as bronchitis and pneumonia. In the UK, the estimated number of excess deaths thought to be due to seasonal Flu varies each year, but has been as high as 10,000.

Healthcare workers, as members of the general population, are susceptible to Flu. When coupled with the potential for a third of flu cases being transmitted by asymptomatic individuals it means patients are at particular risk.

Flu is unpredictable. The vaccine provides the best protection available against a virus that can cause severe illness. The most likely viruses that will cause Flu are identified in advance of the Flu season and vaccines are then made to match them as closely as possible.

Front line health care workers are actively encouraged to have the Flu vaccination. It can take up to three weeks post vaccination to develop immunity therefore the vaccine is made available to staff at the earliest opportunity within the season.

1.2 Letter from NHS England 7th September 2018

In a letter from NHS England, (attached), NHS trusts are being asked to record their commit to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine to anonymously mark their reason for doing so

1.3 ESHT Target for uptake by Frontline Health Care Workers
2017/18 – 70%
2018/19 – 75%

1.4 Evaluation and key points of learning from 2017/18 Flu campaign:

Target to vaccinate 70% of front line staff – (3468 staff)

- Outreach approach – Flu walkabouts (out of hours), attending training, staff meetings and induction all increased uptake from front line staff.
- Use of Temporary Workforce Service Flu nurses during October to facilitate maximum opportunities for staff to access the Flu vaccine
- Clinical intelligence to target optimum times to catch front line staff
- Coordinating requests for Flu clinics and using a Flu bleep for on site requests.
- Improving recruitment, training and support for peer vaccinators
- Monthly Flu preparation meetings and weekly Flu calls from 1st October.
- Participation from stake holders across the Trust – shared responsibility for the Flu campaign.
- Workforce Intelligence data for Individual Performance Reviews to monitor & encourage uptake from front line workers
- Improved Communications – weekly message, high profile clinical staff promoting the vaccine, selfie-frames, social media – Twitter
- Engagement from senior clinical leaders from the outset
- Rewarding peer vaccinator with the highest vaccination figures with free parking for a month (though this was not taken up).
- Time taken to personally thank everyone involved in the 2017/18 Flu campaign via a letter from CEO.

Frontline staff % uptake since 2016

Staff Group	% uptake in 2016/17	% uptake in 2017/18
All Doctors	**39%**	**62%**
Qualified Nurses, midwives and health visitors	**36%**	**60%**
All other professionally qualified clinical staff, which comprises of:- (Qualified scientific, therapeutic and technical staff, Qualified allied health professionals, other qualified ST&T and qualified ambulance staff)	**70%**	**95%**
Support to clinical staff, which comprises of:- Support to doctors and nurses, Support to ST&T staff, Support to ambulance staff.	**81%**	**81%**
Total	**53%**	**72%**

1.5 Plan for 2018/19

Target to vaccinate 75% of front line staff – c3800 staff

- Build on and extend outreach approach
- Early evaluation and planning of the Flu campaign
- Continued participation and increasing participation from stake holders across the Trust – responsibility for success of the Flu campaign is Trust wide
- Building on work with Temporary Workforce Service - extending coordination of requests for Flu clinics by front line staff
- Extending recruitment, training and support of Temporary Workforce Service Flu nurses and peer vaccinators
- Targeting groups where the greatest increase in uptake is required – ie Doctors, qualified Nurses, Midwives and Health Visitors.
- Continued engagement with senior clinical staff in promotion of the Flu campaign
- Increasing use of social media – in particular Twitter
- Sharing best practice via 'Flu Fighter network'
- Improving workforce intelligence for divisional Individual Performance Reviews to identify areas of low uptake and target resources
- Ensure recognition of all staff involved in delivery of the campaign is completed in March/April 2019.

1.6 Risks to success of the campaign

- Last year's campaign able to count in front line decliners into the uptake figure **(300 staff).** Not able to do this in 2018/19.
- Potential delayed delivery of the Flu vaccine

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

Flu Team – monthly since May 2018
Infection Prevention and Control – Helen Tingley & Lisa Redmond – ongoing
HSSG – ongoing
CQUIN lead – Kevin Burns and Liz Lipsham – monthly since May 2018
OD & Engagement – Lorraine Mason – on agenda from October 2018

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

- Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.
- Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt.
- Agree on a board champion for flu campaign.

Wellington House
133-155 Waterloo Road
London SE1 8UG
martin.wilson1@nhs.net

Friday 7 September 2018

To: Chief Executives of NHS Trusts and Foundation Trusts

Dear Colleague

Health care worker flu vaccination

We know you appreciate the importance of all healthcare workers protecting themselves, their patients, their colleagues and their families by being vaccinated against seasonal flu, because the disease can have serious and even fatal consequences, especially for vulnerable patients. Your leadership, supported by the Flu Fighter campaign and the CQUIN has increased take-up of the flu vaccine, with some organisations now vaccinating over 90% of staff. Our ambition is for 100% of healthcare workers with direct patient contact to be vaccinated.

In February, the medical directors of NHS England and NHS Improvement wrote to all Trusts to request that the quadrivalent (QIV) vaccine is made available to all healthcare workers for winter 2018-19 because it offers the broadest protection. This is one of a suite of interventions that can and should be taken to reduce the impact of flu on the NHS.

Today we are writing to ask you to tell us how you plan to ensure that every one of your staff is offered the vaccine and how your organisation will achieve the highest possible level of vaccine coverage this winter.

Healthcare workers with direct patient contact need to be vaccinated because:

a) Recent National Institute for Health and Care Excellence (NICE) guidelines[1] highlight a correlation between lower rates of staff vaccination and increased patient deaths;

b) Up to 50% of confirmed influenza infections are subclinical (i.e. asymptomatic). Unvaccinated, asymptomatic (but nevertheless infected) staff may pass on the virus to vulnerable patients and colleagues;

c) Flu-related staff sickness affects service delivery, impacting on patients and on other staff – recently published evidence suggests a 10% increase in vaccination may be associated with as much as a 10% fall in sickness absence;

d) Patients feel safer and are more likely to get vaccinated when they know NHS staff are vaccinated.

[1] https://www.nice.org.uk/guidance/ng103

In order to ensure your organisation is doing everything possible as an employer to protect patients and staff from seasonal flu we ask that you complete the best practice management checklist for healthcare worker vaccination [appendix 1] and publish a self-assessment against these measures in your trust board papers before the end of 2018.

Where staff are offered the vaccine and decide on the balance of evidence and personal circumstance against having the vaccine, they should be asked to anonymously mark their reason for doing so by completing a form, and you should collate this information to contribute to the development of future vaccination programmes. We have provided an example form [appendix 2] which you may wish to tailor and use locally, though we suggest you use these opt out reasons to support national comparisons.

We specifically want to ensure greatest protection for those patients with specific immune-suppressed conditions, where the outcome of contracting flu may be most harmful. The evidence suggests that in these 'higher-risk' clinical environments more robust steps should be taken to limit the exposure of patients to unvaccinated staff and you should move as quickly as possible to 100% staff vaccination uptake. At a minimum these higher-risk departments include haematology, oncology, bone marrow transplant, neonatal intensive care and special care baby units. Additional areas may be identified locally where there are a high proportion of patients who may be vulnerable, and are receiving close one-to-one to clinical care.

In these higher-risk areas, staff should confirm to their clinical director / head of nursing / head of therapy whether or not they have been vaccinated. This information should be held locally so that trusts can take appropriate steps to maintain the overall safety of the service, including considering changing the deployment of staffing within clinical environments if that is compatible with maintaining the safe operation of the service.

We would strongly recommend working with your recognised professional organisations and trade unions to maximise uptake of the vaccine within your workforce; to identify and minimise any barriers; to discuss and agree which clinical environments and staff should be defined as 'higher-risk'; and to ensure that the anonymous information about reasons for declining the vaccine is managed with full regard for the dignity of the individuals concerned. Medical and nurse director colleagues will need to undertake an appropriate risk assessment and discuss with their staff and trade union representatives how best to respond to situations where clinical staff in designated high risk areas decline vaccination.

It is important that we can track trusts' overall progress towards the 100% ambition. Each trust shall continue to report uptake monthly during the vaccination season via 'ImmForm'. However from this year you are also required to report how many healthcare workers with direct patient contact have been offered the vaccine and opted-out. This information will be published monthly by Public Health England on its website.

By February 2019 we expect each trust to use its public board papers to locally report their performance on overall vaccination uptake rates and numbers of staff declining the vaccinations, to include details of rates within each of the areas you designate as 'higher-risk'. This report should also give details of the actions that you have undertaken to deliver the 100% ambition for coverage this winter. We shall collate this information nationally by

asking trusts to give a breakdown of the number of staff opting out against each of the reasons listed in appendix 2.

You can find advice, guidance and campaign materials to support you to run a successful local flu campaign on the NHS Employers Flu Fighter website www.nhsemployers/flufighter

Finally we are pleased to confirm that NHS England is once again offering the vaccine to social care workers free of charge this year. Independent providers such as GPs, dental and optometry practices, and community pharmacists, should also offer vaccination to staff. There are two parallel letters to primary care and social care outlining these proposals in more detail.

Yours sincerely

- signed jointly by the following national clinical and staff side professional leaders -

Prof Stephen Powis .....National Medical Director, NHS England and on behalf of National Escalation Pressures Panel

Prof Paul Cosford .. Medical Director & Director of Health Protection, Public Health England

Prof Jane Cummings ..... Chief Nursing Officer, NHS England

Sara Gorton (Unison)..... Co-chair, National Social Partnership Forum

Prof Dame Sue Hill..... Chief Scientific Officer, NHS England

Dame Donna Kinnair. Acting Chief Executive & General Secretary, Royal College of Nursing

Prof Carrie MacEwen ..... Chair of the Academy of Medical Royal Colleges

Ruth May..... Executive Director of Nursing, NHS Improvement

Dr Kathy Mclean..... Executive Medical Director NHS Improvement

Danny Mortimer (NHS Employers)..... Co-chair, National Social Partnership Forum

Pauline Philip .....National Director of Urgent and Emergency Care

Suzanne Rastrick ..... Chief Allied Health Professions Officer, NHS England

Keith Ridge ..... Chief Pharmaceutical Officer, NHS England

John Stevens .....Chairman, Academy for Healthcare Science

Gill Walton..... Chief Executive, Royal College of Midwives

Appendix 1 - Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2018

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers (1).	
A3	Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt (2,6)	
A4	Agree on a board champion for flu campaign (3,6)	
A5	Agree how data on uptake and opt-out will be collected and reported	
A6	All board members receive flu vaccination and publicise this (4,6)	
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives (3,6)	
A8	Flu team to meet regularly from August 2018 (4)	
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions (3,6)	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper (4)	
B3	Board and senior managers having their vaccinations to be publicised (4)	
B4	Flu vaccination programme and access to vaccination on induction programmes (4)	
B5	Programme to be publicised on screensavers, posters and social media (3, 5,6)	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups (3,6)	
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered (3,6)	
C2	Schedule for easy access drop in clinics agreed (3)	
C3	Schedule for 24 hour mobile vaccinations to be agreed (3,6)	
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this (3,6)	
D2	Success to be celebrated weekly (3,6)	

Reference links

1. http://www.nhsemployers.org/-/media/Employers/Documents/Flu/Vaccine-ordering-for-2018-19-influenza-season-06022018.pdf?la=en&hash=74BF83187805F71E9439332132C021EFA3E6F24C
2. http://www.nhsemployers.org/-/media/Employers/Publications/Flu-Fighter/Reviewing-your-campaign-a-flu-fighter-guide.pdf
3. http://www.nhsemployers.org/-/media/Employers/Documents/Flu/Flu-fighter-infographic-final-web-3-Nov.pdf
4. http://www.nhsemployers.org/-/media/Employers/Publications/Flu-Fighter/good-practice-acute-trusts-TH-formatted-10-June.pdf
5. http://www.nhsemployers.org/-/media/Employers/Publications/Flu-Fighter/good-practice-ambulance-trusts-TH-formatted-10-June.pdf
6. https://www.nice.org.uk/guidance/ng103/chapter/Recommendations

Appendix 2 – Example opt out forms for local adaptation and use

Form to be potentially co-branded by NHS organisation and key trade unions

Dear colleague,

Did you know that 7 out of 10 front line NHS staff had the flu vaccine last year, and in some departments more than 9 out of 10 staff were vaccinated?

The flu jab gives our body the information it needs to fight the flu, which stops us from contracting and spreading the virus. For those of us who work in care settings, getting the flu jab is an essential part of our work. In vaccinating ourselves we are protecting the people we care for, and helping to ensure that we are able to provide the safest environment and effective care for patients.

We want everyone to have the jab. The sooner you get it, the more people you can protect. We hope that you will agree to having the vaccine – this really helps to protect patients, you and your family. But, if you choose not to have the flu vaccine, we want to understand your reasons for that by filling in this anonymous form.

Signed

Chief Executive, Medical Director, Director of Nursing, and Trade Union representative

Please tick to confirm that you have chosen not to have the vaccine this year:

☐ I know that I could get flu and have only mild symptoms or none at all; and that because of this I could give flu to a patient. I know that vaccination is likely to reduce the chances of me getting flu and of me passing it to my patients. But I still don't want the vaccine.

Please tick each of the boxes below that apply to your decision not to have the jab.

I DON'T WANT TO BE FLU VACCINATED BECAUSE:

☐ I don't like needles

☐ I don't think I'll get flu

☐ I don't believe the evidence that being vaccinated is beneficial

☐ I'm concerned about possible side effects

☐ I don't know how or where to get vaccinated

☐ It was too inconvenient to get to a place where I could get the vaccination

☐ The times when the vaccination is available are not convenient

☐ Other reason – please tell us here ▸

_____

Thank you for completing this form.

Infection Control Annual Report

Meeting information:			
Date of Meeting:	2nd October 2018	Agenda Item:	16
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth

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

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

Summary:

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

- The number of MRSA bacteraemia cases reported was 4, one clinical infection that was assessed as not preventable. Three further samples were assessed as contaminated samples and not actual infections.
- The number of cases of *Clostridium difficile* infections (CDI) reduced to 37 compared with 46 the previous year. The trust was below the limit of 40 set by Public Health England.
- There was discrepancy in the number of infections reported under the Public Health England (PHE) mandatory surveillance scheme, this was largely due to clerical error and has been discussed with PHE/NHS improvement and rectified. The data presented in this report is the amended data.
- There is now a requirement to reduce Gram Negative Bacteraemias by 50% by 2021, this date is included in the report for the first year.
- A significant increase in orthopaedic surgical site infections was reported as a serious incident.
- Almost four times more Influenza was diagnosed this year compared to previous years. This reflected the national prevalence. One complex patient had influenza identified on their death certificate, which was investigated as a serious incident.
- Clinical staff showed their support of world hand hygiene day and there was good compliance with IPC mandatory training and hand hygiene in clinical practice.

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

Trust Infection Prevention and Control Group on 19th September
Quality and Safety Committee on 19th September.

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

The Board is asked to review and note the Infection Control Annual Report and receive assurance on compliance with Infection Control legislation.

ESHT – Safeguarding Annual Report – 2017/18

Meeting information:			
Date of Meeting:	2 October 2018	Agenda Item:	16
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth

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

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

Summary:

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

The 2017– 2018 Annual Safeguarding Report (attached) provides the East Sussex Healthcare NHS Trust (ESHT) Board with an overview of; the safeguarding work undertaken during the year, the planned work to further improve safeguarding practice in 2018 – 2019 and an assurance position on the Trust's compliance with the legislative and regulatory framework. This includes;

- Working Together to Safeguard Children (2013, 2015, 2018)
- Children Act (1984, 2004) ESHT must be able to demonstrate that it safeguards children who access our care under section 11.
- Safeguarding Vulnerable Adults in line with the Care Act 2014 and Department of Health Care and Support Statutory Guidance issues under the Care Act 2014.
- The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment 2007.
- The Modern Slavery Act 2015

During 2017-2018 ESHT has given safeguarding a higher profile and requested greater assurance that the organisation is meeting its statutory and legislative duties. The Director of Nursing leads the strategic direction with strong senior leadership from the Deputy Director of Nursing. The improved governance and reporting has provided a platform to promote divisional ownership and drive improvements. The CQC reported arrangements are robust and the Trust is supported by an expert team to deliver its functions.

The commitment to continuing to improve front line staff practice and knowledge to enable ESHT to better safeguard the people using its services remains strong, and we are looking forward to a challenging year ahead. Throughout 2017–2018 ESHT has been changing practice as a result of safeguarding learning, including;

• Maternity services continued to improve their practice and documentation in relation to pregnant women and domestic abuse (Domestic Homicide Review)

• Developed a programme to support staff working with patients who self-neglect (Safeguarding Adult Review)

• Safeguarding learning will inform the work underway regarding discharge planning (Safeguarding Adult Review)

• Level 3 safeguarding training (implemented from 1st April 2018) will include domestic violence training to improve staff knowledge and help staff to support our patients (Domestic Homicide Review)

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

Quality & Safety Committee – 19 September 2018
Safeguarding Operational Group 22nd October 2018
Safeguarding Strategic Group 26th November 2018

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

The Board is asked to review and note the Safeguarding Annual Report and receive assurance on compliance with Safeguarding legislation.

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE & ORGANISATIONAL DEVELOPMENT (POD) COMMITTEE

Minutes of the People & Organisational Development (POD) Committee meeting held on Wednesday 11th July 2018 15:00 – 17:00 John Cook Room, Post Grad Centre, EDGH

Present:
Mrs Miranda Kavanagh, Non-Executive Director (MK) – Chair
Dr David Walker, Medical Director (DW)
Mrs Dawn Urquhart, Assistant Director HR, Education (DU)
Mrs Jackie Churchward-Cardiff, Non-Executive Director (JCC)
Mrs Jan Humber, Staff Side Chair (JH)
Mrs Lorraine Mason, Assistant Director of HR - OD (LM)
Mrs Lynette Wells, Director of Corporate Affairs (LW)
Mrs Moira Tenney, Deputy Director of HR (MT)
Ms Monica Green, Director of HR (MG)
Mrs Sharon Gardner-Blatch, Deputy Director of Nursing (SGB)

In Attendance:
Ms Ruth Agg, Speak Up Guardian (RA)
Ms Anne Canby, Associate Director of AHP's (AC)
Ms Penny Wright, Head of Workforce Planning, Information & Resourcing (PW)
Mrs Jacqui Ayres, PA to Deputy Director of HR (JA)

No	Item	Action
1.	**Welcome, Introductions and apologies for absence** The Chair welcomed all to the meeting and noted a quorum was present. Apologies for absence were received from: Dr Adrian Bull, Chief Executive (AB) Mr Jamal Zaidi, Associate Medical Director – Workforce (JZ) Mrs Joe Chadwick-Bell, Chief Operating Officer (JCB) Mr Jonathan Reid, Finance Director (JR) Mrs Michele Elphick, General Manager – DAS Division (ME) Mrs Kim Novis, Equality & Human Rights Lead (KN) Mrs Lesley Houston, Deputy GM-Medicine (LH) Mr Salim Shubber, Director of Medical Education (SS)	
2. 2.1	**Minutes and Matters Arising** <u>Minutes of the previous meeting held on 9th May 2018</u> The minutes were reviewed and agreed as an accurate reflection of the meeting, with the following amendments:- In Attendance: Amendment of title for Dr Nadia Muhi-Iddin, Guardian of Safe Working Hours 2.1 The post note to be detailed in full on the minutes:	

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 Nursing Workforce Report – minutes to include the detail of the agenda items: Agenda Items 11 (Establishment Review) and Item 13, (Nursing Report) for information.

4.0 Health & Well-being Report – minutes to include the actions that are being taken to address impacts and measures are 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.

2.2 Review of Action Tracker:
The outstanding items on the Action Tracker were reviewed:

Medical Engagement
A separate Medical Engagement Update is provided later on the Agenda (Item 3.2 – Medical Engagement Update).
Action : Closed

Training Needs Analysis
DU advised that the TNA being undertaken had commenced in many areas, with baseline information received from 40 areas across the Trust. Medicine is the next area to be undertaken, and a meeting has been arranged with Sue Allen. Fifteen Learning Ambassadors have been trained across both sites, so that this process can be carried out in-house going forward.
Action : Full written response and formal report to be provided on completion of analysis. **DU**

Retention of AHPs
Anne Canby (AC) was in attendance at the meeting on behalf of Abi Turner and Katy Lyne. Feedback to be provided under item 4.1 of the Agenda, Retention of AHPs.
Action : Closed

Physician Assistant Roles
DU advised that she had met with Sandra Field and is currently writing a business case to come from her Division. DU has discussed the PA roles with SS, and thought is now being given to these posts being partially or wholly funded, with consideration to offering as a Fellowship for one year. This will be written up formally for SIFT funding, as this would increase the number of posts the Trust is able to offer, particularly in those divisions with less money and cannot afford to have these roles.

The PA role is highly regarded in other Trusts, and increasing these would add value to the services in which they are placed, as it has already in the areas hosting at ESHT. It was agreed that the Trust needs to be innovative, and should understand how other Trusts successfully integrate these posts, to support the strategic plan going forward.

JCC questioned if there is a case for centrally funding new role posts and placing them where they were needed, and that this could be a Trust initiative as opposed to divisional, and it was agreed this should be taken to Execs.

	SGB stated that the same position should be considered for Nurse Associate Roles, as they were currently impacted in the same way. **Action: MG to discuss this with the Execs as an initiative and for decision.**	**MG**
	Multi-Disciplinary Safety Huddles SGB confirmed that following discussion with VC, it had been communicated to Doctors that they were not only welcome, but encouraged to attend the multi-disciplinary safety huddles. **Action : Closed**	
	Apprenticeship Update The Apprenticeship paper was provided, and will be discussed at item 4.2 on the Agenda, Apprenticeship Update. **Action : Closed**	
2.3	Annual Review – Terms of Reference The Terms of Reference were reviewed, and it was agreed that the membership should include an AHP representative, as well as a SAS Dr representative (in addition to a Junior Doctor rep). **Action : To be added to the Terms of Reference** **DW to secure SAS representative**	**JA** **DW**
	LW raised that the ToR should include an annual review and report to be written and presented to the Board on the effectiveness of the committee. **Action : To be added to the Terms of Reference**	**JA**
3	**Well Led**	
3.1	CQC Well Led Domain Assessment LW and LM gave a verbal overview of the submitted report. The CQC rated all our services Good or Outstanding in the Well-Led Domain following the report in March 2018, with an overall rating for the Trust of Good. The Trusts intention is to have a co-ordinated approach to achieving outstanding by 2020, with work being undertaken around: • Succession planning, retention of talent and culture • Embedding excellence in care • Specific action plans for all areas • Introduction of the CQC Assurance tool which will enable monitoring of changes and improvements, amalgamating scores to highlight areas of weakness • Mock inspections to continue together with spot checks • Key questions to be built into the Quality Walks undertaken by Exec Directors. LW stated that the work that needs to be undertaken to achieve Outstanding should not be underestimated, and that the Trust will need to demonstrate innovation and succession planning. A 6-monthly update will be provided to POD, and an updated paper will be provided following receipt of the Deloitte review report. **Action : Six monthly update report to be provided, together with an updated report following receipt of the Deloitte review**	**LM/LW**

	JCC asked that further consideration be given to "Leadership" as this does not solely refer to management but to all areas including clinical leadership. JH raised an issue of low staff morale in the trust, particularly within Outpatients CQ. **Action : SGB to discuss with JH outside of this meeting and take forward.**	**SBG**
	JCC raised feedback she had received from B7 staff regarding the lack of authority they feel they have to manage orders or authorise expenditure. It was understood that this was part of grip and control and financial management, however there must be a balance. LM advised the committee that a piece of work was also being done on responsibility and accountabilities, and that this would be part of a clear message moving forward.	
3.2	<u>Medical Engagement update</u> DW gave a verbal overview of the submitted report. Following issues in Ophthalmology and Gynaecology, DW reported Ophthalmology being much more engaged and working together however the volume of work particularly in areas such as AMD continues to be an issue due to long term treatment. Concerns remain with Gynaecology, with the lead being undermined and timetabling issues following a move to hot weeks. A meeting with AB has been arranged to review this. Schwartz rounds remain very popular, and currently considering holding the CEO Junior Doctors Forum and the Junior Doctors Forum on the same days to improve attendance. Improved CQC report has led to more doctors applying for posts at the Trust. Work is underway with the BMA on the SAS Drs Charter and Autonomous working, and the BMA have asked to be involved in the divisional Drs meetings. MT and JZ are currently working on a project to further improve SAS Dr engagement. 2018 Junior Doctors Survey results have just been received, which show a reduction in red flags. A full review of the results now being undertaken. **Action : Full update on survey results to include the correlation to medical engagement and CQC to be provided at September meeting.**	**DW**
4.	**Recruitment and Retention**	
4.1	<u>Retention of AHPs</u> The Chair welcomed AC to the meeting, after only one week in her current post. • AC advised that she had reviewed reports on AHP staff provided by PW, and responded to concerns that the turnover rate in AHP's was increasing. This figure has now reduced back to 10% (from 10 then 12%). • A review of exit interviews will be undertaken on highest turnover areas. • Working with LM and PW on "stay" interviews as opposed to "exit" interviews. • A review of AHPs who leave to gain experience and then come back will be taken to see if this is few in number, or the "norm" • A citizen's board to be set up with a shared purpose.	

	• A more detailed report to be provided to the next meeting, and it was agreed by the committee that AHPs that sit outside of the Out of Hospitals Division be included. **Action : AC to provide a detailed report to the September meeting.**	**AC**
4.2	Apprenticeship update DU gave a verbal overview of the submitted report. DU confirmed an improved position on last year to date. Weekly team huddles taking place to give a better overview on the current position, and working closely with divisions, although progress remains slow to get more apprenticeships on board. A degree of rigidity remains on how we can spend the Apprenticeship Levy. In April a report was sent to the Health Secretary, and the outcome of a request on the relaxation of the rules is awaited. No decision has been made to date in relation to a suggested 10% Apprenticeship Levy Transfer to the STP to support the wider health economy partners who are not able to access the levy. 10% is considered quite substantial, and therefore a suggestion has been made to transfer between 1% and 2% to be managed through the STP regional forum. JCC highlighted that there isn't anything on our website in relation to Apprenticeships in the "Working for Us" section, which could reduce the Trusts attraction of some potential candidates. **Action : DU to review and look at this through the National agenda, and ensure a more visible presence on both the Website and Social Media.** MK thanked DU for the very comprehensive report.	**DU**
5.	**Workforce Planning**	
5.1	Integrated Workforce Planning Update and Workforce return to NHSI PW was in attendance to provide a verbal overview of the submitted report. Key headlines discussed were: • Successful integration of workforce planning within the ongoing Business Planning process as part of the Business planning deliverables. • 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. JCC asked how divisional issues, gaps and cost pressures were being picked up and translated to the workforce strategy. PW advised that this is picked up through a variety of established meetings i.e. Sustainable Services Group and IPR's. The focus has been the development of robust workforce analytics to understand today and undertake gap analysis with each of the divisions to ward level to build their plans. Associated cost pressures are being highlighted and reviewed through working with other support services to cover	

	Activity/Demand, Finance, Financial CIP Improvement and Business Planning. In addition, MT advised that a new Strategic Workforce Resourcing Group had been set up looking at individual staff groups, and what is required to build the workforce plan, with feedback from professional leads. Challenging conversations have to take place to look at using the fte in an alternative way. LM stated that during a recent NHSi visit regarding Nurse Retention Project, they had commented that they were using the work undertaken by PW as best practice and could see the benefits of that work. **Action : A more in-depth report on workforce/business planning will be provided to the September meeting**	**PW**
6.	**WRES** In KN's absence, LW gave a verbal overview of the submitted report. LW explained that 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 suggest that:- 1. Jnr Drs and career grade doctors have a higher number of staff not declaring ethnicity. This is under review to identify whether this is administrative issue or a reluctance amongst these groups to declare. 2. Just under 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. The results do not highlight any significant changes, however this has been considered in the development of the BME Networks action plan. JCC acknowledged that the result this year shows an improving picture. LW agreed, and confirmed there was still more work to do in supporting BME staff. RA stated that violence and aggression could be being picked up more due to Datix reporting. Training is being provided in having difficult conversations and in leadership courses. MK noted there was an increase in discrimination from team leader/manager – this is currently being reviewed by AB/MG/RA. It was agreed that this could be due to an increase in reporting, and RA stated that staff are still nervous to report, and highlighted that the Trust must also support the person being accused. MT referred to KF21 – "Percentage believing that the trust provides equal opportunities for career progression or promotion" showed a slight improvement for BME staff linked to discrimination, and there may be more work to be done in this area, looking at trends in data and undertaking positive deep dives.	
7. 7.1	**Items for information:** <u>Nursing Report</u> JCC raised the current bed changes/consultations, and some negative feedback	

	expressed by some staff regarding the loss of beds and a subsequent reduction in morale. MG advised that we must of course, be alert to any feedback, and ensure all staff are having 121's and where necessary working in a different way. JH advised that staff morale was extremely low, particularly in relation to ward closures and re-openings, and asked that staff side be involved earlier in consultation processes, and allow teams to be involved in redesign to ensure consultations progress smoothly. Management should also be in a position to discuss/respond to staff on changes. MT advised that the Escalation Policy meant that wards were re-opened following a surge in demand, and had been left fully equipped. SGB stated that senior nurses and matrons that were also impacted by the bed changes worked extremely hard to keep up staff morale. Lessons have been learned, but we must have balanced feedback and there had been excellent nurse leadership over this period. MK stated that any comments were not a criticism, but needed to be addressed with the correct people present. It was agreed by the Chair that a separate conversation would take place outside of this meeting.	
7.2	<u>Workforce Report</u> MK stated that the Appraisal rate had dropped. MG advised that this had been picked up at IPRs, and subsequent to that, a review of appraisal rates over a 16 month period (rather than 12) showed that appraisal rate was in excess of 90%. This would indicate that appraisals are taking place, but falling outside the 12 month period. DU advised that she and Julie Allen (L&D) are monitoring the appraisal process, and further exploring e-appraisals.	
7.3	<u>Feedback from sub-groups:</u> Engagement & OD Group Item noted. Education Steering Group Item noted. Workforce Resourcing Group Item noted. HR Quality & Standards Group Item noted.	
8.	**Any other business** JCC queried the date of the next meeting, which was confirmed as 5th September.	
9.	**Dates of 2018 meetings** **Wednesday 5th September 2018 - 09:00 – 11:00** **Bob Webster Room, EDGH with vc to Room 1, Education Centre Conquest** **Wednesday 7th November 2018 - 15:00 – 17:00** **John Cook Room, Post Grad, EDGH**	

Use of Trust Seal

Meeting information:			
Date of Meeting:	2nd October 2018	Agenda Item:	18
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.

2nd July 2018 – agreement between Brighton & Sussex University Hospital NHS Trust and East Sussex Healthcare NHS Trust for the lease of ground floor and part of basement at EDGH.

2nd July 2018 – agreement between Brighton & Sussex University Hospital NHS Trust and East Sussex Healthcare NHS Trust for lease of land comprising linear accelerator bunkers at EDGH.

2nd July 2018 – agreement between Aramark and East Sussex Healthcare NHS Trust for ten year rental of lower ground floor café and ground floor café at EDGH.

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.

Winter Planning 2018-19

East Sussex Local A&E Delivery Board

V1.41

23 August 2018

Contents

Executive Summary

The purpose of this document is to set out the East Sussex local A&E delivery board's plan to ensure that the system is able to manage effectively the capacity and demand pressures anticipated during the Winter period. The plan should also ensure that the local system remains resilient and is able to manage demand surge effectively, maintain patient safety and support delivery of the system urgent care improvement plan during the this period.

The East Sussex Local Health Economy (LHE) has developed a winter plan, which is supported by the East Sussex Systems Surge and Capacity Plan. Both plans provide an input from all of the partners in the East Sussex Health and Social Care economy. The Surge and Capacity Plan describes the way in which East Sussex Health and Social Care Economy will respond to the additional demands of Easter and peak pressures throughout the year. A copy of the plan can be found in Appendix 1 of this document.

The objectives of the plan are as follows:

- To maintain patient safety at all time;
- To achieve an acute bed occupancy of no more than 85% by Monday 24th December and to maintain bed occupancy below 95% throughout Winter;
- To ensure that all community bed and service capacity is fully utilised;
- To avoid ambulance delays of over 30 minutes;
- To deliver the 90% 4 hour standard and as a minimum deliver the agreed system performance trajectory of 95% by March;
- To ensure the system delivers and sustains the national reducing long length of stay (super stranded) ambition;
- To ensure system DTOCs are no greater than 3.50%.

Key Reference Documents

- Five Year Forward View
- Refreshing NHS Plans for 2018/19
- Pauline Philip Letter dated 13 June 2018 - Reducing Long Length of Stays in Hospital
- ESBT Winter Full Debrief and Lesson Learnt AEDB Report
- NHSE/I Regional Winter 2018/19 Debrief
- NHSE/I Regional Flu Management Debrief
- NHSI good practice guide: Focus on Improving Patient Flow
- NHSI Managing increased demand from winter illness – June 2018
- Excess Bed Day Incentive Scheme Letter dated 3rd August 2018

Winter 2017/18 Lessons Learnt: System Performance & Reporting

Theme	Things that went well	Areas/opportunities for Improvement	Actions
System Performance & Reporting	• Q4 2017/18 4 Hour Standard Performance ESHT only (Type 1) 86.3% ranked 39/137 nationally (England average 85%) • Q4 2017/18 4 Hour Standard Performance ESHT system (all types) 90.1% ranked 26/137 (England average) • Delayed Transfers of Care remained under 2% during the period: 1.3% for Jan-18 and 1.7% for Feb-18, Mar-18 to be confirmed • 15% CHC Assessment in Hospital standard was achieved during Q4 2017/18 • Use of SHREWD has become embedded across the ESHT system • NEL Length of stay reduced by over 1 day year on year (Jan 5.2 Days, Feb 4.9 Days and Mar 4.9 days).(JCB to provide split between <24 Hours and >24 hours) • Occupied Acute Bed Days were 2.46% lower than in Q4 2016/17 • Community Length of Stay improved by year on year • ESHT System only declared OPEL 4 escalation on 13 days during Winter 2 days in January, 2 Days in February and 9 Days in March. • Cold Weather Plans were effective during adverse weather period but performance was affected.	• A&E activity in the quarter was 9.6% higher than in Q4 2016/17 • Ambulance Conveyances were 4.2% higher than in Q4 2016/17 • Non-Elective admissions were 23.2% higher than in Q4 2016/17 • Flu admissions to ESHT during the quarter were up by 248% on the same period in 2016/17 – significant operational and flow impact. • Adverse Winter Weather had a material impact on system performance during early March. • STP wide consistency in use of SHREWD including escalation triggers. • Proportionate STP wide escalation and response.	• System demand driver diagnostic to be undertaken. • Seasonal Influenza Debrief and 2018/19 seasonal planning taking place on the 8th May. • Further development of SHREWD and review if BRAG ratings. • Development of STP SHREWD dashboard

Winter 2017/18 Lessons Learnt: Primary Care

Theme	Things that went well	Areas/opportunities for Improvement	Actions
Primary Care	• Walk in Centres performance was maintained over the Winter period; • IC24 Weekend Proactive Care Home Visits in place since March 2018.	• Use of Clinical Navigators at practice level needs to be encouraged – vision that everyone who answers a phone at practice is a licensed navigator – need to link in with locality planning groups; • Overall Primary Care element of the system winter plan was light, provision of Extended Hours capacity was late in being commissioned due to late notification of funding and was localised to a small number of individual practices; • Need to improve engagement of the locality planning groups and the GP federations in planning for Winter; • Perception that some patients were not seen in a timely fashion by primary care leading to patients deteriorating and then presenting to A&E; • Comprehensive proactive ward rounds at Care and Nursing Homes needed.	• Out of hours pharmacy provision needs to be aligned to plans for extended primary care access; • Directory of service needs to be reviewed; • Need to understand drivers of demand to inform the design of solutions and plans for next winter; • Extended Primary Care Access 30 mins per 1,000 head of population (>40,000 appointment slots per annum) by 31st October 2018; • Need to evaluate impact of IC24 weekend proactive care home visits.

Winter 2017/18 Lessons Learnt: Acute Services

Theme	Things that went well	Areas/opportunities for Improvement	Actions
ESHT Acute Services	• Plan included a focus on reducing NEL average LOS from 5.5 days to 5.0 days, which has largely been achieved and this represents over a 1 day reduction year on year; • ESHT held its nerve and did not open up escalation bed capacity until 27th December; • MADE events run prior to Christmas and was adapted into Enhanced Discharge Control process, which has become business as usual; • 72% of ESHT staff vaccinated against Flu – significant improvement on 2016/17; • In agreement with NHSI full elective programme was undertaken during Winter. <10 cancellations due to no bed, some ITU cases cancelled including 1 cancer case, which was rescheduled within 48 hours. All decisions to cancel patients had to be escalated to the ESHT COO.	• Further speciality level targeted work in 2018/19 to reduce LOS further; • SAFER implemented but not fully embedded; • EDGH Ambulatory Care and Medical Assessment Unit opened just before Christmas – daily throughput has doubled, but not yet fully covered and not running 14 hours x 7 days a week; • Primary Care Streaming opened 31st October but was not fully covered and not yet 12 hours a day x 7 days a week on both sites. Conquest now fully covered. Gaps still at EDGH. • Operational systems and processes to manage medically fit patients remains fragmented with multiple manual processes and poor information flows. • Number of Flu admissions during Winter were unprecedented – 404 during Dec 17 to Mar 18 compared to 116 last year – 248% increase	• 2018/19 improvement plan includes actions to fully embed SAFER by Autumn 2018; • 2018/19 plan to establish full cover in Ambulatory Care and Medical Assessment Unit at EDGH and embed; • New Ambulatory Care unit at Conquest to be open by October 2018; • Plan in 2018/19 to establish full cover for Primary Care Streaming (subject to funding stream confirmation from May 2018); • Need to consider what the system does differently in escalation to support Enhanced Discharge Control; • ESHT to procure a bed management system by October 2018 (potential for whole system implementation). • OPEX to undertake a review of the operational systems and processes for system wide tracking and management of medically fit/ready for discharge patients. • Regional Seasonal Influenza Debrief and 2018/19 planning event on 8th May. • ESHT planning to have Flu testing machines in ED departments next Winter.

Winter 2017/18 Lessons Learnt: Community Services

Theme	Things that went well	Areas/opportunities for Improvement	Actions
Community Services	• Improved LOS in community/IMC beds and improved bed occupancy during Winter; • Discharge to assess pathway 1 implemented; • HIT referrals into D2A pathways increased; • Non-weight bearing pathway clinically managed by ESHT from mid Jan-18 – benefits through reduced LOS expected; • Good crisis response capacity was maintained throughout the majority of the Winter period; • Introduction of new Intermediate Care Co-ordinators had a positive impact in effectively managing patient flow and supporting discharge; • Pilot to commission 5 beds at St Wilfrid's Hospice was very successful and led to a reduction in CHC related acute delays for EoL patients.	• Opportunity to develop and adapt D2A pathways using interim bed capacity. • Limited demand from wards in terms of D2A pathways; • Opportunity to increase utilisation of crisis response capacity. • Non-weight bearing pathway - Opportunity as 6 to 8 patients were reported regularly on daily OPEX calls as awaiting NWB pathway beds. Ortho Trauma ESHT acute LOS is at significant adverse variance to national benchmarks; • Opportunity for next Winter to develop and establish SECAMB pathways involving HSCC and to pilot the use of SCFT Onecall over night to provide 24/7 access.	• Need to understand if improved LoS in the community/IMC beds and improved bed occupancy was due to better management of patients or a change in the mix of patients. Need to review admission criteria for 2018/19; • Review crisis response model and integrate front door admission avoidance teams. • Need to evaluate impact of clinical management of non-weight bearing pathway by ESHT; • ESHT to take over NWB contract from May 2018. • Decision required for 2018/19 on funding for commissioned St Wilfrid's beds. • Implement HSCC Ambulance pathways – Non-Injury Falls, UTIs, Blocked Catheters • Work with SCFT and HWLH CCG on OneCall overnight pilot to support ambulance pathways

Winter 2017/18 Lessons Learnt: Adult Social Services

Theme	Things that went well	Areas/opportunities for Improvement	Actions
Adult Social Care	• Successfully commissioned additional interim beds; • Block purchase of additional 4 week homecare over Xmas and New Year period was successful with improved utilisation compared to previous year; • Extra staff were provided to support both acute hospital sites; • Agreement for ASC to work to local 48 hour assessment standard was reached and was largely delivered over the Winter period; • Development work undertaken by ASC team has resulted in a number of nursing home suspensions being lifted and has improved the access to nursing home beds.	• Occupancy for additional interim beds was not as high as hoped; • Additional interim bed capacity possibly came on stream too early and should plan next year for capacity to become available as per ESHT escalation capacity post Xmas; • Trusted Assessor pilot was not successful due to a variety of issues and system model was not aligned; • Extra staff - Next year plan to support 7 day flow; • Care Home Plus scheme – Did not get implemented and no plans to take forward into 2018/19 due to improved nursing home capacity..	• Interim beds - Plans for 2018/19 to include a modified and more structured approach linked to D2A and Trusted Assessor model. Fewer homes involved and concentrations of additional beds with therapy and primary care support, including improved case management and co-ordination. Proposal being developed by ESHT Opex; • Trusted Assessor steering group to review lessons learnt and report to system Discharge Improvement Group and Opex • Opex to develop and agree system wide bed capacity plan for 2018/19 by May 2018.

Winter 2017/18 Lessons Learnt: Ambulance Service (SECAmb)

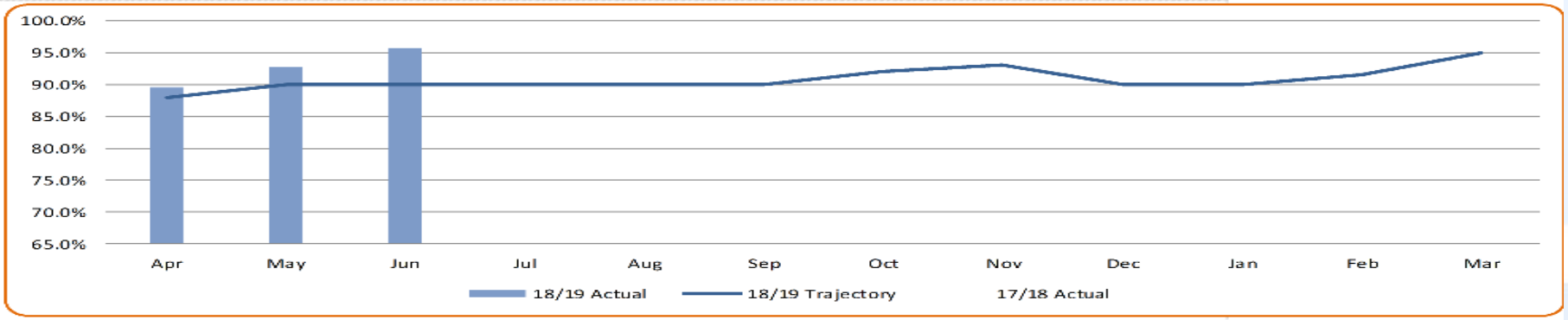
Theme	Things that went well	Areas/opportunities for Improvement	Actions
SECAmb	• Handover delays improving - downward trend and marked improvement over last 4 weeks; • Fit to Sit approach improving; • Improved collection of PIN numbers by A&E staff; • ESHT piloting use of Rapid Assessment has proven the concept; • Double handover issue resolved; • 111 response to patients who were able to get through was very good.	• Handover delays improving but remained a challenge at Eastbourne DGH; • Further work needed across the wider system on changing the culture towards Fit to Sit and to develop a standardised system plan; • Opportunity to develop SECAMB direct to ambulatory care and assessment streams; • Exceptional and unpredicted activity spikes presented significant challenge to SECAMB and to ESHT EDs; • SECMAB escalation communications with local systems needs to be improved; • 111 call abandonment performance during Winter was poor. • Call routing issues affected 111 performance • 111 call volumes were well above expected f'casts.	• Plans to roll out and fully implement rapid assessment model during 2018/19; • Demand & Capacity review being undertaken and planning for next Winter has already commenced. • ESBT CCGs to work with lead commissioner for 111 to ensure lessons learnt from 2017/18 are incorporated into plans for 2018/19 • Development of SECAMB SHREWD indicators to include SECAMB escalation level to improve communication of escalation and system response.

Winter 2017/18 Lessons Learnt: Mental Health, PTS and Communications

Theme	Things that went well	Areas/opportunities for Improvement	Actions
Mental Health	• Improved relationships and joint working between ESHT and SPFT; • 20% reduction in some patient cohorts who frequently attend A&E; • Use of new Urgent Care Lounge has had a positive impact. • Implemented changes required to respond to s136 changes.	• Some challenges at EDGH due to volumes of MH attendances – Room in A&E department will help support required improvements; • Periods of concentrated referrals from A&E presented an operational challenge for both SPFT and ESHT ED staff – Could this have been predicted. What are the contingencies and options for responding to this in future? • Opportunity to review the activity profiles at EDGH and to match staffing profile to better meet demand; • Opportunity for SECAMB to access rapid response service to avoid conveyance to A&E or place of safety.	• Need to understand why attendances at EDGH A&E are higher than at Conquest A&E – Additional services and town centre locations in Hastings may account for some of the differences; • SPFT reviewing the balance between management at presentation versus managing high acuity in the community; • Impact of s136 changes to be understood • SPFT to consider options on how to better manage demand spikes in ED.
Non-Urgent PTS	• Fantastic working relationship with SCAS.	• Governance concerns expressed by lead PTS commissioner about use of Wealden crew to provide extended PTS in the evenings and at weekends.	• Need to address service gap through lead commissioner and SCAS contract – data from Wealden to be shared with lead commissioner. ESBT CCGs to liaise with lead commissioner.
Communications	• Improvement on previous years • Text reminders to patients particularly in relation to repeat prescriptions were positive. • Joined up communications approach across STP was helpful in ensuring consistency in messaging and utilised coms resources more effectively	• National communications on access to GPs unhelpfully increased public expectation when service capacity was not fully aligned to meet this expectation.	• Reflect on the 2018/19 campaign and ensure lessons learnt are reflected in the 2018/19 campaign.

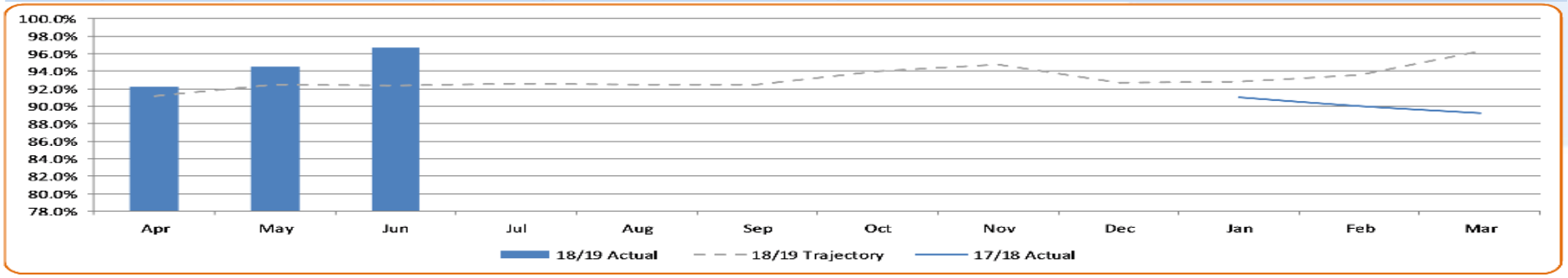
4 Hour Standard 2018/19 Performance Trajectory

A&E Monthly Performance (4Hr Wait)-Type 1 and Type 3



	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	89.5%	92.8%	95.7%									
17/18 Actual	80.1%	81.4%	88.0%	87.7%	92.5%	87.8%	92.1%	91.4%	86.7%	86.7%	86.8%	85.5%

Trust Footprint - Monthly 4 Hour Performance (ESHT A&E Types 1 & 3 and WiC Performance)

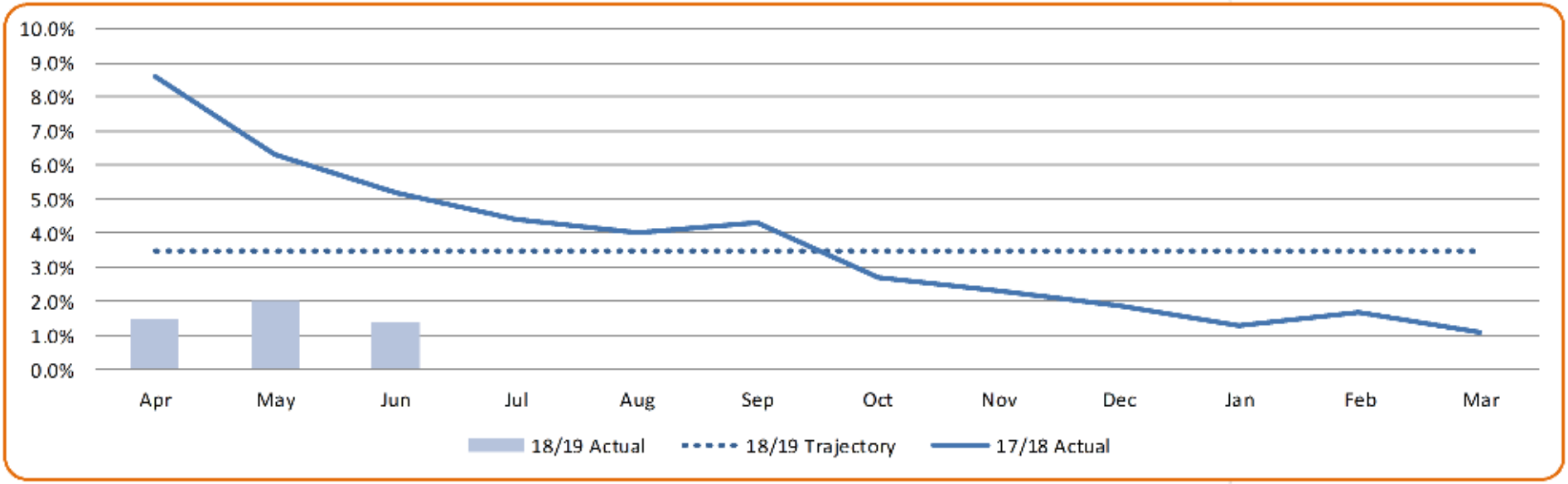


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	91.1%	92.5%	92.4%	92.6%	92.5%	92.5%	94.0%	94.7%	92.7%	92.8%	93.6%	96.3%
18/19 Actual	92.2%	94.5%	96.7%									
17/18 Actual										91.0%	90.0%	89.2%

East Sussex County Council

System DTOC Performance Trajectory

Delayed Transfers of Care



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
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%	1.9%	1.3%	1.7%	1.1%

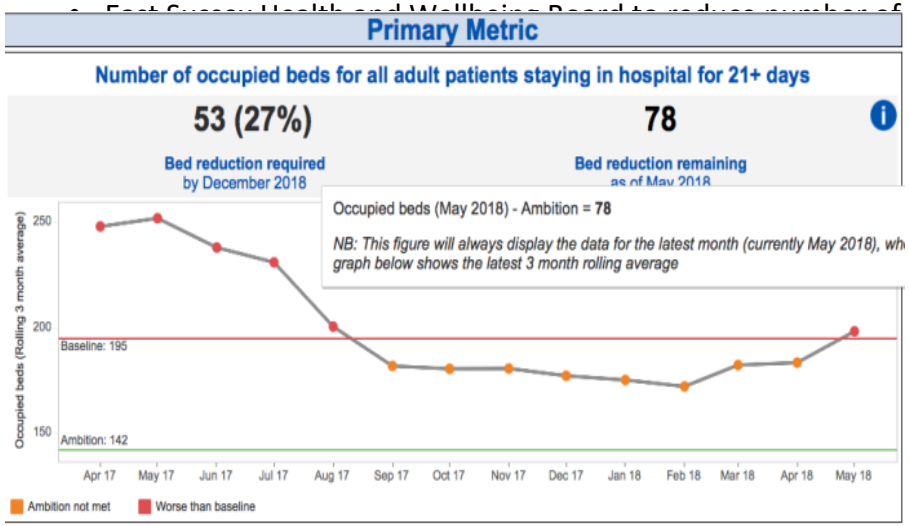
East Sussex County Council

National Long Length of Stay Ambition

Letter from Pauline Philip dated 13 June, sets out a national ambition to lower bed occupancy by **reducing** the number of long length of stay patients, know as **super stranded** (21 days LOS and over) (and long bed days) in acute hospitals by **25%** by **December 2018**.

The letter sets out a number of expectations that systems are required to have in place to support the delivery of the stated ambition along with the measurable improvements required as follows:

- East Sussex Healthcare Trust to reduce number of beds occupied by long stay patients from **195** to **142** as per national definition – 3 month rolling average of patients discharge in the month.
- Hastings and Rother CCG to reduce number of beds copied by long stay patients from **87** to **64**
- Eastbourne, Hailsham and Seaford CCG to reduce number of beds occupied by long stay patients from **112** to **82**
- High Weald Lewes Havens CCG to reduce number of beds copied by long stay patients from **50** to **40**
- East Sussex Health and Wellbeing Board to reduce number of beds copied by long stay patients from **262** to **192**



Month	Longest Spell Discharged	Super Stranded Discharged	Avg Super Stranded Days per discharged spell	Super Stranded Days	Avg Super Stranded Per Day	3 Month Rolling Avg
Apr 17	184	256	24.30	6222	207.40	250
May 17	272	319	26.69	8513	274.61	253
Jun 17	199	310	22.88	7094	236.47	239
Jul 17	147	252	22.67	5713	184.29	232
Aug 17	215	263	22.13	5819	187.71	203
Sep 17	170	264	20.35	5372	179.07	184
Oct 17	148	277	20.00	5540	178.71	182
Nov 17	168	267	21.05	5621	187.37	182
Dec 17	161	273	19.61	5354	172.71	180
Jan 18	213	276	19.54	5393	173.97	178
Feb 18	125	247	19.81	4893	174.75	174
Mar 18	134	319	19.29	6154	198.52	182
Apr 18	132	274	19.28	5284	176.13	183
May 18	158	271	25.01	6777	218.61	198
Jun 18	139	241	19.38	4670	155.67	183

System Super Stranded Ambition –Gap Analysis

Reducing Long Length of Stay Actions Required	Level of Compliance		
	Complaint	Partial Compliance	Non-Compliant
Whole system leadership and partnership working with a shared aim grounded in patient safety and avoiding harm			
Long-stay patient reviews and multi agency discharge events to ensure whole system partnership working in delivering the overall ambition			
Putting in place executive lead escalation arrangements working with senior leadership across health and social care systems to tackle blockages that can't be addressed locally or internally			
Delivering the existing delayed transfer of care reduction ambitions			
7 day working to reduce the variation between weekday and weekend non-elective discharge volumes from acute hospitals			
Treating lengths of stay above best practice guidelines as a safety issue which need urgently addressing			
Getting and using accurate daily information on all long stay patients in hospital, supported by real time use of Patient Administration Systems used for bed management and to give automatic capacity and occupancy information			
Work at the front door (and ideally before it), including ambulatory emergency care, therapy services and appropriate care pathways to avoid admissions for patients who do not require acute care in hospital and are at risk of deconditioning if they do. This will reduce the number of complex discharges			
Routinely screening within 2 hours of presentation all older people (aged 75 and over) for their prior degree of frailty using a validated tool, their prior level of functional need and their present cognitive status. This data and clinical judgment should be used to identify within 72 hours of admission and pro-actively plan for discharge home of vulnerable and end of life care patients			
Trusts implementing processes so that patients who require admission for more than 72 hours are not moved from their admitting ward until discharge from hospital except where this is deemed necessary on clinical grounds by a senior clinician (equivalent ST3 level doctor or above)			
Ensuring that simple and timely discharges are optimised, including through criteria led discharge			
Work in the hospital to address bottlenecks and expedite discharges, including by implementing Red2Green and SAFER patient flow bundle systematically across ALL wards			

Reducing Long Length of Stay Actions Required	Level of Compliance		
	Complaint	Partial Compliance	Non-Compliant
Supporting hospital therapy, medical and nursing teams to identify and address inappropriate risk adversity which may be delaying assessment for , or leading to the requesting of excessive packages of community care			
Work closely, supportively and continuously with community health and social care partners to expedite discharges from acute and community beds in order to ensure whole system flow			
Ensuring effective Board accountability, including publishing monthly board reports on number of stranded (7 days or more) and long stay (21 days or more) patients delayed in hospital and the coded reasons for these delays			
Delivering 100% access to extended GP services			
Preventing unnecessary hospital admissions - the default should be that all care home residents with 'urgent' and 'less urgent' needs at risk of admission to hospital, first have a clinical assessment, through a GP, paramedic or other health professional based 'Hear & Treat'/'See & Treat' model			
Ensuring that home and bed based intermediate care, crisis response and reablement should be available in all areas for step up care as an alternative to hospital admission as well as on discharge. These should be available to self funders as well as people needing council or NHS funded support			
Ensuring staff in hospitals have timely access to social care assessment staff and social care practitioners seven days a week, and that multi-disciplinary teams work together to make referrals and support discharge seven days a week			
Ensuring that all inpatients and their relatives, and in particular those who arrange and fund their own support, have access to information and advice in hospitals so that they can begin to make plans for discharge as soon as possible			
Offering a co-designed and mutually supported (by care providers) trusted assessment service for care homes, so that care home managers do not have to come into hospitals themselves and can rely on a trusted assessment in order to decide about potential admissions			
Home and bed based intermediate care, crisis response and reablement (for step up and step down care) should commence within 2 days of receiving the appropriate referrals. [NICE guidance (NG74) for bed based services extended to home based services to avoid a perverse incentive to refer patients to bed based services			
Care homes accept admissions (discharges from hospital) 7 days a week; for new residents until 5pm and returning residents up until 8pm			
Ensuring discharge to assess services are available in all areas, so that there is default expectation of home first, with increasing proportion of patients supported to return to their own home rather than going into long term care			

East Sussex County Council

System Super Stranded Ambition – Action Plan

Action plan in development to be completed by 31st August 2018

Excess Bed Day Incentive Scheme -=.

CCG	Excess Bed Day per 1,000 weighted population Jan to Dec 2017
EHS	45.2
HR	33.4
ES CCG	45.2
HWLH CCG	42.1
B&H CCG	38.8
HMS CCG	36.0
Crawley CCG	32.0
CWS CCG	32.7
National	**37.8**
Upper Quartile	**21.4**

- Significant Improvement in excess bed days performance Q4 2017/18 and Q1 2018/19
- £1m QIPP Plan for 2018/19 – Q1 performance circa £800 better than plan
- Currently benchmarking current performance against national upper quartile to ascertain further opportunity to improve further
- Range of already established improvement schemes expected to contribute to a reduction in excess bed days:
  - Further reductions in acute NEL LOS, including focus on 2 outlying specialties/pathways (Trauma and Stroke).
  - Further development of discharge to assess pathways
  - First 72 hour and out of hospital improvement workstreams.
  - Stranded Patient Operational Tracking App
  - Bed Management System development but not for Winter 2018/19
  - System commitment to maintain DTOC improvement of 2%
  - CHC in hospital assessment to be less than 10%.
- Review correlation and alignment to current system improvement initiatives and investments in community services.
- Gap analysis and action plan to be developed by 30 September 2018

NHSI: Managing increased demand from winter illness – June 2018

- Introduce acute frailty services in the emergency department (ED) and acute medical unit (AMU) for at least 10 hours a day, 7 days a week. – System Priority Workstream linked to System NHSI/E 12 week intense support/recovery programme – SRO - Joe Chadwick- Bell
- Maximise ambulatory/same day emergency care for at least 12 hours a day, 7 days a week – System Priority Workstream linked to System NHSI/E 12 week intense support/recovery programme – SRO - Joe Chadwick- Bell
- Ensure rapid microbiological confirmation of all suspected influenza/norovirus patients – Capital equipment required circa £20k, ? Bid submitted to NHSI – Pauline Butterworth
- Ensure Red to Green methodologies on all wards – SAFER not fully embedded, ongoing work with divisions, communication being launched in Aug and workshop with divisional leads in August to further embed. JCB and PB taking forward. ASC support required.
- Plan capacity on the basis of lived experience and data from recent winters. – In place as part of system capacity planning.
- Introduce an ED surge protocol to maximise available space, prioritise patient safety and make best use of staff – PB to review with Vikki and further embed with site team, HONs and wards
- Plan for increase in patients presenting with respiratory conditions – e.g. Hot Clinics. –Review of respiratory pathway, services and readiness for Winter. SRO Pauline Butterworth to lead as an extension to the ambulatory care model.

Primary Urgent Care Services

Target/Initiative	Period Covered	Risks if any	Mitigating Actions
100% Coverage of Primary Care Extended Access by October 2018 (95 hours per week H&R and 97.75 hours per week EHS)	October 2018	• Not able to award contract • Short mobilisation timescales • Primary care workforce availability	• Robust procurement and evaluation. • Interim provision • Project management
Additional Walk In Centre capacity at Hastings Walk in Centre over Christmas and New Year Week	December 2018	• Workforce availability • Funding implications	• Capacity and demand plan in place – see slide 9 • Contractual Agreement to utilise resources at less busy times (e.g. Xmas day)
IC24 Urgent Care Practitioner Care Home Rounds Saturday and Sunday 8am to 6pm Pilot targeting top 5 care homes calling GP OOHs (residential and nursing).	To be confirmed following outcome of current pilot (evaluation August 2018)	• Financial	• To fund from existing GP OOH contract funding.
Vulnerable Patient Scheme including Enhanced Care Home Service provision.	October 2018	• Lack of primary care engagement/consensus • Financial impact	• Stakeholder workshop and options appraisal taking place in June/July.
100% GP Out of Hours Rota Fill	December 2018 to March 2018	• Staff availability	• Proactive management of rota and commissioner oversight.

East Sussex County Council

System Flu Management Plan Winter 2018/19

Target/Initiative	Period Covered	Risks if any	Mitigating Actions
Adoption of Influenza near patient testing equipment within acute providers	Out of hours	• Financial • Training and competency of staff • Availability of equipment • Accuracy of testing	• Training programme for select staff group within urgent care department • Early purchase of equipment to ensure company is able to fulfil order
Commissioning of an in and out of season outbreak service to care homes and community settings	Annual	• Financial • Availability of provider service	• Lessons learnt from 2017/18 flu season • Early discussions with potential provider services
Increase in Vaccination uptake across East Sussex	Annual	• Low flu vaccination uptake may impact on number of influenza cases which will impact on health and social care system.	• Drive improvements in Vaccination programmes with all providers including adult social care settings • Improve communication regarding National Flu Campaigns and high risk groups locally and across STP • Work with Primary Care to ensure early flu vaccination clinics and provision of an active flu campaign
Development of influenza working group	August 2018 – May 2019		• Development of ESBT and STP Influenza Plan • STP wide Health promotion campaign on influenza vaccination promotion

Ambulance Service Winter Operational and Capacity and Demand Plan

Draft Plan attached as appendix 3

111 Winter Capacity and Demand Plan

Update Required

1. STP Commissioner Working Group established – What are the planning arrangements for 2018/19?.
2. xx Demand Increase over Christmas and New Year expected.
3. Promotion of use of NUMSAS.
4. Align GP out of hours capacity plan
5. Use of 111 Comfort Scripts.
6. Review of escalation process and triggers.
7. Communication Plan for 111
8. Updating of Directory of Services

Capacity and bed modelling and planning assumptions

- 17/18 activity levels
- Capacity model completed at the 85th percentile of variation in demand for summer, and 95th percentile for winter. Using percentiles provides assurance that demand will fall within available capacity for a greater proportion of the time and will only occasionally exceed. Separately analysing winter and accounting for 95% of the variation allows for the surges during this period, equivalent to an increased capacity requirement equivalent to 51 beds.
- Improvements in Trust NEL length of stay in line with improvement programme – Target average NEL length of stay of 4.40 days at EDGH and 4.20 days at Conquest Hospital
- Assumes growth in NEL admissions in M1 and M2 continues at the same rate for the remainder of the year (worst case model).
- Assumes further reductions in Intermediate Care Length of Stay based upon benchmarking across all IMC units equivalent to 17 beds. (actuals to be confirmed).
- Assumes no changes to core community bed capacity provision from that provided during Winter 2017/18.

Draft Winter Bed Capacity Plan 2018/19

2018/19 Winter Bed Capacity Required	**739**
ESHT Core Beds	-673
System Winter Capacity Gap	**66**
Acute Escalation Ward at EDGH	-28
Acute Escalation Ward at Conquest	-28
Community Beds - Irving Unit	-12
Community Beds - Rye	-5
Revised System Winter Capacity Gap/Surplus (-)	-7
NEL Admission Growth Risk	40
IMC Capacity Change Risk	24
Risk Adjusted Winter Capacity Gap/Surplus (-)	57
Risk Mitigation - Discharge to Assess Community Beds	-27
Risk Mitigation – Community IMC LOS Improvement	-28
System Capacity Plan Residual Gap	**2**

ESHT Acute Services

Target/Initiative	Dates	Risks if any	Mitigating Actions
Primary Care Streaming fully covered during– 12 hour per day across 7 days (Current cover 33% EDGH and 73% CONQUEST)	November 2018	• Staff availability • Financial • Poor utilisation	• Service review currently taking place.
Additional 56 Acute Winter Beds – 28 at EDGH and 28 at Conquest Hospital	Mid December to March 2019	• Financial • Staff availability	
Reconfiguration of acute bed base at EDGH and Conquest Hospital	October 2018	• Increasing demand	• System based work with opex to reduce admission/ attendances
Further development of EDGH Ambulatory and Acute Assessment Model extended to 7 days	TBC	• Workforce • System agreement for funding	
Establish Ambulatory Care Ward at Conquest	October 2018	• Potential delays to start of building work • Workforce • Funding	• Prioritised by E&F
Targeted reduction in Emergency LOS to 4.4 days at EDGH and 4.20 Days at Conquest Hospital (Including focus on three outlying specialities)	December 2018	• Insufficient Our of hospital capacity	
Detailed Acute Winter operational pan to be developed by October 2018.	October 2018		
MADE and Enhanced Discharge Events to held across Acute bed base through out Winter Period	December 2018 to March 2019		

Community Services

Target/Initiative	By when	Risks if any	Mitigating Actions
MADE event to be run across IMC beds week before Christmas	December 2018	• Ability to release staff to participate	• Forward planning beginning now
Target to reduce community IMC LOS to 21 days	December 2018	• Appropriate services for onward DC	• D2A pathway 4
12 escalation IMC beds at the Irvine Unit and 5 at Rye Hospital to remain open until Mid April	26th December to March 2018	• Workforce • Ability to close capacity by 31st March as no funding in April.	• Early block booking of temporary staff
Review of IMC Bed Admission Criteria and access times.	July 2018	• Restrictive Criteria in the EHS area leading to DTCs for complex patients • Weekend access arrangements	• Opex to review solutions
System focus on 5 key priority pathways (UTIs, Non-Injury Falls,Cellulitis, Flu/Pneumonia, Catheters) to reduce NEL demand	October 2018	• Capacity for IV therapy	• Debbie Lennard working with DNs to ensure capacity for delivery
Development of Discharge to Assess pathways including pathway 4 using additional system winter bed capacity to support model	December 2018 to March 2018	• Funding agreement	• System to agree funding to enable teams to work at capacity
Detailed ESHT community operational Winter plan	October 2018		

East Sussex Adult Social Care

Target/Initiative	By when	Risks if any	Mitigating Actions
ESx -0 DToCs attributable to assessment or funding	December 2018	• Staff availability • Referral Pathway	
ESx – 27 Discharge to Assess beds (ESBT only) reducing DToCs	December 2018	• Independent Sector Capacity	
Confirmation of additional ASC care managers to support 7 day assessment and discharge over the Winter period	December 2018	• Staff availability	
ESx – Flexing criteria for Joint Community Rehab. service to accept delayed patients with agreed PoC start dates but no rehab. goal.	December 2018	• JCR (care) capacity in HWLH	
ESx – 104 hours per day Pre-Booked independent sector home care capacity for the 3 week Christmas/New Year period	December 2018	• Engagement of home care providers. • Low levels of referral and utilisation (previous experience)	
Target LOS reduction at Milton and Firwood to 14 Days average	December 2018	• Restricted admission criteria • Capacity to support discharge	

East Sussex Mental Health Services

Target/Initiative	By when	Risks if any	Mitigating Actions
Urgent Care pathway i.e. Liaison, Crisis Resolution and Home Treatment teams will be fully operational around the 24 hr clock and Street triage nurses work up until midnight.	• The Adult CRHT provides24 support currently but do not do home visits after 9 pm. • Adult Liaison Nurses operational hours 24 /7 • Street Triage in Eastbourne 7 days a week from 3pm -10 pm and in Hastings 9-9 5 days a week from Wednesday to Sunday The reason for different shifts ifs due to population demand needs.	• There is not a consultant linked to Eastbourne Liaison • Young age profile as there is not 24 hr liaison children's service	• Patients/Carers on the case load can access telephone support after this time • Street Triage will stay until the job they are allocated is completed • There is a flow chart in place of how to access expert resource for direction and advice on management of the young person
ESx – CRHT teams will provide additional support to service users known to community teams who are at risk and may not be able to keep themselves safe, or who are considering attending A&E	• This is currently operational	• Demand and Capacity • Staff Capacity	• Offer additional shifts to staff and Bank Nurses to mange increase and demand
Confirmation of additional resource to support 24 hour opening of the urgent care lounge on the Eastbourne site	• January 2019 to March 2019	• Financial	• Allocation of Winter Fund
Additional Consultant cover at EDGH (4 PAs per week)	• January 2019 to March 2019	• Financial	• Allocation of Winter Funds
Provision of additional acute inpatient capacity	• This is not on the agenda of SPFT	• Demand and Capacity	• If demand exceeds capacity to local or SPFT beds and this is required then and ECR will be sought

Other

Target/Initiative:	By when	Risks if any	Mitigating Actions
CHC 7 day assessment over Winter weekend	December 2018 to March 2019	• Availability of resourcing	• TBC
CHC target 5% assessments in hospital	January 2019		
Daily operational executive calls every day from 1st December 2018. Weekend call to be held at 11.00am	December 2018 to March 2019	• None	• None
Non-urgent PTS additional dedicated vehicles 1 per site.	December 2018 to March 2019	• Financial	• Allocation of Winter Funds
Community pharmacy opening times and NUMSUS coverage (detailed opening hours have been received	December 2018 to March 2019	• None	• None
Establish Enhanced Weekend System Flow Teams	December 2018 to March 2019	• Financial	• Allocation of Winter Funds
Review system and organisational escalation systems and processes including review of SHREWD indicators and triggers	November 2018	• None	• None
Work with STP colleagues to develop STP wide SHREWD dashboard.	November 2018	• STP Partner engagement	• None

Winter Funding Allocation 2018/19

Theme	Organisation	Scheme	Details of what would be delivered	Timescales		Priority Scheme Costs	If beds, number of beds	Draft Prioritisation	Opex Agreed Option Priority Scheme Costs	Deliverability (RAG)
				Start Date	End Date					
Acute Hospital Flow	ESHT	28 Additional Acute Escalation Beds at EDGH	Additional 28 acute beds to be open for 4 months based upon capacity and demand modelling assumptions (see attached appendix 1)	26/12/2019	31/03/2019	£868,221	28	1	£868,221	GREEN
Acute Hospital Flow	ESHT	28 Additional Acute Escalation Beds at Conquest Hospital	Additional 28 acute beds to be open for 4 months based upon capacity and demand modelling assumptions (see attached appendix 1)	26/12/2019	31/03/2019	£845,498	28	1	£845,498	GREEN
Community Capacity	ESHT	12 Additional IMC Beds at Bexhill Irvine Unit	Additional 12 IMC beds to be open for 4 months based upon capacity and demand modelling assumptions (see attached appendix 1)	27/12/2018	31/03/2019	£287,126	12	3	£287,126	GREEN
Community Capacity	ESHT	5 Additional IMC Beds at Bexhill Irvine Unit	Additional 5 IMC beds to be open for 4 months based upon capacity and demand modelling assumptions (see attached appendix 1)	27/12/2018	31/03/2019	£65,286	5	3	£65,286	GREEN
ASC Transitional/Interim Beds	ESCC	Provision of additional discharge to assess pathway 4 bed capacity	Block purchase of additional transitional and interim beds to meet system caoacity gap	016/12/2018	31/03/2019	£352,450	27	5	£352,450	GREEN
ASC Care Capacity	ESCC	Povision of additional care hours	Provision of additonal care capacity of a 3 week period from 26th December	23/12/2018	12/01/2019	£75,000		6	£75,000	GREEN
Hospital Discharge	CCGs	Non-Urgent PTS - Extra Contractual Cover	Additional dedicated PTS vechile cover per hospital site from 00:00 to 00:00 7 days week from December to March	01/12/2018	31/03/2019	£51,000		7	£47,000	GREEN
System Flow	CCGs	Winter Plan Communications	Provision of targetted winter pla communciations linked to loca and STP wide communcations plan	01/12/2018	31/03/2019	£10,000		8	£10,000	GREEN
ED Flow	SPFT	24/7 Opening of Urgent Care Lounge	Extend opening hours of Urgent Care Lounge from 9pm to 9am to support direct referrals and rapid trasnfer of patients from ED and 136 suite capacity benefit and avoids ED attendance	01/01/2018	31/03/2019	£49,051		9	£49,051	GREEN
Acute Hospital Flow	CCGs	Walk in Centre additonal capacity	Additonal Walk in Centre Capacity over Christmas and New Year	26/12/2018	02/01/2019	£21,500		10	£0	GREEN
System Flow	CCGs	Flu Management - Care Homes	Improved provision of flu management support and cover to care homes	01/01/2019	31/03/2019	£25,000		11	£0	GREEN
System Flow	CCGs	Flu Management - Care Homes	Improved provision of flu management support and cover to care homes	01/01/2019	31/03/2019	£25,000		11	£0	GREEN
ED Flow	SPFT	Mental Health Medical Cover to Eastbourne DGH Liaison Services	4 PA of Mental Health Consultant to expedite clinical assessment of MH patient in ED, Inpatient snad Urgent Care Lounge	01/01/2018	31/03/2019	£20,375		12	£0	GREEN
System Flow	CCGs	Care Home GP/MDT Support	Extended Enhanced Care Home Support over Xmas and New Year - Additional care home ward rounds = GP, Pharmacist	16/12/2018	05/01/2019	£25,000		13	£0	GREEN
Acute Hospital Flow	ESHT/ASC	Weekend System Flow Teams	Additional ASC and Health flow teams at weekends to support 7 day flow across the system	01/01/2019	31/03/2019	£100,000		14	£0	GREEN
			Total			**£2,820,507**	**100**		**£2,599,632**	
			Available Funding			**£2,600,000**			**£2,600,000**	
			Balance			**-£220,507**			**£368**	

East Sussex County Council

Winter Plan Risks 2018/19

The ESBT Operational Executive have identified the following risks:

- Growth in NEL activity increases above the stated assumptions above.
- There is as risk that the end of the Bowes House contract (13 beds) on the 30th September and the changes being made to Milton and Firwood in December 18 (net impact 11 beds reduction) will not be able to be absorbed through associated and planned reductions in community and IMC LOS.
- Financial risk relating to the funding required to fully support the system winter plan proposals exceeding the £2.6m funding available.

The mitigations against the above risks are as follows:

- The assumed growth in NEL activity included within the capacity and demand model is assessed as being the worst case assumption due to the focus of the ESBT system on urgent and emergency demand management as one of key workstreams within the AEDB system improvement plan and System Financial Recovery Plan.
- The ESBT Operational Executive have assessed the potential risk of proposed system community bed changes as high without mitigation. The potential impact is estimated to be a system capacity risk of approx. 28 beds. Mitigations identified are:
  a) Re-allocation of released therapy resource from Bowes House contract to support D2A pathways,
  b) Targeted system action to reduce NEL admission growth to below the model assumptions – linked to system financial recovery plan workstreams.
  c) Purchase of additional interim/D2A pathway capacity during Winter.

Further work is required to confirm the mitigating actions against this risk and the detailed action being undertaken by the ESBT operational executive to reduce LOS in community and IMC services.

- Financial Risk - Agreement to the use of the £2.6m available winter resilience funding has been reached

Communications Plan

The aim of this plan is to set out and contribute to a strategic, coordinated, STP-wide approach to communications to help encourage behavioural change that will mitigate the pressure within the local health system over the Winter period – focusing on admission avoidance and flu prevention.

The objectives of the strategy are:

- To raise the awareness among the public of the alternative local services to A&E and when they should be used.
- To raise awareness among the public of when they should use GP services and what alternative Primary Care services are available to them.
- To raise awareness of prevention and public health messages – including a separate strand on flu prevention, tapping into the established Public Health England-led 'Stay Well' campaign.
- To raise awareness of the benefits of self-management and to provide information that encourages and supports patients to self-care.
- To remind people to get their repeat prescriptions in early so that they have enough medication to last them over the holiday period.

Communications Plan

The #HelpMyNHS and #HelpMyGP campaign, which ran across Sussex during winter 2017/18, successfully established a 'brand' that can be used to promote the objectives above, regardless of the time of year. Our Winter campaign will draw on content and imagery from this campaign ensuring continuity of messaging to further encourage and reinforce behaviour change. We will also include a 'separate' but related campaign on flu prevention, localising the established national 'Stay Well' branding and messaging.

Communications channels

Posters

Posters will be produced with relevant information and made available in a wide range of public locations including GP surgeries and hospitals.

Press releases

Proactive press releases will be issued during the winter period (dates TBC) reinforcing the key messages of the #HelpMyNHS, #HelpMyGP and 'Stay Well' campaigns.

Websites and social media

Press releases will be posted on the CCG websites and shared with partner organisations (ESHT, ESCC, HealthWatch, etc.) for their websites/Facebook accounts. The campaign will also be promoted through CCG and provider organisation social media channels, particularly Twitter.

Existing CCG communications

The campaign will be promoted through the CCGs' existing communications to staff, members and the public. These include the weekly staff and GP practice bulletins and external newsletters such as the ESBT newsletter.

East Sussex County Council

System resilience and surge management

The East Sussex Surge and Capacity Plan for 2017/18 is an operational document with the intention that it is referred to for guidance throughout periods of high system pressure and challenge.

Principles of the plan:

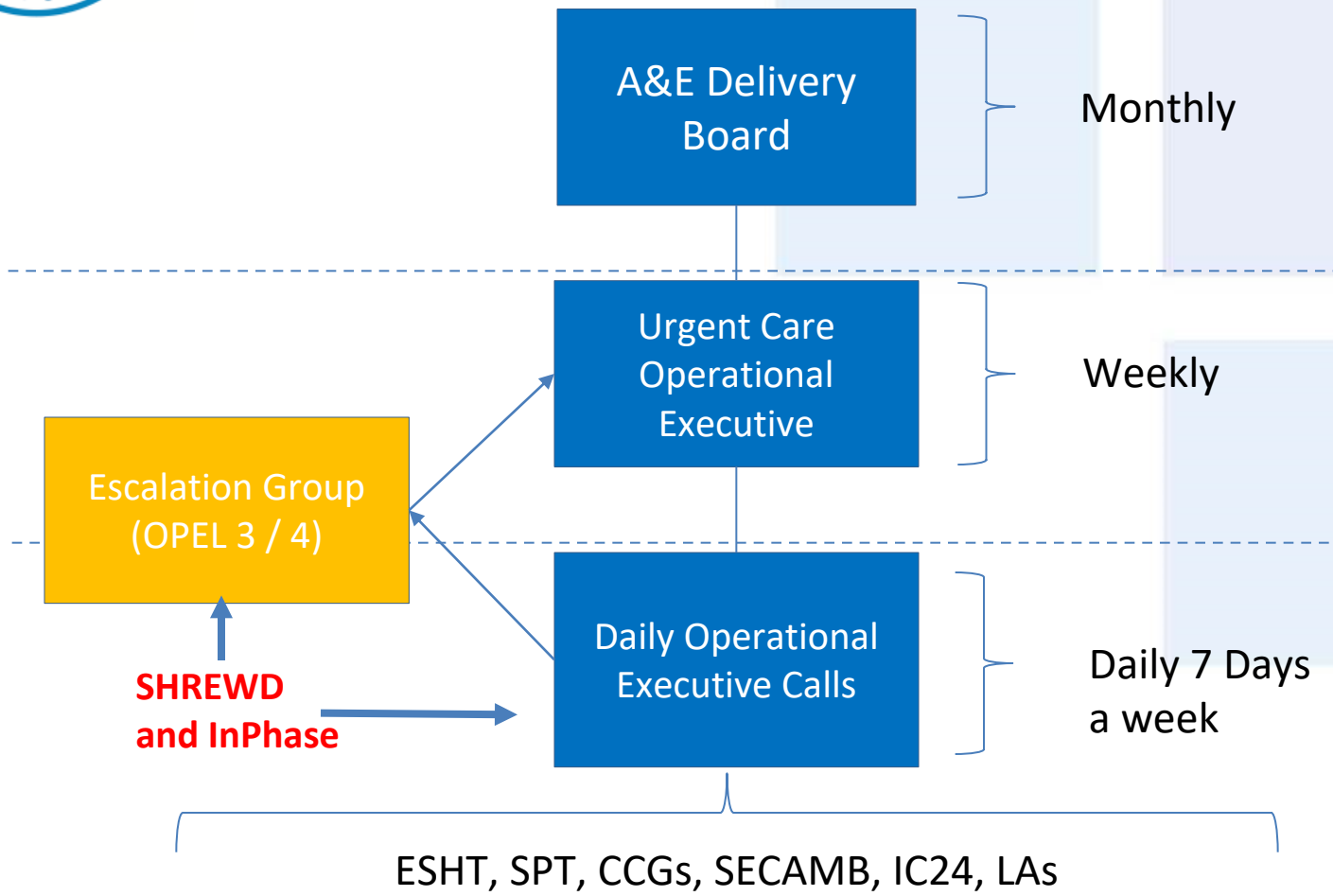
- Built on system reviews of previous winters, A&E sustainability plans and organisational planning
- Transparency of using lessons learnt into current resilience plans
- Addressing key aspects that create pressure within our local system for admission avoidance or discharge support
- System-wide engagement in developing and agreeing a plan that meets the strategic needs of the local health and social care economy.

The ultimate point for decision making for the implementation of the surge plans across East Sussex will be the East Sussex A&E Delivery Board which convenes monthly throughout the year. The group consists of representatives from all key organisations across Health and Social Care and is chaired by the Accountable Officer for Hastings and Rother CCG.

Daily Operational responsibility rests with each organisation who will report into the an operational task group (Operational Executive, (OPEX)) on a daily basis through a series of daily system calls. The OPEX report through to the Chair of the A&E Delivery Board.

East Sussex County Council

System winter plan delivery governance



Next steps

Action required	By When
Operational Executive to review and update draft plan	13th July 2018
Draft Winter Plan to LAEDB	1st August 2018
Submission to NHS England (see attached letter and appendices)	17th August 2018
Second Draft Plan to LAEDB	31st August 2018
Final Plan to AEDB	28th September 2018
System Winter Plan Operational Resilience Plan Test Event	October 2018
Detailed Operational Plan for Christmas and New Year Period confirmed, including MADE events, etc.	November 2018

Appendices

- Appendix 1 – Draft East Sussex Surge Management and Capacity Plan (abridged version)
- Appendix 2 - NHSE Regional Winter Plan Letter – dated 25th July 2018
- Appendix 3 – South East Coast Ambulance NHS Trust Draft 999 Winter Plan
- Appendix 4 – South East Coast Ambulance NHS Trust Draft 111 Winter Plan
- Appendix 5 – Draft STP Flu Management Plan
- Appendix 6 – NHSE Winter Assurance Template – Submitted 17.08.18

2017-18 Action plan for compliance with NHS England Core Standards

No.	Core Standards Description	Actions	When by?	Who by?	Oct 17	Mid-year	Oct 18
	Governance						
DD1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a pubic Board/Governing Body meeting for sign off within the last 12 months.	Board will receive annual report on EPRR assurance	Nov 2017	Accountable Officer		Completed Nov 17 (now have 6 monthly EPRR Board Reports).	**Done**
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	The 2017/18 assessment will be published in the Trust's Annual Report	Sept 17	Accountable Officer		Completed Sep 17 AGM & annual report	**Done**
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	ESHT to confirm Non-Executive Director with an EPRR portfolio is identified	Apr 2018	Head of EPRR		NED Mike Stevens involved with EPRR	**Done**
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Annual plan to be updated. CCG to confirm timeline of recruitment of additional EPRR resource at ESHT	Nov 2017	Head of EPRR (now in place)		Annual EPRR work-plan Completed in March 18 and now live.	**Done**
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and those adequate resources are made available to enable the organisation to meet the requirements of these core standards.	Report scheduled for presentation to the board Head of Emergency Planning and Business Continuity to start in post	Nov 2017 Dec 17	Accountable Officer		June report drafted: Board reports scheduled for June & Oct Board Meetings	**Done**
	Duty to assess risk						
5	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	Develop a structure to identify, review and manage risks presented to LHRP	Nov 17	Head of EPRR		**Meeting with RM Team held, RA's drafted as per team RR, & sent to LF for signoff. Lower risks on Risk register**	**Done**
8	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan)) Effective arrangements are in place to respond to the	CCG to review ESHT's Major Incident Plans, specifically with regards having a separate major	Aug 18	Head of EPRR		**IRP Drafted incl Command / Control Framework for**	**Done**

	risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity.	incident plan for each site, the absence of reference to Community Services in these plans and their narrowly focussed sub-titles. (One Trust MI / IRP Needed)				**EPRR Steering Grp DoneApril Meeting, signed-off. MIP for Casualties drafted for EPRR Grp 18th July, now complete and signed off**	
9	Business Continuity Plan (As above)	ESHT to confirm that it has a Business Continuity plan that includes community services	Sept 18	Head of EPRR		**Drafted. EPRR Steering Grp has now signed off.**	**Done**
18	Evacuation Plans (As above)	Review hospital evacuation Plans for EDGH, Conquest, Rye and Irvine Unit.	Oct 18	EPRR Team in conjunction with Est & Fac, Fire Officer and M/A partners		**EDGH Evac plan complete but needed update. Plan now re-drafted for sue at any ESHT site. Published to extranet.**	**Done**
15	Fuel Plans	Fuel plan that aligns with the NEP- to be ratified at June EPRR group	Jun 18	Emergency Planning Officer in conjunction with Facilities		**Drafted. Went EPRR Steer Grp June 18. Now signed-off**	**Done**
		Command and Control					
34	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPS) and/or commonly recognised information picture (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.	Draft section in command and control plan (MI) MI plan to be reviewed post formal debrief following Sep 17 MI. Plans to be agreed at EPRR group June 18 and then signed off	Jun	Emergency Planning Team		**Incident Response plan Incl command / control includes sitrep arrangements. Drafted for EPRR Group signed-off. Complete.**	**Done**
31	That on-call must meet identified competencies and key knowledge and skills for staff.	On-call staff needs to be scoped as part of CS 49. On-call cadre to be grouped, assessed as to current skills, and trained accordingly.	Jun 18	Emergency Planning Team		**KS reviewing On-call pack. KC meeting L&D to agree mandatory training, ESR / portfolio arrangements**	
36	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Confirm arrangements in place Ensure BC and MI plan reflects arrangements	Aug 18	Emergency planning officer		**Meeting held May 18. Agreed Nuc Med staff from BSUH will provide.**	**Done**
		Training and Exercising					

2017-18 Action plan for compliance with NHS England Core Standards

49	Arrangements include a current training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	A training matrix (and full training program) to be completed including training needs analysis and programme. Specific Role base training to be completed - Gold and Silver - Other roles	Mar 18	Emergency planning Team		**TNA at April EPRR Mtg & Training programme now finalised. Meeting with L&D agrees links with advertsing etc. Training is now being delivered. Complete**	**Done**
50	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	A programme is partially developed	Jun 18	Emergency planning officer		**Schedule Completed for April EPRR Group meeting. Emergo Exercise in planning stage & BC Ex for jan/Feb 19 being planned**	**Done**
52	Preparedness ensures all incident commanders (on call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.	To be completed as part of a rolling programme. Attendance certificates to be issued.	Jul 18	Emergency planning officer		**Progressed as part of training review. (CS 31+49) We now know who has had what training. Portfolio to be agreed and introduced. Certificates agreed and in use.**	
	Business Continuity Management						
BCM	Contractors to have suitable BC Plans	As part of annual plan undertake review of new contractors to ensure compliance	Aug 18	Emergency Planning Officer and Trust Policy Group		**Corporate BCP review draft complete. service level & Contractor register being developed by J Thomas**	

ESHT EPRR Annual Work-plan 17-18 (Red text = Top Priority)

No	Item / Task	Risk	P	Links to:	Lead	Freq	Comments	RAG	Due	Date
1	Annual EPRR (team) work-plan review	**High**	**1**	EPRR CS	Claxton	quarterly	This doc to incl KPI's & inform man't		Apr 18	Apr 18
2	EPRR Core Standards Action Plan and prep for next submission	**High**	**1**	CS / Board report	Claxton	quarterly	Review done. Link to Board reporting (June drafted - see below)		May 18	May 18
3	EPRR Policy Statement Review (incl BC)	**High – P1**	**1**	CS / Objectives	Claxton	Bi-annually	Prev doc has been updated, and has been to EPRR group. Signed off by AEO. To be placed on extranet ASAP		May 18	July 18
4	Major Incident arrangements and plans (being reviewed but Clarity needed re format / style	**High**	**1**	CS / Objectives	Claxton / Taylor	Once annually	New all-in-1 overarching 'Incident Response Plan' drafted, been to EPRR group. Now signed-off. (2nd stage-review of MIP for casualties below)		Jul 18	Jul 18
5	Major Incident plan for numbers of Casualties needs 3 plans combining into one document (to sit as risk-specific plan UNDER IRP as above)	**High**	**1**	CS / Objectives	Claxton	Annually	Plan drafted. With EPRR Steering Group 18th July. Now in consultation. Will then need update and sign-off at Sept EPRR Steering Group.		Sept 18	Aug 18
6	Trust EPRR meeting exists. Re-vamp of ToR needed mandate EPRR corporatly, and commitment of (agreed list of) key staff (champions) needed to raise EPRR profile	**High**	**1**	CS / Objectives	Claxton	Once (full review)	Tor Review completed. Agreed at EPRR Grp Apr 18. Now signed off by HD. Timely Agenda's to include all services , updates affecting EPRR, Events Calendar, Trust & Nat Incidents, (**Grenfell**) changes in trust, Debriefings, Plan reviews and sign-off / Training programme etc.		July 18	June 18
7	Raise Trust EPRR Profile to assist with whole-Trust EPRR culture change	**High**	**1**	Objectives	Claxton	On-going	1. Big 3 (IRP, EPRR Policy and EPRR Group ToR 2. Comms strategy developed for EPRR 3. Lessons learned / EPRR updates in a newsletter (S Purkiss) 4. Social media presence 5. Effective training regime incl CBRN 6. EPRR involved in Estates changes / E&F EPRR meeting		Aug 18	Aug 18

							7. Coffee mornings and walkthroughs / exercises (in time) 8. Improvements to EPRR on Extranet / EPRR App for staff			
8	Board Reports / Corp buy-in for EPRR i.e. budgets for CBRN (kits suits / heaters screens) / ICCs etc	**High**	**1**	CS / Objectives	Claxton	June / Nov	KC has meet NED. Board report templates obtained. June Board report submitted. KS to Chair EPRR Meeting. Nov Report to be drafted. There is no money (but 'cost pressures' now understood) Complete		Nov 18	Aug 18
9	EPRR Section of Trust Annual Report	**High**	**1**	CS	Claxton	Annually	Completed & sent to Co Sec		Apr 18	Apr 18
10	Agree program of attendance at external meetings (SRF and LHRP, SAGs etc). (Threatened due to volume of internal work necessary)	**Med**	**1**	Objectives	Claxton / Taylor	1. Weekly 2. Quarterly	1. Attendance at SRF meetings agreed with NHS E / SRF 2. SHRG (LHRP) both to attend. 3. SAG's on demand		Mar 18	Mar 18
11	Horizon Scanning	**High**	**1**	CS / Objectives	Taylor / Claxton	Continuous	Reports, SRF teleconference weekly, updates, social media, news monitoring etc. System in place. Urgent updates to Exec as required		Mar 18	Mar 18
12	Corporate BC Plan review	**High**	**1**	CS / Objectives	Claxton	Annually	Review to ensure plan in line with ISO, contains BCMS, ref to BIA's etc, with EPRR Mtg June 18, now signed-off		Sept 18	Aug 18
13	Training program and TNA need agreeing at EPRR Group, incl training dates for all groups / who buy / who isn't getting it?	**Med**	**2**	CS / Objectives	Taylor	Annually	Incl On-Call (Tac), Strategic, Site Team & ED & Project Griffin training. Program drafted & at Apr EPRR Mtg. Now finalised and being implemented. Linked to L&D re advertising. Complete		Aug18	Aug 18
14	Training for silver role & On call rota / Portfolios	**Med**	**2**	Objectives	Claxton	6 monthly	KS reviewing on-call pack. Now agreed. training (via training program) to be drafted + delivered + portfolios needed.		Oct 18	
15	Mass Casualties Plan needs review (Sussex Trauma Network link Barbara Rayner / J Flaherty) Ventilator capacity / Paeds / ICC's, Clinb Decision Unit & reception not in plan	**Med**	**2**	Objectives	Taylor / Claxton	Bi-Annually	Head EPRR at Trauma Network Meetings (Plan will be in hosp MIP for casualties. New guidance from SECAmb and Trauma network agreed. Built into MI Plan for Casualties. Closed		Aug 18	Aug 18

16	Link SRF Risk process and Trust EPRR Risks to Trust Risk man system	**Med**	**2**	CS / Objectives	Claxton	Once	KC to link Trust to SRF risk. (Meeting with risk manager held). Policy & templates obtained. Team Risk Register drafted and at EPRR St Grp June 18. Risks now drafted and signed-off, and on ESHT risk register.		Sept 18	
17	Team Finance V Performance to savings plan. Identify and maintain realistic budget. (Admin support in JD). EPRR Officer post being replaced. Consider Intern / apprentice / other options.	**Med**	**2**	CS / Objectives	Claxton	On-going	Currently no extra budget (clarified). Costs re CBRN suits etc now subject of a risk & added as cost pressure. Maintain VFM. Team had no Admin Support as in JD now identified and in place. Finance training obtained. Now both obtained without cost. CBRN Options paper re damage to tent / inappropriate storage and PRPS letter being responded to. (Potential significant costs) Assistance from finance obtained.		Oct 18	
18	Reviews and debriefings: Birling Gap and Gardner ward BCI incident learning to feed into Smart Actions and plan development	**Med**	**2**	CS / Objectives	Claxton / Taylor	As necessary	Recommendation's from incident debriefs for Birling Gap & Gardner Ward added as actions to debrief reports agreed at Apr EPRR Meeting, and update at June Mtg. Being progressed. (KC in SRF T&F group re SRF / health actions). Now complete.		July 18	Aug 18
19	Severe Weather Feb / winter plan to be debriefed / reviewed in June / July 18 for next winter. Heatwave plan reviewed for Apr EPRR Mtg	**Med**	**2**	CS / Objectives	Claxton	6 monthly	Heatwave plan updated for June EPRR meeting. Cold / Severe weather plan now updated for Sept EPRR Group sign-off.)		july18	Aug 18
20	Develop options brief (incl costs for location of operational control centre and the strategic control centre on both sites	**Med**	**2**	Objectives	Taylor	Once	Work in progress. Minor works form signed by KS. EDGH work now largely complete. Conq work to be progressed in action 22		Jan 18	Apr 18
21	Review of Trust Lockdown procedure	**Low**	**3**	CS / Objectives	Taylor	Bi-Annually	Plan in place from E & F tested cross site June 2017. 16th at EDGH and 23rd at Conquest. Updated plans received, appropriate, and to be presented to		Nov 18?	July 18

							EPRR meeting in July 18			
22	Some plans needing minor re-fresh. (Pan Flu)	**Low**	**3**	CS / Objectives	Blackwell	Bi-Annually	Pan flu plan review underway		Oct 18	Sept 18
23	Control room set-up. (KC to ensure progressed through EPRR meetings / Exec. IT to manage site-specific issues) (Terminology in Incident response plan / are these in the right places? Particularly at Conquest). Also signage is an issue.	**Med**	**3**	CS / Objectives	Claxton	Once	ICC EDGH: Major work completed and minor works now completed with view to confirmed move in June 18. ICC Conq approval obtained. Schematic for Conquest provided together with list of equipment, IT and telecommunications required. Schedule progressed. Points installed and work re data connection completed. Phones in hand, TV moving and cupboard completed & partially stocked. (Room is operational)		Sept 18	Sept 18
24	Hospital Evacuation Plans need drafting / reviewing	**Med**	**3**	CS / Objectives	Taylor	Bi-Annually	EDGH plan (2015) needs review. Reviewed as I 1 Trust plan, Completed for Sept EPRR Steering group.		Sept 18	Aug 18
25	VIP Response Plan review	**Low**	**3**	Objectives	Taylor	Bi-Annually	Drafted. Signed off at June EPRR Mtg completed.		July 18	Aug 18
26	Inclusive Plan Hierarchy& Review Schedule to be maintained and kept in perf folder	**Low**	**3**	Objectives	Taylor	Quarterly	Drafted and now complete		June 18	June 18
27	Trust Exercise schedule to be kept then maintained & retained in perf folder. Ex to be drafted for later this year.	**Med**	**3**	CS / Objectives	Taylor	6-monthly	Draft agreed at April EPRR meeting . Discussion with partners re exercises. Auth for Emergo MTN Ex Nov 18. BC Ex being planned for Jan / feb 2019		Dec 18	
28	Review of service-level BC plans	**Low**	**3**	CS / Objectives	Claxton / Taylor	On-going	Commenced. To be followed up once Corp BC plan is reviewed. (Being followed up via EPRR meetings)		Sept 19	
29	Team to have PDR's and maintain skills, abilities, knowledge.	**Low**	**3**	PDR's / Objectives	Claxton / Taylor	Weekly 1:1PDR reviews	KCs appraisal drafted and is with KS after discussion – needs signing. KC to start appraisal with LB		Ongoing	Ongoing
30	Trust does not have Fuel Plan	**Low**	**3**	CS / Objectives	Taylor	Bi Annually	Drafted. Agreed at June EPRR Mtg Now in signed-off. Complete		Apr 19	Aug 19
31	Events Calendar – Requested by ED's	**Med**	**2**	PDR's / Objectives	Claxton	Monthly	Completed and in EPRR Steering Group folder		Apr 18	Apr 18

32	E&F state Trust Helicopter Policy never signed off. Possibly no R/A's. Conq site unusable	**High**	**1**		Claxton	Bi-Annually	Drafts & MTW plans obtained. Agreement for working group for re-drafts and signoff via EPRR group. EPRR team & fac & Est linked to Air Amb Charity re developing Conq site.		Sept 19	
33	Staffing gaps. I Taylor has left. Vacancy agreed to be filled at 1.0 FTE. Further gap re admin / project support. Risk of non-delivery of workplan	**High**	**1**	CS / Objectives	Claxton COO / HD	On-going.	EPRR Officer vacancy advertised, filled & starts 13/8/18. Admin supportr by new managers PA with EPRR Secretariat and other tasks. Proj Man support from J Thomas re training, BC plans and Comms. Poss 4th post via apprenticeship / intern . Happy to show as complete.		Sept 18	July 18
34	Clarification needed re attendance level at LHRP	**Med**	**2**	CS / Objectives	Claxton	Once	Raised at SHRG Apr. Discussion on-going at June 18 SHRG. NHS E suggest 'AEO or nominated deputy'. COO agrees LF will be DEP AEO, will att LHRP and now lines manages EPRR. Colosed.		Oct 18	Aug 18
35	Secure extra staffing	**Med**	**2**	Objectives / CS	Claxton	On-going	EPRR Officer left – role now replaced at 1.0 instead of 0.8 FTE. Proj mentt and admin support now obtained 0.4 FTE. Apprentcie support EPRR officer now obtained 0.1 FTE		Aug 18	Aug 18
36	General training Delivery	**Med**	**2**	Objectives / CS	Team	On-going	Feb 18 all training except induction had stopped. Training TNA & program agreed. External training opps identified. Now delivering 2 x induction and MI training monthly, plus range of external provision. Practical training day for on call Exec and managers required urgently.		Oct 18	

East Sussex Healthcare NHS
NHS Trust

Infection Prevention & Control Annual Report - 2017 to 2018

"Our patients will not be harmed by a preventable infection"

NHS
ESHT
Infection Prevention and Control

CONTENTS

Executive Summary

This report outlines the infection prevention and control (IPC) activities of East Sussex Healthcare Trust (ESHT) for the financial year 2017/18. Arrangements made by ESHT to allow the early identification of patients with infections, measures taken to reduce the spread of infections to others, audit, surveillance, achievements and challenges are presented.

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

Key points during 2017/18 are:-

- The number of MRSA bacteraemia cases reported was 4, one clinical infection that was assessed as not preventable (in a patient with multiple indwelling devices who had been in hospital for many months), one case initially classed as community case was later attributed to ESHT as it was considered to be representative of a contaminated sample rather than actual infection and two further samples were assessed as contaminated samples and not actual infection.
- The number of cases of *Clostridium difficile* infections (CDI) reduced to 37 compared with 46 the previous year. The trust was below the limit of 40 set by Public Health England.
- There was some disparity between the nationally reported number of E. coli bacteraemias, C. difficile infections and MSSA bacteraemias and the number identified by ESHT. This was mainly due to reporting errors of a clerical nature and did not result in significant increases in the number of infections attributed to ESHT.
- The Infection Prevention and Control Team (IPCT) provide education and training and clinical advice.
- Significant increase in orthopaedic surgical site infections was reported as a serious incident.
- At ESHT a total of 415 cases of Influenza were diagnosed from April 2017 to May 2018. This was nearly a four-fold increase on the previous year and reflected the national prevalence of Influenza. There were outbreaks of Influenza on several wards which were well managed. One patient had Influenza identified on their death certificate, this was investigated as an amber serious incident. The outbreaks reflected delays in diagnosing index cases on wards which enabled the infection to spread to others. Preventing outbreaks was complicated by high occupancy.
- *Legionella species* continues to be isolated in low numbers from water supplies in several areas at the Conquest site. No patients have developed *Legionella* infection as a result of this. Success of control measures is monitored by the Trust Water Safety Group.
- CQC assessment of IPC at ESHT reported that "*Infection prevention and control was now a real strength".*

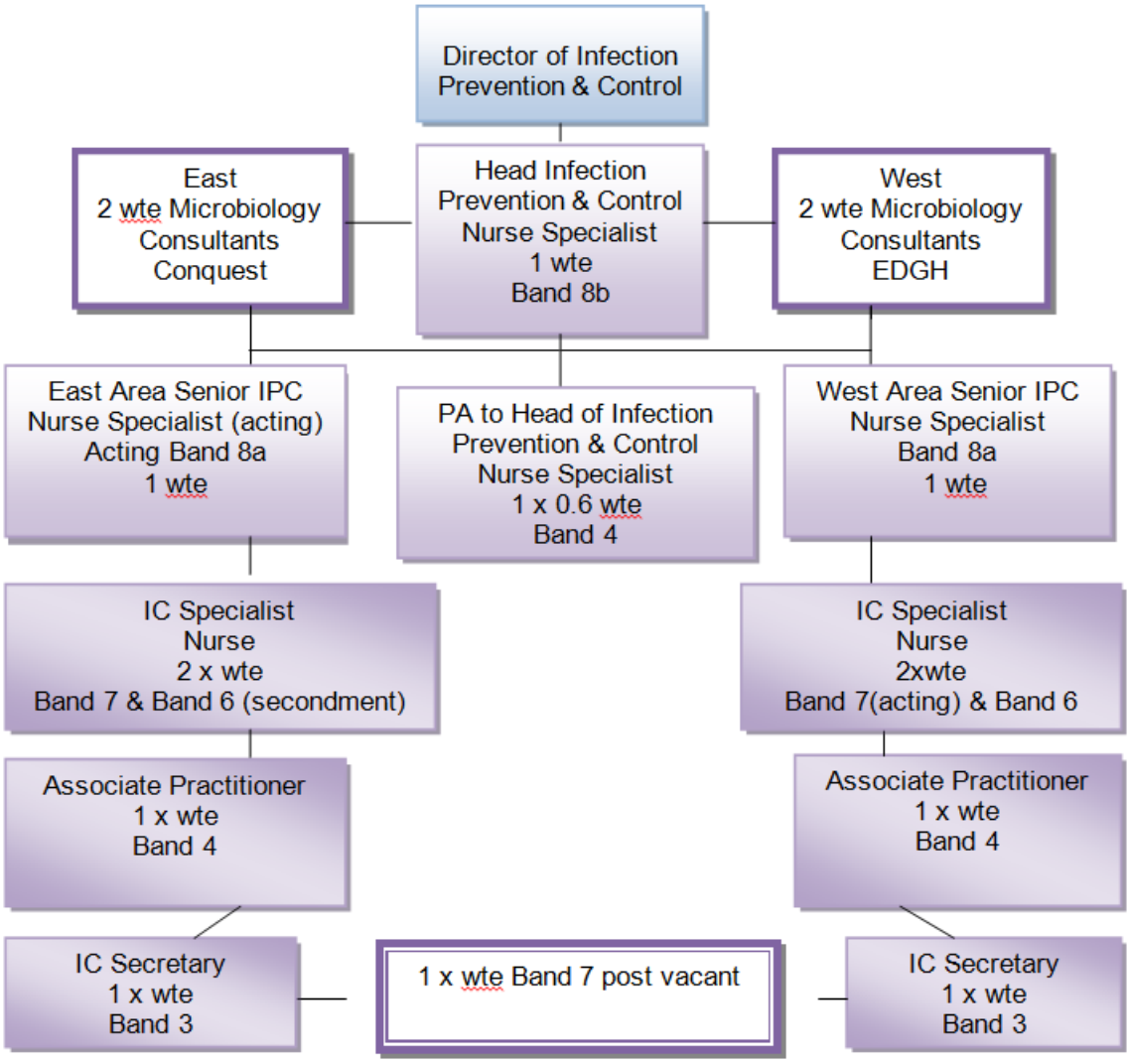
Lisa Redmond, Head of Infection Prevention and Control

1. Structure

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

During 2017/18, there were many changes to personnel within the IPC service. The Director of Infection Prevention and Control (DIPC), who was also the infection control doctor, and the Head of Infection Prevention and Control both left the trust in October 2017. The DIPC role is currently being fulfilled by the Director of Nursing and the Head of Infection Prevention and Control recruited to from within the team. Recruitment to the vacant Consultant microbiologist/DIPC/Infection control doctor post was unsuccessful and is ongoing.

Infection Prevention & Control Team Structure

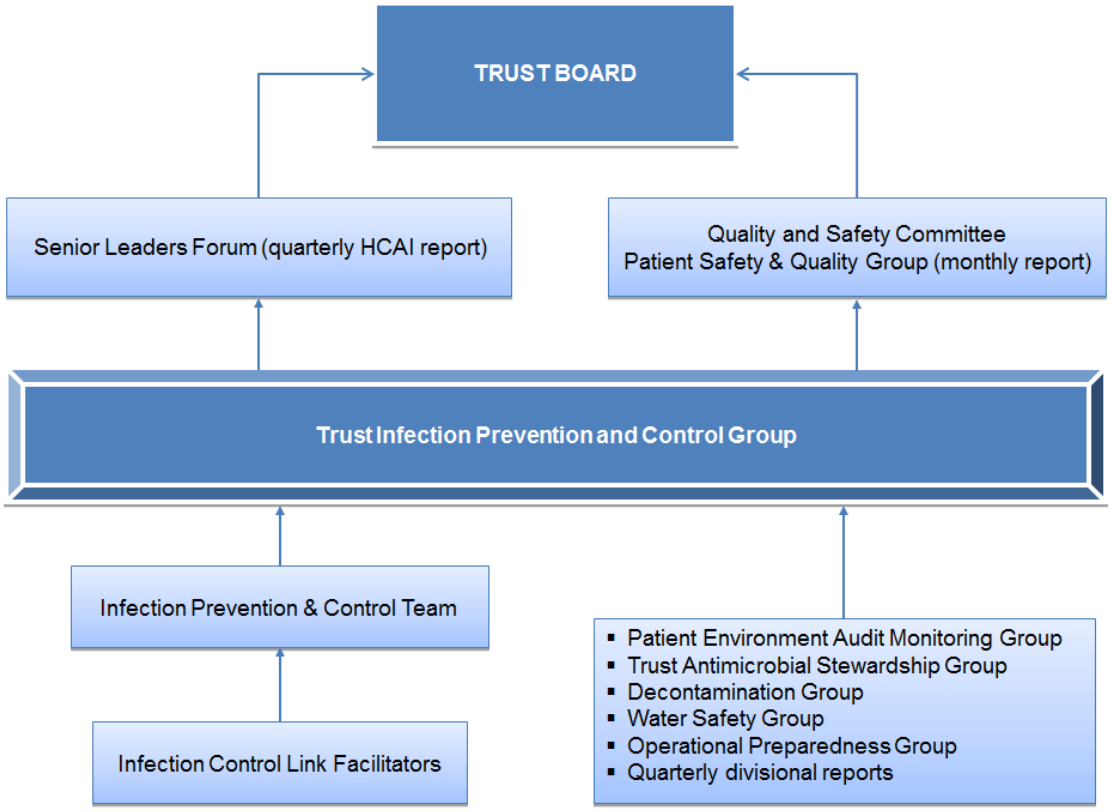


The IPCT comprises of specialist Infection Prevention and Control nurses and administrative staff. Two area teams (East and West) based in each of the acute hospital sites provide Infection Prevention and Control support to all ESHT services in their local area (acute, community, inpatient and domiciliary). Two band 4 Associate Practitioners to the IPCT are undertaking the Foundation Degree in Health and Social Care which is funded through the apprenticeship scheme.

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

An Orthopaedic Surgical Site Infection Surveillance Nurse is appointed within the Diagnostics Anaesthetics and Surgery Division and an Antimicrobial Prescribing Lead post is appointed within the Out of Hospital Division.

1.1 Infection Prevention & Control internal reporting arrangements



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

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

1.2 Infection Prevention & Control external reporting arrangements

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

- Hastings & Rother CCG
- Eastbourne Hailsham and Seaford CCG

1.3 Infection Control Link Facilitators

There are approximately 80 Link Facilitators across the Trust. Each new ICLF is provided with an induction programme provided by the IPCT. With the educational support and guidance from the IPCT, they are responsible for cascading and monitoring compliance with infection prevention and control practices at clinical level. The IPCT hold monthly ICLF meetings on each acute site.

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

The results of the monthly hand hygiene compliance audits are readily available on the Trust electronic information system (Meridian). If repeated non-compliance by an individual member of staff is identified, letters are sent out to the non-compliant staff members and it is escalated to their line manager to performance manage.

1.4 Joint working across the local health economy

The Trust IPCT continues to work with the Clinical Commissioning Group (CCG) IPC Nurse and Public Health England (PHE) colleagues towards joint strategies for the reduction of healthcare associated infections which can lead to hospital admission.

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

The IPCT in collaboration with PHE, East Sussex County Council and the Network Group have continued to focus efforts on the reduction of catheter associated urinary tract infections in response to the new reduction targets set by NHS improvement for reducing Gram negative bacteraemias by 50% across the whole health economy by 2021.

Surveillance of community acquired E. coli bacteraemias is undertaken by the IPC team on behalf of the local CCGs under a service level agreement.

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

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

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

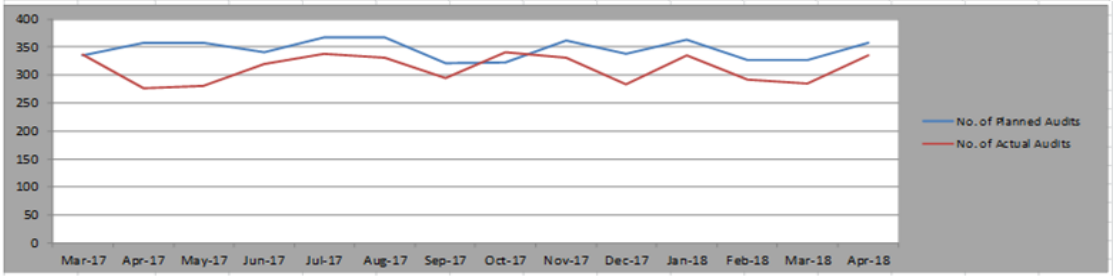
One of the greatest challenges to the Trust in demonstrating compliance against Outcome 8 is in the provision of isolation facilities. During 2017/18 the provision of side rooms remained unchanged. IPC risk assessed patients in isolation at least three times per week, prioritising those of most risk to make the best use of available facilities.

The CQC inspection in October 2016 reported that Infection Prevention and Control oversight had been significantly strengthened and following the re- inspection this year they reported that "*Infection prevention and control was now a real strength*".

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

Number of NSC Audits Planned vs Number Completed

Month	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
No. of Planned Audits	335	357	357	340	367	367	321	322	361	338	363	327	327	357
No. of Actual Audits	337	276	280	320	338	331	295	340	331	284	335	292	285	335



The Trust NSC target score for Clinical (formerly Nursing) and Housekeeping was assessed as >92%, overall this was achieved although there continues to be some low scoring areas. Where an area has consistently low scores they are asked to attend the Patient Environmental Audit Meeting (PEAM) to provide assurance of the actions being taken to address the low compliance. The introduction of the Clinical Orderly role to support cleaning of clinical equipment has significantly improved compliance scores.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
House Keeping	96.93%	96.42%	97.16%	97.09%	97.48%	96.31%	96.36%	96.90%	97.29%	96.85%	96.14%	94.96%
Clinical Staffing	97.93%	97.77%	97.69%	95.94%	97.66%	94.78%	91.38%	96.00%	93.06%	91.39%	92.05%	90.58%
Estates	91.67%	89.00%	87.67%	90.75%	88.28%	88.59%	87.80%	89.36%	90.14%	91.55%	88.68%	90.03%

Lower compliance for clinical equipment in quarter 4 relates to low scores within the community clinics and therapies where there are no clinical orderlies. Management of these buildings transferred from ESHT to a commercial company during 2017/18, concerns about lower cleanliness scores was raised with the managing director who agreed to introduce cleaning schedules and auditing as they are used by ESHT staff and patients. The issue of low scores was placed on the ESHT risk register and will be monitored via PEAM with quarterly auditing by ESHT NSC team for assurance. Out of hospitals division also monitor via performance review. Clinical equipment scores for Conquest and EDGH were compliant.

3. Mandatory Surveillance

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

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

Since 2011, bloodstream infections due to meticillin sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli* have been added to the national mandatory surveillance. However, these infections are more often community acquired and up until March 2017 no hospital or Trust objectives for reduction have been set. In 2017/18 a new Quality Premium was introduced to reduce the number of *E. coli* bacteraemias (community and HCAI) by at least 10% and mandatory reporting of *Pseudomonas aeruginosa* and *Klebsiella species* bacteraemias was also introduced.

3.1 MRSA bacteraemia

We continue to have a zero tolerance approach to cases of MRSA bacteraemia which could potentially be avoidable. ESHT reported 4 cases of MRSA bacteraemia in 2017/18 compared to one case in 2016/17.

MRSA	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD
Limit	0	0	0	0	0	0	0	0	0	0	0	0	0
Actual >48hrs	0	0	0	1	0	1	0	1	0	1	0	0	4

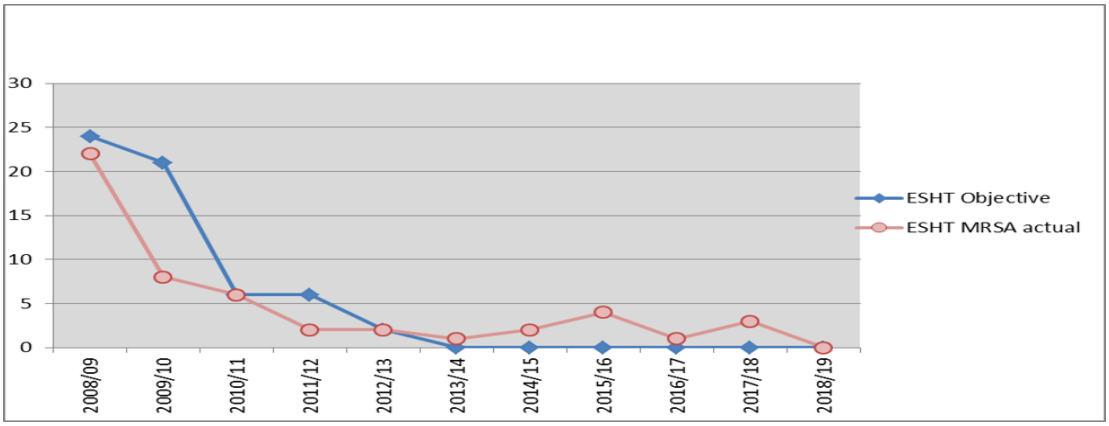
One case of hospital acquired (>48 hours) MRSA bacteraemia reported in July in a patient with complex medical needs and vulnerable to infections. The outcome of the Post Infection Review was that all Trust policies where followed and this was an unavoidable infection in a patient with significant co-morbidities and most likely related to the Hickman line.

One community acquired MRSA bacteraemia diagnosed from a child in September recorded as community acquired however, the Post Infection Review by the CCG assessed the case as a contaminant so the case was allocated to ESHT. Two further MRSA bacteraemia identified as contaminated samples. There was difficulty obtaining the sample. The reviews identified a need to improve documentation of the procedure as sticker previously supplied were no longer being placed in blood culture packs, this has now been addressed.

Compliance with the Trust MRSA policy has improved significantly this year. A re-audit of MRSA compliance showed that compliance with screening and decolonisation was over 80%. Preventing patients with MRSA colonisation of the skin developing subsequent infection is challenging, particularly in patients who have severe underlying conditions, skin problems or require the insertion of intravenous lines and other devices as part of their treatment. For many years we have had in place regimes to screen all admissions and give topical antiseptics to the skin for patients with known MRSA colonisation. We continued screening all admissions to ESHT throughout 2017/18.

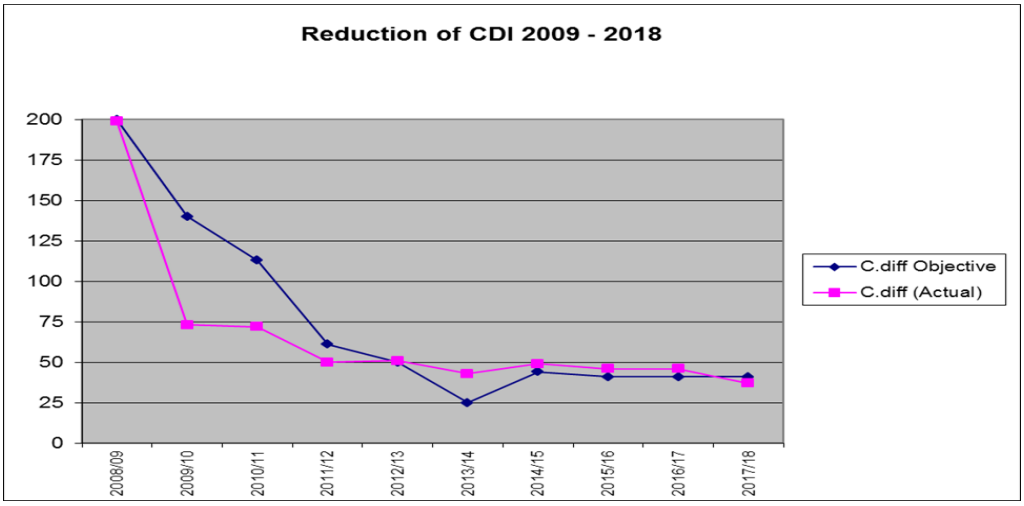
The table below shows the number of cases of MRSA bacteraemia reported since 2008. It should be noted that prior to 2011 the data reported was for the previous acute organisation (East Sussex Hospitals NHS Trust) only.

Reduction of MRSA cases reported between 2008/09 and 2017/18



3.2 *Clostridium difficile* infection (CDI)

The number of *C.difficile* infections reported annually within ESHT is shown in the chart below. In 2017/18 the Trust reported 37 cases of CDI against an objective of no more than 41.



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

Each case of CDI diagnosed beyond 72 hours of admission undergoes a post infection review (PIR) investigation. Findings of these PIRs are presented to the DIPC who agrees with a representative from the local CCG if each case constitutes a lapse of care likely to have resulted in CDI, a lapse of care unlikely to have resulted in CDI or no

lapse of care. In 2014/15 the DH revised the objectives for reduction of CDI for Trusts so that where no lapses in care have been identified Trusts may appeal to their local commissioners for these CDI cases not to count towards annual objectives. ESHT worked with the local Commissioners and agreed a process and criteria for review of all cases.

Outcome of Post Infection Reviews (PIRs)	Total 2017/18
Lapse in care contributory to CDI	4 cases
Lapse in care not contributory to CDI	25 cases
No Lapse in care	7 cases
Unknown (PIR not undertaken as case incorrectly apportioned to CCG	1 case

The national data capture service (DCS) report via Public Health England showed that ESHT had 39 cases for 2017/18, investigation revealed that two of these samples were community cases that had been inputted incorrectly and one case did meet the criteria for allocation to ESHT but had been incorrectly assessed, the correct number of cases has now been reported to the DCS and future national reports will show the amended data.

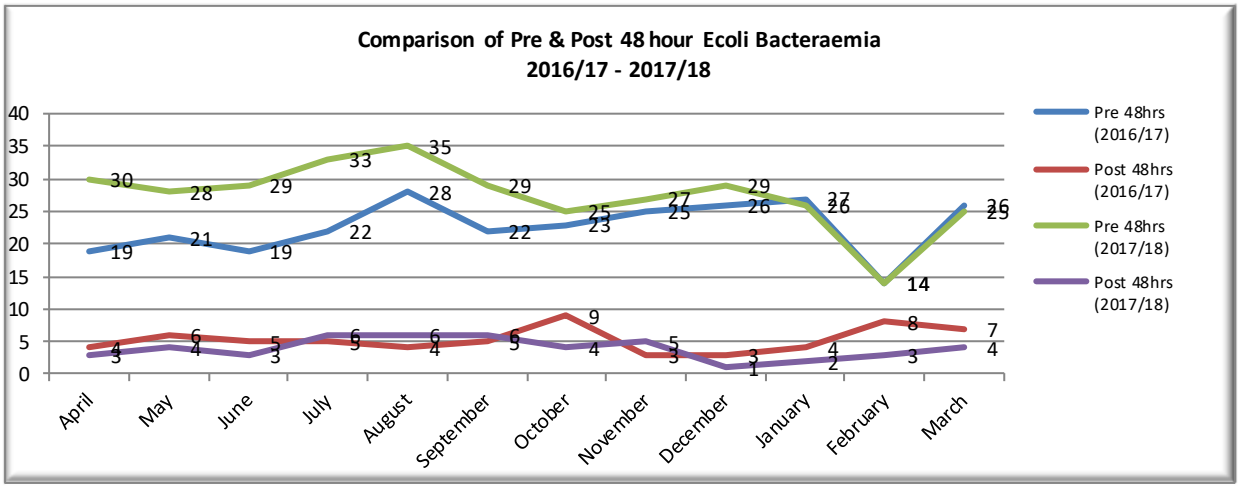
Outbreaks and Periods of Increased Incidence (PIIs)
In line with national guidelines, if there are two or more cases of CDI identified on the same ward within 28 days of each other these are investigated as a PII. Further tests are performed at a specialist reference laboratory to compare the *C. difficile* bacteria and to see if they are the same type (known as ribotyping). Any found to be the same ribotype are considered to be outbreaks. All CDIs related to ESHT as sent routinely for ribotyping to help detect outbreaks.

There were two cases shown to be related to each other that occurred on Gardner ward in quarter 4. Additional control measures were instigated. This was investigated as an Amber serious incident and reported to the patient safety group. No further acquisition occurred.

3.3 *E.coli* Bacteraemias

The reporting of *E.coli* bacteraemia is mandatory for all provider Trusts. This year the Government announced it plans to reduce healthcare associated Gram-negative bloodstream infections in England by 50% by 2021. *E.coli* bacteraemia represents 55% of all Gram negative infections therefore the initial focus is expected to be for Trusts to demonstrate a 10% reduction in both pre and post 48 hour cases with baseline data collected from January 2016 to December 2016. During this period ESHT reported 67 cases of E. coli bacteraemia compared to 49 cases this year, representing a reduction of >20%.

The IPC team is also currently undertaking the *E.coli* bacteraemia primary care data collection on behalf of the CCG under a service level agreement. An upward trend in the numbers of community attributed cases (<48 hours) has been noted.



Urinary tract infection (UTI) is the most common source of these blood stream infections. The data shows that a greater number of people experience UTI during the summer months when the weather is warmer and the risk of associated dehydration increases.

The IPC team reviews all cases of *E.coli* bacteraemia which are thought to be related to hospital acquired catheter associated urinary tract infections (CAUTI). There were six cases related to CAUTI. Post Infection Reviews (PIRs) were completed in collaboration with the urology specialist nurse and clinicians involved in the patients care and once completed they are shared with the divisions.

A Trust wide audit of urinary catheter compliance and management was undertaken to support the Gram negative reduction target. The audit noted that 80% of catheters had documented evidence of review of care. Documentation through use of UCAM form and catheter care passport requires improvement. The findings of the report were disseminated to senior nurses and will inform the forthcoming programme of work.

3.4 Pseudomonas and Klebsiella bacteraemias

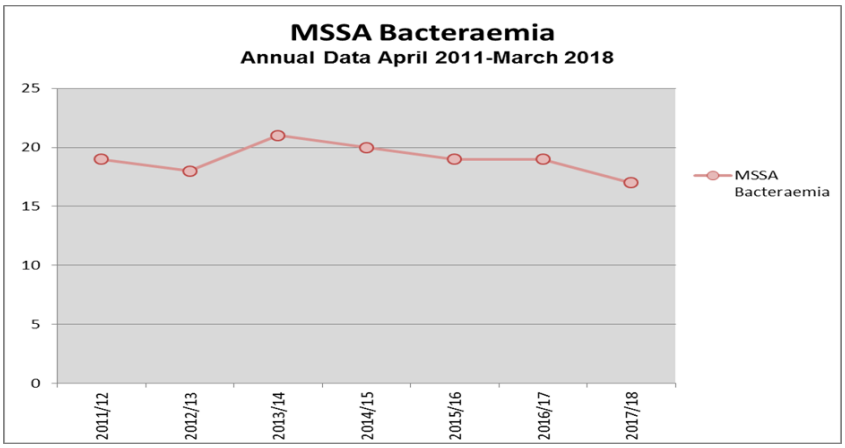
This is the first year of mandatory reporting of Pseudomonas and Klebsiella bacteraemias as part of the new gram negative bacteraemia reduction target. Cases are apportioned according to either community onset (CO) if diagnosed within two day of admission or hospital onset (HO) if diagnosed after this time.

Period	April to June 2017			July to Sept. 2017			Oct. to Dec 2017			Jan to March 2018		
Onset	Total	HO	CO	Total	HO	CO	Total	HO	CO	Total	HO	CO
***Pseudomonas* bacteraemia**	5	2	3	9	2	7	9	2	3	10	5	5
Klebsiella bacteraemia	13	3	10	34	8	26	20	4	16	22	5	17

We will be tracking our progress against the reduction target in the coming year.

3.5 Mandatory reporting of Methicillin sensitive Staphyloccocus aureus

There is no reduction target set for these bloodstream infections. PIR is requested by IPC if it is considered that that the infection is HAI and related to practice i.e. vascular access devices, surgery. The rate of MSSA bacteraemia at ESHT remains stable.



3.6 Mandatory Surgical Site Surveillance

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

Please note: PHE SSISS studies are undertaken prospectively and submitted quarterly but results are published 12 months retrospectively as infection rates are influenced by performance and readmissions within the audit population over each 12 month surveillance period. Finalised results are therefore only available up until end March 2017 although data from April 2017 onwards is within the surveillance system and continues to be analysed and officially reported by the PHE at the end of the following year. ESHT submitted data for the first three quarters of the year (April – December 2016).

Core data 1st April 2016 – 31st March 2017

Category of surgery	Number of procedures	Number of infections	Infection rate	Mean infection rate for all participating Trusts (data April 2011-March 2016)
Total hip replacement	254	2	0.8%	0.6% (95% CI 0.6-0.7%)
Total knee replacement	353	1	0.3%	0.6% (95% CI 0.6-0.6%)

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

There has been an increase in post-operative wound infections in Trauma & Orthopaedic patients during June, July and August 2017.
The Infection Prevention and Control Team have undertaken an investigation to establish if the higher rates represent an outbreak of infection. None of the 11 cases

occurring during the peak incidence or the background cases have been shown to be linked by time, place and person and the same organism.

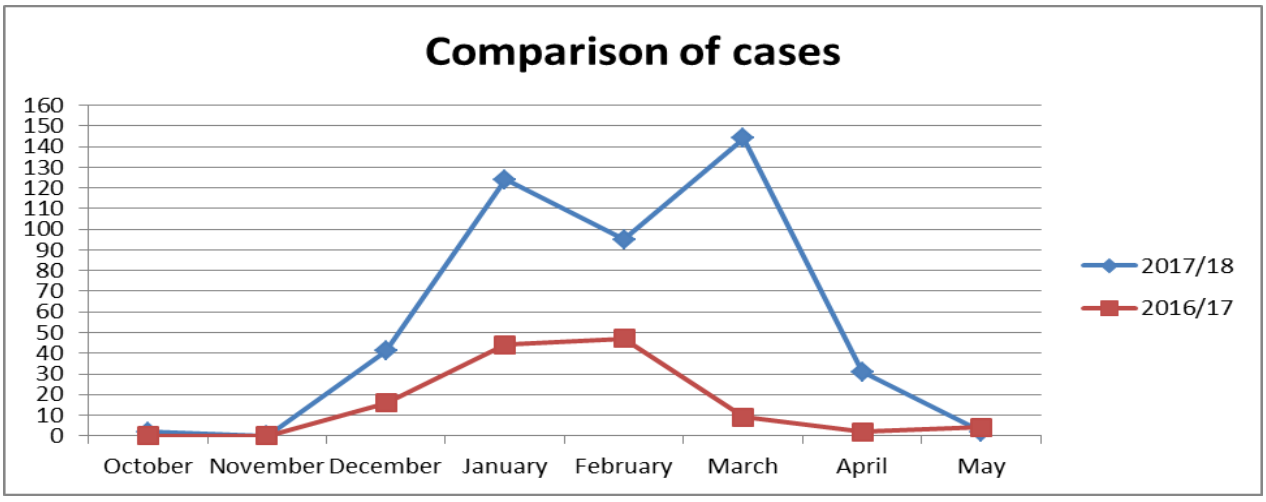
The source of the infections is likely to be from the patient's own bacteria on their skin. During the peak incidence 8 of the 11 cases had MSSA isolated from the wound. Only two samples were available to send for further analysis and they were found to be different. Three further MSSA samples have been sent that were also shown to be different from each other and all the other samples tested. The available microbiological analysis does not indicate an outbreak. An action plan has been commenced to address some practice issues identified during the investigation, which may be contributing to the overall increased rate.

The higher background rate of surgical site infection in hip and knee surgery is being monitored by the orthopaedic surgical site infection surveillance nurse through the national mandatory surveillance of orthopaedic surgical site infection scheme. Ongoing Surveillance of surgical site infection of spinal surgery will be undertaken on as part of the national voluntary scheme under Public Health England (PHE).

3.7 Influenza

All acute trusts are required to report on a weekly basis during the Influenza season the number of cases of Influenza requiring admission to intensive care to determine the burden on critical care units nationally.

At ESHT a total of 415 cases of Influenza were diagnosed from April 2017 to May 2018. 208 were Influenza A, 202 cases were Influenza B, 3 cases tests positive for both Influenza A and B, and 2 cases were positive for Influenza A H1N1 strain. 199 cases occurred at the Conquest Hospital (CH) and 217 cases at Eastbourne District General Hospital (EDGH). A total of 22 patients with Influenza infection were admitted to critical care.



The IPCT responded to each case of Influenza to assess the risk and provide advice to patients and staff. The majority of confirmed Influenza patients presented to the Trust with flu like symptoms on admission indicating that they had acquired the infection in the community (incubation period 1-4 days) but there were several wards at EDGH where patients acquired the infection while on the ward, these incidences occurred when Influenza diagnosis had not been made and at a time of severe operational pressure both locally and nationally. The IPC submitted an internal investigation report to the patient safety group who agreed that this was not representative of a serious incident. The IPC assisted with a serious investigation of one patient who had Influenza on their

death certificate. The outcome was that the increased circulating Influenza resulted in an outbreak on the ward where the patient remained for an extended period due to delayed discharge. Over 70% of ESHT staff were vaccinated against influenza.

4. Incidents related to infection

4.1 Serious Incidents (SIs) and risks managed by the Infection Prevention & Control Team

ESHT reports outbreaks of infection as possible serious incidents to the patient safety group who agree if an SI report or Amber (for internal learning) SI is required. These include incidents where there has been a significant impact on the running of the Trust's services (ward closures for example), or where there has been a severe impact on patient outcome. In addition to this the team undertook 40 risk assessments in response to organisms that could pose a risk to patients and/or staff in order to ensure they were safely managed.

Three serious incidents were investigated and managed by the IPCT. The PIR/RCA investigations and subsequent recommendations and completion of actions are monitored by the TIPCG. The table below provides a brief outline of these incidents.

Month	SI No	Incident
August 2017	2017/21231	Increase in Orthopaedic Surgical Site Infections (see 3.4)
December '17 February '18	Amber SI	Outbreaks of seasonal Influenza on five wards at EDGH.
Feb/Mar 2018	Amber SI	Cross Infection of CDI on Gardner ward
Feb/Mar 2018	Amber SI	Influenza related death. Reported on behalf of Medicine.

4.2 Norovirus

During the winter months Norovirus is often circulating in the community and the risk of outbreaks in the in-patient setting related to Norovirus increases.

- In April 2017 the Coronary Care Unit at Conquest was affected by Norovirus although the Unit was not closed due to the clinical risk. 10 patients were affected with 20 bed days lost.
- The Irvine Unit was also closed due to Norovirus during May with 50 bed days lost and 36 patients affected. The Unit was closed from the 01/05/17 to 12/05/17.
- Tressell ward was closed due to a confirmed outbreak of Norovirus on 30/10/17. 15 out of 28 patients and five staff and one visitor had symptoms. The ward was fully cleaned and opened on 8/11/17.
- Seaford 3 was closed on 14/12/17 with 16 of 28 patients affected. The Irvine Unit was closed on 26/12/17 to admissions and discharges in response to a confirmed outbreak of Norovirus affecting 22 out of 54 patients.

The outbreaks were well managed and wards reopened in accordance with national guidance.

5. Emerging threats and operational preparedness

5.1 Carbapenemase-producing *Enterobacteriaceae*

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

5.2 Operational preparedness

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

6. Infection Prevention Activities and Innovation

6.1 Hand Hygiene Promotion

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

- Monitoring of compliance by clinical staff with monthly audits.
- Monthly hand hygiene promotional posters
- Series of focussed hand hygiene promotion events for staff and patients including participation in the International World Hand Hand Hygiene Day on 4th May 2017.
- Training of ICLFs to facilitate cascade training at local level of practical hand hygiene technique.
- Providing training of all staff on induction (joining the organisation) and at regular mandatory updates.
- Ad-hoc training when indicated for focused improvement.

6.1.2 Hand Hygiene Compliance

Monthly hand hygiene audits are undertaken by ICLFs measuring compliance by healthcare staff in direct contact with patients. Observations are made in each clinical

area and feedback is given at the time of audit by the ICLF. Staff responses are noted as part of the audit and results are monitored to detect trends and act where frequent non-compliance occurs.

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

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

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

Results: 2017/18 *(data obtained from Meridian)*

	Apr 2017	May 2017	June 2017	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Overall Trust compliance (%)	97.43	98.07	99.48	97.99	98.28	99.03	97.88	98.18	95.81	95.33	96.76	98.84
Number of audits undertaken	809	787	726	745	754	783	781	758	704	699	701	648
Number of Non Compliance	20	15	3	13	13	7	19	13	32	32	24	9
Number of letters sent	10	10	2	9	11	5	17	6	6	13	9	0
Areas which submitted 0 audits	5	4	11	4	3	3	6	4	10	6	6	11

In order to validate this data and provide assurance of its accuracy the ICLFs have undertaken peer hand hygiene observations on wards that they don't work on.

6.2 Audit activity

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

The following audits were completed:

- Monthly staff hand hygiene audits (see above)

- Quarterly Peer hand hygiene audits
- National Specification of Cleanliness audits reported and monitored monthly at TIPCG
- Audit of compliance with Control of Carbapenemase Producing *Enterobacteriaceae* (CPE). Audit no. 4027
- Audit of compliance with Diarrhoea Assessment Tool Audit no. 4095
- Re-audit of compliance with the Trust MRSA policy for management of emergency admissions with a known history of MRSA. Audit no.3890

6.3 Training and Education

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

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

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

6.4 Professional Development

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

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

- Infection Prevention Society, London South Branch development days

- Annual Infection Prevention and Control Conference
- Visiting other Trusts to learn from others experiences in implementing programmes of improvement
- Mentoring skills development workshop
- Foundation degree in Health and Social Care
- Public Health Practitioners Register Course
- Functional skills assessment
- MSc in Infection Prevention and Control

7. Housekeeping Services

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

7.1 Deep clean programme

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

7.2 Activity

Housekeeping continued to receive demands from all areas for cleaning support from the Rapid Response Team including single rooms, bed space cleans, and others this averages at about 200+ calls per month per acute site. To meet this demand calls for cleans are prioritised and communication and support is structured from the IPCT and clinical site leads and clear plans are in place at all levels to ensure patient disruption is minimised

7.3 Service development

The Housekeeping department continues to use HPV Hydrogen Peroxide Vaporisation units to support the reduction of infections by destroying organisms, this process is

undertaken by the rapid response team who are on site 24hrs and can be deployed to any site if called upon this will be sustained in the modernisation plan.

8. Antimicrobial Stewardship Activities and Innovation

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

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

8.1 Antimicrobial Prescribing Policy and Guidelines

During 2017/18 the Antimicrobial Prescribing Guidelines for Adults and Children (which contains the antimicrobial formulary of drugs) were made separate documents. The aim of separating the guidance is to improve access for prescribers and streamline the update process. The Paediatric guidance was updated and prescribing guidance was provided to additional indications.

The adult and paediatric guidelines are reviewed, and updated if required, by the ASG on regular basis. The guidance is peer-reviewed, evidence based and specialist Consultants and/or AHP are consulted in writing prescribing advice. The antimicrobial guidelines are available on a smartphone app and desktop.

8.2 Multi-disciplinary Ward Rounds

The Consultant Microbiologists (CMM) and antimicrobial pharmacists continue to participate in daily Intensive Care Multi-disciplinary team ward rounds at both sites. In addition, there are weekly *Clostridium difficile* infection ward rounds, if necessary, at both acute sites and a weekly ward round to discuss immunocompromised haematology-oncology patients on Pevensey ward at EDGH. The aim is to ensure specialist input into the highest risk/most critical patients in the hospitals.

8.3 Training

The Trust antimicrobial e-learning module prescribing has been updated and is available on the internet. All Trust doctors are required to pass this module – as part of

induction or at least every three years. In addition, the Consultant Microbiologists and pharmacy provide face to face teaching about antibiotic prescribing for FY1 and FY2 doctors.

For pharmacy, there is an antibiotic training pack to help support the development of rotational pharmacists in antimicrobial use and prescribing. This training pack is based on the Royal Pharmaceutical Society antimicrobial training guidance.

8.4 European Antibiotics Awareness Day and World Antibiotic Awareness Week

The lead antimicrobial pharmacist led a campaign in November 2017 to promote European Antibiotics Awareness Day and World Antibiotic Awareness Week. The aim was to educate patients and the general public on antibiotics. Activities undertaken were posters in common areas .on the intranet and handing out of leaflets.

8.5 Audits

The lead antimicrobial pharmacist continues to conducts monthly snapshot audits to monitor the quality of antimicrobial prescribing within the Trust. The ward pharmacist undertakes the audit to ascertain the prescribing practice at ward level. Any issues or concerns are highlighted to the appropriate division. The audit data is provided to TIPCG and the ASG..

8.6 Antibiotic Incident reports

The lead antimicrobial pharmacist is also involved in reviewing of incidents reported on Datix involving antimicrobials. An antimicrobial and ward pharmacist, where possible, attend Post Infection Reviews - for example *C. difficile* PIR cases.

8.7 Antibiotic intervention system on eSearcher

During 2016/17 monitoring of restricted antibiotics using the Trusts e-Searcher system was introduced. This facility is available however, it is under-utilised. A vancomycin and gentamicin report has been developed. The report allows for the user to view gentamicin and vancomycin drug levels for all patients reported by Trust pathology for a set period. The aim is ensure any low/high drug levels are highlighted to the ward pharmacist and addressed appropriately.

8.8 Antibiotic CQUIN 2017/18

In 2017/18 antimicrobial stewardship CQUIN indicators for East Sussex Healthcare NHS Trust were to reduce total antibiotic, piperacillin-tazobactam and carbapenem use by 2% against a baseline - 2016 use. The indicators were challenging. The Trust partially achieved the reduction in piperacillin-tazobactam (reduction of 25%), carbapenem (reduction of 22%). The Trust did not meet the indicator for total antimicrobial consumption (increase of 14.7%).

9. Water Safety Incidents

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

As reported previously, elevated counts of *Legionella species* were reported at Conquest Hospital in July 2015. Initial actions and investigations were implemented in line with National guidelines and Trust policy and Public Health England (PHE) was notified. Despite additional control measures there continues to be low levels of mainly non-pneumophila isolated from several areas. A meeting was held with PHE water safety experts and representative from the Estates department, IPCT and the DIPC to seek assurance on the actions taken to date and advice on any further actions required. The situation continues to be monitored by the Water Safety Group. It is believed that insufficient flushing of taps is a factor in the on-going problem with *Legionella species.* However a decision may have to be made in the future to consider a chemical dosing system if it cannot be resolved. No cases of hospital-acquired *Legionella* infection have been detected.

9.2 Isolation of *Pseudomonas aeruginosa* in augmented care

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

10. Clean care award

The quarterly clean care award was introduced during the end of 16/17. To win the award they had to demonstrate the following:

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

Winners of the Clean Care award 2017/18

Quarter 1	Decham Ward, Conquest and Hailsham 2 ,EDGH
Quarter 2	Gardner Ward, Conquest and CCU at EDGH.
Quarter 3	Rye memorial Care ward and CCU at EDGH.
Quarter 4	Richard Ticehurst SAU Conquest and Emergency dept. EDGH

11. Annual Programme of Work / Priorities for 2018/19

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

Gram Negative Bacteraemia Reduction objective = 3 year reduction programme

- Quality Improvement plan
- implementation – Participate in NHSi UTI collaborative

- Work streams for prevention of UTI and CAUTI
- Training and Policy development

MSSA QIST

An 18 month research programme, involving screening and decolonisation of patients for MSSA as well as MRSA; for primary total Hip and Knee replacement surgery in order to reduce surgical site infection rate.

Revised CDI objectives

- Establish benchmark for what our rates will look like under new objectives?
- Agree new categories and definitions with CCG

Patient information

- How to reduce your risk of infection – including action to reduce risk of UTI & CAUTI

Influenza planning

- Support Vaccination programme
- Prepare a business case for near patient testing for Influenza

The above will be incorporated into the Infection Prevention and Control's Annual Programme of Work and monitored through the Infection Prevention and Control's integrated action plan.

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

East Sussex Healthcare NHS Trust

Annual Safeguarding Report

2017 - 2018

Contents

East Sussex Healthcare NHS Trust Annual Safeguarding Report

1.0 - Introduction

The 2017– 2018 Annual Safeguarding Report provides the East Sussex Healthcare NHS Trust (ESHT) Board with an overview of; the safeguarding work undertaken during the year, the planned work to further improve safeguarding practice in 2018 – 2019 and an assurance position on the Trust's compliance with the legislative and regulatory framework. This includes;

- Working Together to Safeguard Children (2013, 2015, 2018)
- Children Act (1984, 2004) ESHT must be able to demonstrate that it safeguards children who access our care under section 11.
- Safeguarding Vulnerable Adults in line with the Care Act 2014 and Department of Health Care and Support Statutory Guidance issues under the Care Act 2014.
- The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment 2007.
- The Modern Slavery Act 2015

2.0 - Safeguarding Governance

2.1 ESHT Safeguarding

Providers of NHS funded healthcare are required by NHS England to comply with the Safeguarding Vulnerable People in the NHS – Accountability Framework (2015). ESHT needs to demonstrate is has effective arrangements to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and their commissioners that these arrangements are working. These arrangements include;

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable adults, as appropriate.
- A suite of policies including a chaperone policy
- Effective safeguarding training of all staff commensurate with their role and in accordance with; Safeguarding Children and Young People: roles and competences for healthcare staff (Royal College of Paediatrics and Child Health, 2015) and Looked -After Children: Knowledge, skills and competences of healthcare staff (Royal College of Paediatrics and Child Health, 2016).
- Effective supervision arrangements for staff working with children/ families or adults at risk of abuse or neglect.
- Effective arrangements for engaging and working in partnership with other agencies
- Named Safeguarding Professionals
- Head of Safeguarding, Named Nurse Adult Safeguarding / Mental Capacity Act assessment Lead.
- Compliance with the Head of Safeguarding having a statutory role for managing adult safeguarding allegations against staff, alongside HR colleagues.
- Developing an organisational culture where all staff are aware of their personal responsibility to report concerns and to ensure poor practice is identified and tackled.
- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance, including MCA (2005) and the Children's Act (1989 and 2004).

The Intercollegiate Document 2014 requires NHS organisations to have structured safeguarding leadership with clinical and safeguarding expertise. The Director of Nursing is the Executive Lead and strategically leads the safeguarding agenda, the Deputy Director of Nursing, who has corporate responsibility to ensure effective trust wide safeguarding; expertise, arrangements and reporting are in place. The Deputy Director of Nursing supports the Head of Safeguarding and

safeguarding team, and co-ordinates with the Associate Directors of Nursing; who are responsible for ensuring robust safeguarding arrangements and practice in each clinical division.

The governance and reporting arrangements, to provide floor to Board scrutiny and assurance, in place reflect the organisational structure divisionally and corporately. The Safeguarding Operational Group and Divisional Governance Meetings are held monthly and report into the bi-monthly Strategic Children and Adults Safeguarding Group, which reports to the Trust Board via its' Quality and Safety Committee.

ESHT safeguarding policies for adults and children set out the key arrangements for safeguarding practice, roles and responsibilities. During 2017 – 2018;

- Safeguarding governance structures have been revised to improve operational understanding of safeguarding responsibilities.
- The Safeguarding Children Policy has been updated to reflect current safeguarding issues, including Child Sexual Exploitation, County Lines and Trafficking.
- A Policy for Allegations of Abuse against Staff, was introduced replacing the Policy for Allegations of Child Abuse against staff, to ensure it is relevant to both adult and child safeguarding.
- Compliance with all safeguarding policies being in date was maintained at 100%.

Divisional safeguarding reporting, via a standardised reporting tool, has improved visibility of safeguarding practice in divisions, highlighted challenges and shared them for resolution. These reports are a standing item at every Strategic Children and Adults Safeguarding Group meeting. There is increasing divisional ownership and engagement across the safeguarding agenda and a resulting increase in workload for the safeguarding team.

2.2 System Safeguarding

The legislative and regulatory safeguarding requirements set out duties for ESHT to co-operate and support wider system safeguarding practice with our statutory partners, the Local Authority and the Police. The Director of Nursing is a member of both the Local Safeguarding Adults and the Local Safeguarding Children's Boards in East Sussex. The Head of Safeguarding and members of the team fully support the sub-committees, groups and processes of both safeguarding boards enabling ESHT to drive forward both the national and local safeguarding agenda in partnership. This supports ESHT to actively learn from safeguarding reviews, partner agency reports, national safeguarding challenges and local issues to drive improvements in our practice.

Safeguarding staff are involved in the East Sussex Better Together (ESBT) programme, developing integrated health and social care for the residents of East Sussex. The team provide safeguarding advice and expertise to a range of colleagues.

2.3 Care Quality Commission (CQC) inspection

The CQC inspection of the Trust in March 2018, reviewed safeguarding arrangements both corporately and within the divisions. Whilst noting the significant improvements from their previous inspection, they found;

- There were robust safeguarding adults and children arrangements that were in line with current national guidance.
- The Trust had 'done much work on staff responsibilities in respect of the Mental Capacity Act, 2005, all Deprivation of Liberty Safeguard applications were appropriate and referrals to the Court of Protection were made when necessary.

- Staff knew how to access the safeguarding team and explained clearly how to make a safeguarding referral. Each area had a safeguarding champion who linked to the Trust's safeguarding team. Safeguarding vulnerable adults, children and young people was given sufficient priority.
- The Annual Report (2016-2017) provided evidence of learning from safeguarding incidents within the organisation and also from external reviews and investigations.
- Staff the CQC spoke with had the correct level of safeguarding training for their roles. However there were specific areas where compliance fell below expected standards; overall completion rate for medical and dental staff in Medicine was 83.4%, not all nursing staff in outpatient clinics where children were catered for were trained to safeguarding children level 3.
- Whilst training rates for the Mental Capacity Act (2005) exceeded the Trust's target of 90% and staff demonstrated good knowledge of this, monthly audits indicated low compliance with documentation relating to mental capacity assessments in some areas.

Overall, the Trust Board can be assured that it has robust safeguarding arrangements in place, that it can evidence learning through safeguarding leading to change and that staff have a commitment to safeguarding the people using our services. However, there will always be further improvements, changing requirements and best practice to embed through the organisation.

3.0 - Key Achievements in Safeguarding 2017 – 2018

- Restructured the safeguarding team, within current resource, to provide clarity on roles, fulfil requirements and increase visibility and clinical presence in clinical areas.
- Redesigned the Mental Capacity Act and Deprivation of Liberty training and support to staff, moving to e-solutions, following a review of training and staff knowledge. Our staff now have access to the NHS Safeguarding app.
- Revised collaborative working arrangements with Sussex Partnership NHS Foundation Trust to ensure compliance and improved practice with the Mental Health Act (2007) where detained patients are admitted to our inpatient beds.
- Delivered training, using a risk based approach, to key teams in ESHT to ensure the rights of patients detained under the Mental Health Act are safeguarded.
- Refined safeguarding governance systems and processes delivering increased collaborative working with the divisions and visible assurance information for the Board.
- Implemented the mandatory Child Protection Information System (CP-IS) in the emergency departments to ensure clinicians are supported to safeguard children.
- Successfully as a system, with CCG safeguarding colleagues, secured external funding for an Independent Domestic Violence Advisor (IDVA) who works with the emergency departments, maternity services and Special Care Baby Unit to improve practice and support affected persons.
- Raised the PREVENT profile across the Trust through awareness and targeted WRAP training.

Throughout 2017–2018 ESHT is changing practice as a result of safeguarding learning, including;

- Maternity services are improving their practice and documentation in relation to pregnant women and domestic abuse (Domestic Homicide Review)
- Developing a programme to support staff who are working with patients who self-neglect (Safeguarding Adult Review)
- Safeguarding learning will inform the work underway regarding discharge planning (Safeguarding Adult Review)
- Level 3 safeguarding training (being implemented from 1st April 2018) will include domestic violence training to improve staff knowledge and help staff to support our patients (Domestic Homicide Review)

- Child S Serious Case Review learning focused on a lack of clinical supervision and a need for improved management of non-engagement. Health Visiting staff now have regular clinical supervision and the Did Not Attend/Was Not Brought Policy has been expanded to include further guidance on non-engagement. Additional training on management of engagement challenges has been delivered to Locality Managers by the Community Named Nurse.

4.0 - National Context

4.1 Child Safeguarding Arrangements

The Wood Report: was a review of the role and functions of Local Safeguarding Children boards (2016) setting out a new framework for improving the organisation and delivery of multi-agency arrangements to protect and safeguard children. The recommendations apply to the Local Safeguarding Children boards themselves, Serious Case Review and Child Death Overview Panel processes. The East Sussex child safeguarding system progresses the local work to respond to the Wood Report recommendations, and whilst the impact of any changes is not yet known, health remains a statutory partner in safeguarding children.

4.2 Learning Disabilities (LD) Mortality Review Programme (LEDER)

ESHT fully participates in the LEDER programme, which ensures that all deaths of people with learning disabilities aged 4 years and over, are subject to external review following the nationally mandated processes. These reviews ensure all appropriate health and care records from all providers involved with the person are reviewed to identify learning.

The Deputy Director of Nursing represents the Trust on the East Sussex and Surrey STP LEDER Steering Group, which reports into the STP Transforming Care Group. The LEDER steering group ensures a collaborative commissioner and provider approach to investigation, learning across the STP and sharing of best practice to influence how services are provided the residents with LD.

4.3 Policing and Crime Act, 2017

The introduction of the Policing and Crime Act in December 2017 removed the use of police cells as places of safety for under 18 year olds, restricted the use of police cells as places of safety for adults being held under the Mental Health Act (2007); Section 135/6 powers, reducing the length of time someone can be held from 72 hours to 24 hours.

Senior Trust staff and the safeguarding team have collaborated with the key stakeholders across the STP to agree aligned processes and procedures to implement the revised legislation locally. ESHT have seen, alongside other healthcare providers, an increase in mental health related presentations to our emergency departments. This picture is being reflected nationally and local partnership work continues to ensure people are safeguarded.

4.4 Multi –agency Female Genital Mutilation (FGM) guidance

ESHT has effective arrangements in place to meet the requirements set out in the Home Office guidance for FGM. The FGM Lead is responsible for all mandatory returns, monitoring local incidences of FGM and staff training and support to ensure we can identify females at risk, detect FGM and report it effectively.

ESHT identified and reported 11 cases of FGM between April 2017 and March 2018. This is the first full year of data collection, with robust comparative data not yet available. All cases were reported to children’s social care for follow up.

4.5 Independent Inquiry into Child Sexual Abuse (Goddard Inquiry)

The Goddard Inquiry was set up from July 2014 to investigate institutional child sex abuse following the death of Jimmy Saville. The safeguarding team have proactively worked with ESHT staff to increase awareness of child sexual exploitation and abuse. ESHT have undertaken audits of high risk children, already known to the Missing and Sexual Exploitation Group, who attended our emergency departments. There is a weekly meeting to identify specific high risk children are flagged for updating information, discussion and planning at the Missing and Sexual Exploitation Group to safeguard them.

The Named Safeguarding Nurse for Community represents ESHT at the Missing and Sexual Exploitation Group and ensures learning which is shared with the Trust. Child Safeguarding training, policies, procedures and checks have all been reviewed in response to improve awareness and action in response to these risks to children. Training focuses on ensuring staff are aware of the risk factors that make children and young people increasingly at risk of being missing and/or sexually exploited. It is known that these risks can increase a child or young person's risk of further exploitation in relation to being trafficked.

East Sussex has a sizeable population of Looked After Children. This group, particularly those placed by other local authorities into the county, are known to be particularly vulnerable. ESHT has a significant role in relation to safeguarding children from this type of organised abuse.

4.6 County Lines

ESHT has supported all multi-agency work to identify children at risk of criminal and sexual exploitation. In 2017, Operation Rattle was launched to support children experiencing similar forms of exploitation. This includes being drawn into serious crime including drug dealing and being pressured to carry weapons. 'County Lines' is the term used to describe the distribution of drugs from major cities into the counties. This approach exploits vulnerable adults and children through; 'cuckooing' where drug dealers take over the house of a vulnerable adult and supply drugs from the address, using children as runners.

ESHT staff must remain vigilant of the potential for exploitation. Intelligence has highlighted young males are particularly at risk of being criminally exploited and abused and staff receive awareness training in relation to the additional barriers young men may have to disclosing sexual abuse.

4.7 Modern Slavery

East Sussex LSCB, including its partner members, has pledged to reduce the risk of children being sexually exploited, trafficked or going missing from/ in East Sussex. Section 54(1) of the Modern Slavery Act (2015), places a legal requirement on ESHT to prepare our staff to identify patients at risk of modern slavery and being trafficked. Whilst it is not a mandated requirement yet to provide information centrally, we have identified suspected cases in 2017-2018, which have been reported to the police.

4.8 The Care Act (2014) - Making Safeguarding Personal

The Care Act, 2014 defined safeguarding adults as 'protecting an adult's right to live in safety, free from abuse and neglect'. Making Safeguarding Personal (MSP) defines an approach to safeguarding which focuses on outcomes rather than process. It aims to answer, in partnership with the adult at risk / their advocate, three questions;

- What difference would they want or desire?
- How will you work with someone to enable that to happen?
- How will you know a difference has been made?

It has been agreed that to enable ESHT to deliver MSP focused safeguarding practice, a framework of reflection and revised training alongside the learning from complaints, safeguarding enquiries and case reviews is required. An approach will be developed in 2018-2019.

4.9 PREVENT

The Head of Safeguarding is the Trust lead for the PREVENT programme, which supports the local and national counter terrorism strategy, and is a requirement under the Counter Terrorism and Security Act, 2015.

Locally the Trust is active in the PREVENT Board and submits numbers of PREVENT referrals from health quarterly. Safeguarding training has PREVENT training embedded within it for both children and adults, as radicalisation is considered comparable with other forms of exploitation. There were no referrals under PREVENT in 2017 – 2018.

4.10 Multiagency Risk Assessment Conference (MARAC)

MARAC is a multiagency forum managing high risk cases of domestic abuse, stalking and honour based violence. Chaired by the police, they bring together statutory and voluntary partner organisations to share information and work collaboratively to safeguard the person at risk by developing a coordinated plan of protection.

ESHT are members of both MARACs in East Sussex, where specialist nurses and midwives represent the Trust. Confirmed cases of domestic abuse are flagged on patient administration systems at the Trust to alert staff working with the individual. To strengthen arrangements at the Conquest, the Care, Grow, Love organisation and the Hastings and Rother CCG have funded an Independent Domestic Violence Advisor for 12 months. This post will focus on supporting staff to identify domestic abuse and through the process of referral, once made.

5.0 - Local Case Reviews

5.1 Adult A

Adult A was a 64 year old man, who lived in a care home in East Sussex, commissioned for him by his local CCG in Kent. At the time of his death he was deemed to lack the mental capacity to decide where to live and was subject to a Deprivation of Liberties (DOLS) order. There were concerns, for this gentleman, about self-neglect as he often refused care.

The case review identified wide learning for a number of organisations involved. There was one recommendation for ESHT, to review record keeping and information sharing between agencies and make proposals for transferring information with particular reference to hospital discharge.

These recommendations are being progressed by the Head of Safeguarding and Adult Social Care Operational Lead for acute hospitals. The work is aligned with the wider discharge work being led operationally by the Deputy Chief Operating Officer.

5.2 Child S

Two children aged 7 and 22 months were identified as suffering from hidden neglect and, in the case of the older child -unaddressed impairments. Both now require lifelong medical treatment. The parent had successfully distanced professionals and family from the home.

There was learning across all organisations involved. For ESHT specific learning was identified in relation to;

- Professionals being able to recognise and act upon the signs of neglect
- Escalation of concerns when families are hard to engage
- A greater need for professional curiosity

Actions to embed the learning and change practice are being taken forward in the Health Visiting Service regarding routine appointments and improved reporting of concerns. Clinical supervision has been re-invigorated with robust documentation and a system of compliance for health visitor visits. This is the responsibility of the Integrated Health Visitor and Key Worker Service.

5.3 Domestic Homicide Review – Adult E

A woman, in her early 20s was the subject of domestic abuse and knew the perpetrator. For ESHT, learning is focused on the importance of front line staff in being professionally curious, recognising and reporting domestic abuse particularly in ED and Maternity Services. Learning is being embedded in practice through;

- Safeguarding training, which includes domestic abuse.
- Mandating the completion of an Additional Support Form (ASF) for all women who have a past history of substance misuse, domestic abuse and/or mental health concerns.
- Implementation of a discrete notification, on hand held records, to support community midwives to track whether women have been asked the domestic abuse screening questions.
- At least one mandated, home visit for all women with an ASF form during their antenatal care.

The changes to practice are being audited and will be monitored at the Safeguarding Children and Adults Strategic Group.

6.0 - Safeguarding Work plans

The work plans for all aspects of safeguarding and learning disabilities and the processes for reviewing and reporting progress, risks and compliance was revised as part of the overall review of safeguarding governance. There is now one annual work plan which contains the learning, mitigations and the planned developments and improvements in relation to national, regional and local guidance.

The Safeguarding Children and Adults Strategic Group monitors progress, compliance and risk management through the Head of Safeguarding Report and the Divisional Safeguarding Reports received at each meeting.

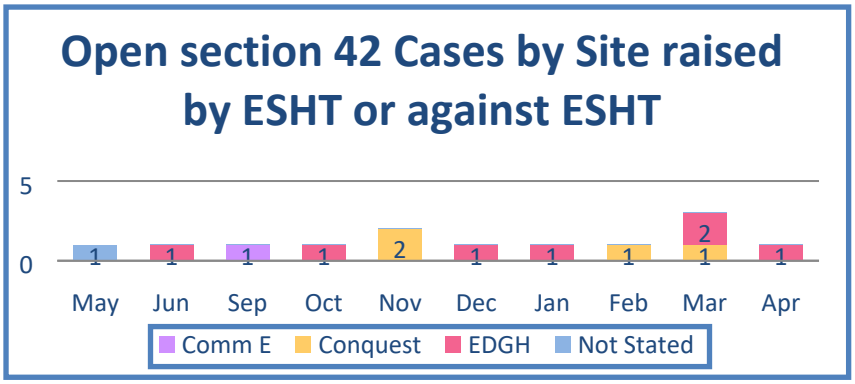
The work plan for 2017-2018 has been completed, although it is recognised the cultural change work regarding domestic abuse, safeguarding reporting and MCA will continue each year. The high level work plan for 2018- 2019 is included in this report as Appendix 1.

7.0 - Safeguarding Activity

7.1 Adult Safeguarding referrals

Safeguarding referrals can be raised by staff, patients, family members or the public and are received by Social Care, who apply three key tests to decide if the concern raised meets the threshold for a Section 42 Adult Safeguarding concern.

Table1: Section 42 safeguarding enquiries accepted by ASC.

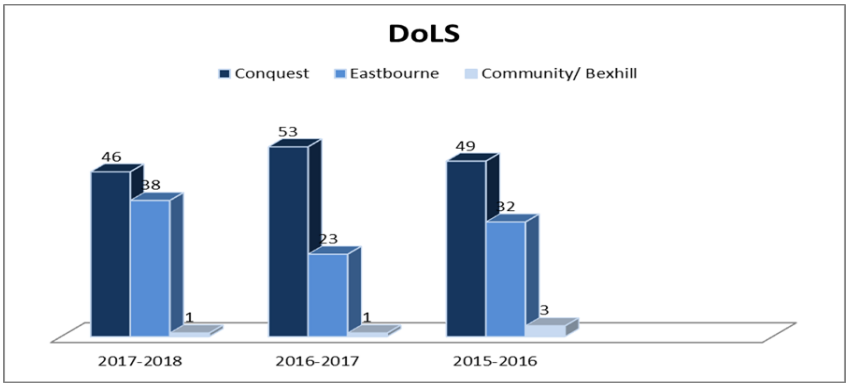


There has been an increase in the number of concerns raised, compared with the previous year. However, as expected the numbers of reports related to 'newer' safeguarding concerns e.g. modern slavery. The safeguarding team will continue to focus on front line staff awareness of safeguarding and how to raise concerns as this is the best way to ensure the trust captures concerns and safeguards people in a timely way.

7.2 Deprivation of Liberties (DOLS)

ESHT monitors all Deprivation of Liberties applications for authorisation by the Local Authority. During 2017-2018 the number of referrals and authorisations remained consistent each quarter

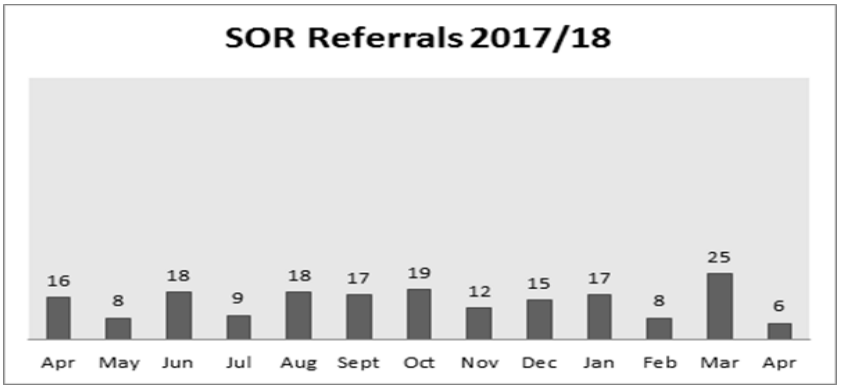
Table 3: Deprivation of Liberties activity 2015 – 2018



7.3 Safeguarding Children Referrals

Child safeguarding referral activity has remained unchanged over the last three years, as set out in Table 2

Table 2: Safeguarding Children Statement of Referrals

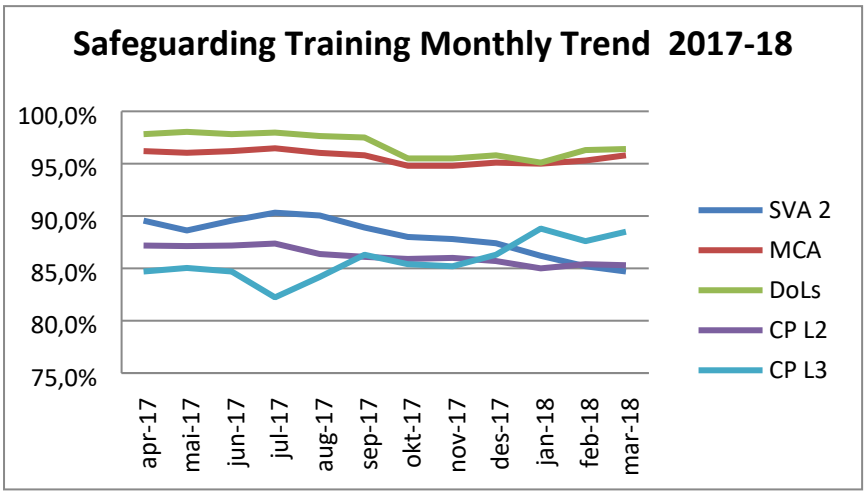


Children referred may have a Child Protection Plan (CPP) which indicates they are considered to be in need of protection from either neglect, physical, sexual or emotional abuse or a combination of one or more of these. The CPP details the concern and actions being taken to mitigate these and outcomes. In East Sussex the number of children with a CPP has remained unchanged at 476 as at March 2018.

7.4 Safeguarding Training

The safeguarding team completed a training needs analysis in 2017, reviewing which staff needed which training to support their roles. Training compliance at Trust level (table 3) demonstrates commitment to training, with the CQC inspection in March 2018 reporting staff knowledge was generally good.

Table 3: Safeguarding Training compliance 2017-2018



In December 2017, the safeguarding team identified a number of staff who worked with children, whilst recognising it was not their main work, and to whom the requirement for Level 3 Child Safeguarding now applies. The teams within the divisions affected are working with the safeguarding team to improve compliance for these staff with a target of 85% compliance in Autumn 2018.

7.5 Safeguarding Supervision

In 2017-2018 safeguarding supervision has been provided formally to paediatric and maternity staff. It is know that 'effective safeguarding supervision has a significant function in maintaining

focus on the child' (Intercollegiate Document, RCPCH, 2015) as the requirements relate to child safeguarding at present.

The Trust is launching its safeguarding supervision policy for nurses who predominantly work with adults.

8.0 - The Mental Health Act – ESHT Duties

There is a service level agreement with Sussex Partnership NHS Foundation Trust (SPFT) to enable the Trust to meet its legal requirements to ensure patients admitted to our inpatient beds have their rights maintained and their mental health care needs are met by the Responsible mental health clinician.

The Deputy Director of Nursing instigated regular meetings to monitor ESHT compliance and to work collaboratively with SPFT team to address any issues with non-compliance. This work has enabled the following:

- The site team have all been trained to undertake the duties of the receiving officer and maintain detained patients' rights.
- Section 135/136 training for ED staff continues to be delivered.
- Revision of the Policy for the Mental Health Act to support staff
- Audit agreements to be reached with SPFT to begin to measure compliance more systematically
- Completion and submission of the KP90 return on mental health activity

9.0 - Looked After Children

During 2017-2018 the Looked after Children arrangements within ESHT were reviewed. This led to the role of Named Nurse for Looked after Children being separated from the Designated Nurse for Looked after Children, ensuring compliance with a recommendation from a previous Inspection of Special Educational Needs and Disabilities Legislation (ISEND) inspection in 2016. The Named nurse for Looked after Children is a statutory role for ESHT as a provider of NHS funded services. The Designated Nurse for Looked after Children sits within the CCG.

ESHT is locally commissioned to provide the operational Looked after Children's health services as nationally defined. In 2017-2018, it was agreed that the operational service would move to the Women, Child and Sexual Health Division. The division have undertaken significant work with the Local Authority to improve the timeliness of health assessments and will continue to improve in 2018-2019. There is a separate Annual Report for Looked after Children which is being written by Women's & Children's Division with Named Nurse input.

10.0 - Learning Disabilities

The Trust has a Lead Nurse for Learning Disabilities, supporting and facilitating equality of care, access and treatment for children and adults with learning disabilities when they use ESHT services, ensuring
our compliance with the Mental Capacity Act (2005) and the Equalities Act (2010) through training and clinical support.

There is a network of LD champions across all sites to promote best practice, which are supported by monthly network events, role update sessions and education around specific areas. The Lead Nurse for LD represents the Trust in the wider system and is a member of the Strategic Group.

11.0 - Conclusion

During 2017-2018 ESHT has given safeguarding a higher profile and requested greater assurance that the organisation is meeting its statutory and legislative duties. The Director of Nursing leads the strategic direction with strong senior leadership from the Deputy Director of Nursing. The improved governance and reporting has provided a platform to promote divisional ownership and drive improvements. The CQC reported arrangements are robust and the Trust is supported by an expert team to deliver its functions.

The commitment to continue to improve front line staff practice and knowledge to enable ESHT to better safeguard the people using its services remains strong, and we are looking forward to a challenging year ahead.

Name: Sue Curties, Head of Safeguarding

Date: 12th September 2018

References

Intercollegiate Document: Safeguarding Children and Young People roles and competencies for healthcare staff (2014) Royal College of Paediatric and Child Health.

Intercollegiate Role Framework: Locked After Children Knowledge, Skill and Competences of healthcare staff (March 2015) Royal College of Paediatric and Child Health

Adult Safeguarding: Roles and Competencies for Health Care Staff (First edition: August 2018) Royal College of Nursing

Mental Capacity Act 2005 and the Deprivation of Liberties Code of Practice
https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

Equality Act (2010) HM Government

Working Together to Safeguard Children (2013,2015,2018) HM Government

Children Act (1984, 2004) HM Government

Care Act (2014) HM Government

The Modern Slavery Act (2015) HM Government

SAFEGUARDING WORKPLAN 2018/2019

APPENDIX 1 - Workplan

Action Number	Source	Requirement	Action	Executive Lead	Responsible PERSON	Progress
1	Children Act 1989 and 2004 and the Care Act 2014.	East Sussex Healthcare NHS Trust Safeguarding Team must ensure that it meets its statutory responsibilities identified within the Children Act 1989 and 2004 and the Care Act 2014.	Comply with the legislative guidance within the Safeguarding Acts and meet the statutory responsibilities Tranining compliance all staff all settings Documentation of MCA processes in records	DON	Head of Safeguarding	
2	Children Act (2014) Section 11 Audit	To ensure the duties of the Section 11(Children Act 2004) are complied with.	Complete section 11 action plan to address non compliances / improve pacrice.	DON	Head of Safeguarding April 2019	
3	LSCB SCR	To undertake the LSCB Child T Case Review	Investigate SCR and complete all actions to implement recommendations following publication by LSCB	DON	Named Nurses for children	
4	SAB SAAR	To undertake the Adult B Case Review	Complete all actions to implement recommendations following publication	DON	Named Nurse for adults	
5	NHSE/ NHSI	To comply with the LD Improvement Standards for NHS Trusts (2018)	Baseline assessment and action plan to address any concomplinaces with LD standards to achieve ESHT compliance	DON	Specialist Nurse Learning Disability	
6	CQC / Safeguarding Legisaltion	Competent and trained workforce who are able to discharge their safeguarding responsibilities in line with the Safeguarding Roles and Responsibilities (Intercollegiate Documents)	All divisions to meet standards of compliance with training and remedial action plans in place to address any non compliances	DON	Assistant Directors of Nursing April 2019	
7	CQC / Safeguarding Legisaltion	To ensure that there is a competent and trained workforce who are able to discharge their safeguarding responsibilities in line with the Safeguarding Roles and Responsibilities (Intercollegiate Documents)	All divisions to meet standards of compliance with safeguarding supervision and remedial action plans in place to address any non compliances	DON	Assistant Directors of Nursing April 2019	
8	Mental Health Act (2017)	To comply with the requirements set for acute NHS providers in relation to detained patients and staff competency	To comply with the legislative guidance within the Mental Health Act and meet the statutory responsibilities	DON	Deputy Chief Operating Officer	
9	Mental Health Act (2017)	To ensure the annual KP90 return is submitted for ESHT	Complete and submit the KP90 return annually	DON	Deputy Director of Nursing	
10	Prevent Statutory Duty (s26 Counter-Terrorism and Security Act 2015) to safeguard	To meet the statutory requirement to promote the national PREVENT strategy at a local level throughout the NHS	Ensure that there is a nominated lead for PREVENT, staff are trained in PREVENT Awareness and WRAP, and that the quarterly PREVENT return is submitted for ESHT	DON	Head of Safeguarding	
11	Female Genital Mutilation (FGM) Statutory Duty to safeguard	To meet the statutory requirement to promote the national FGM strategy at a local level throughout the NHS	Ensure that there is a lead for FGM, staff receive training in FGM Awareness at the appropriate level, and the quarterly FGM Return is submitted for ESHT	DON	Named Midwife	