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 April 2019, commencing at 09:30 in Manor Barn, 4 De La Warr Road, Bexhill-on-Sea, TN40 2JA

	AGENDA		Lead:	Time:
1.	1.1 Chair's opening remarks 1.2 Apologies for absence 1.3 Monthly award winner(s)		Chair	0930 - 1015
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 5th February 2019	A		
4.	Matters arising	B		
5.	Quality Walks Board Feedback	C	Chair	
6.	Board Committee Chair's Feedback		Committee Chairs	
7.	Board Assurance Framework	D	DCA	
8.	Chief Executive's Report	E	CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
9.	Integrated Performance Report Month 11 (February) 1. Quality and Safety 2. Access, Delivery & Activity 3. Leadership and Culture 4. Finance	Assurance	F	DN/MD COO HRD DF	1015 - 1120
10.	Learning From Deaths (Quarter 2)	Assurance	G	MD	
11.	Seven Day Working	Assurance	H	MD	

BREAK

STRATEGY

					Time:
12.	East Sussex Integrated System Governance	Assurance	I	CEO	1135 - 1215
13.	2019/20 Plans Update	Assurance	J	DS	

14.	Quality Improvement Priorities	Assurance	K	DN	

GOVERNANCE AND ASSURANCE

					Time:
15.	Delivering same sex accommodation annual declaration of compliance	Assurance	L	DN	1215 - 1230
16.	Delegation of approval of Annual Report and Accounts 2018/19	Assurance		DCO	
17.	Annual Self-Certification	Assurance	M	DCO	
18.	Board Sub Committee Minutes	Assurance	N		

ITEMS FOR INFORMATION

				Time:
19.	Questions from members of the public (15 minutes maximum)		Chair	1230 - 1245
20.	Date of Next Meeting: Tuesday 4th June, St Mary's Boardroom, EDGH		Chair	

Steve Phoenix

Chair man

4th March 2019

4th

Key:	
Chair	Trust Chairman
CEO	Chief Executive
COO	Chief Operating Officer
DCA	Director of Corporate Affairs
DS	Director of Strategy
DF	Director of Finance
DN	Director of Nursing
HRD	Director of Human Resources
MD	Medical Director

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 5th February 2019 at 09:30 in the Oak Room, Hastings Centre, Hastings.

Present: Mr Steve Phoenix, Chairman
Mr Barry Nealon, Vice Chairman
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Dr Adrian Bull, Chief Executive
Ms Catherine Ashton, Director of Strategy
Mrs Vikki Carruth, Director of Nursing
Mrs Joe Chadwick-Bell, Chief Operating Officer
Miss Monica Green, Director of Human Resources
Mr Jonathan Reid, Director of Finance
Dr David Walker, Medical Director
Mrs Lynette Wells, Director of Corporate Affairs

In attendance:
Mrs Angela Ambler, NHSI Next NED Programme
Mr Mark Friedman, Director of Recovery
Miss Jan Humber, Joint Staff Committee Chairman
Mr Christopher Langley, System Improvement Director
Mr Adam Finnie, Deputy Health promoter and Making Every Contact Count Team (for item 05/2019 only)
Ms Penny Walker, Making Every Contact Count Lead (for item 05/2019 only)
Mr Peter Palmer, Assistant Company Secretary (minutes)

001/2019 **Welcome**

1. Chair's Opening Remarks
Mr Phoenix welcomed everyone to the meeting of the Trust Board held in public, noting that this was his first Board meeting as Chair of the Trust. He praised the contribution of his predecessor, David Clayton-Smith, noting the huge impact that he had made to the Trust during his time. He thanked him for the legacy and platform that he had left and hoped that he would be able to build on the work that Mr Clayton-Smith had done.

2. Apologies for Absence
Mr Phoenix reported that apologies for absence had been received from:

Mrs Miranda Kavanagh, Non-Executive Director
Mrs Karen Manson, Non-Executive Director
Mrs Nicki Webber, Non-Executive Director

3. Monthly Award Winners
Mr Phoenix advised that the monthly award winner for November had been Giles Smith, an Occupational Therapist with the Hospital intervention Team at EDGH.

The winners for December had been Emma Jones-Davies, Emma Tate and

Sammi Foy who formed the Clinical Improvement Team.

002/2019 **Declarations of Interest**

In accordance with the Trust's Standing Orders that directors should formally disclose any interests in items of business at the meeting, the Chairman noted that no potential conflicts of interest had been declared.

003/2019 **Minutes**

The minutes of the Trust Board meeting held on 4th December 2018 were considered. Mrs Carruth noted an error on page two where the mentioned Never Event concerned a retained needle and not a diagnostic procedure.

004/2019 **Matters Arising**

There were two matters arising from the previous meeting, both of which had been completed.

005/2019 **Health Promotion at ESHT**

Ms Walker and Mr Finnie provided a brief overview of the successes of the Making Every Contact Count (MECC) scheme, which had been introduced to the Trust in 2015. This scheme aimed to motivate people to lead healthier lifestyles by utilising the regular contacts that staff had with members of the public. In 2016/17, the Trust became a health promoting trust, bringing together all aspects of health and wellbeing for staff and patients, working to meet an international standard.

Approximately 3,000 staff had undertaken MECC training since 2015. A large focus of the training programme was on the reduction of risky behaviours, such as smoking and drinking alcohol. MECC's benefits were not just in stopping unhealthy lifestyle choices, but also reducing inpatient stays and demand on the Trust.

Other successes of MECC included around 1,000 NHS health checks carried out on Trust staff over the age of 40 in 2016. Active travel options had been implemented to encourage healthier travel options and the quality of food in the canteen had improved, with healthier options available.

The project's next steps would include looking at Family and Friends feedback and meeting international standards for health promotion. Work was being undertaken with partner agencies including public health and the CCG, and other organisations had been in contact with the Trust for advice about implementing their own schemes.

Miss Green asked how the impact of the work was measured. Mr Finnie explained that it was hard to measure MECC conversations as they happened naturally. Conversations were recorded in the community on SystmOne, but were not recorded in the acute setting. One of the main measurable outcomes was the number of outgoing referrals to lifestyle providers, which had increased. Patient feedback also showed an improving picture of outcomes for patients. Feedback was also received from the annual Staff Survey, and from staff following training.

Dr Bull asked about the focus on smoking in pregnant mothers as part of the better births campaign. Ms Walker explained that following work with staff and the CCGs referral processes for mothers who smoked had been improved, with a focus on deprived areas where smoking amongst mothers was prevalent.

Mr Nealon asked how the service would be funded in the future. Ms Walker explained that funding came from CCGs and from public health, whose funding had recently dramatically decreased. She hoped that the Trust would consider continued investment in the team in order to continue the good work that had been undertaken. A business case for MECC would be written in the coming months.

006/2019 **Quality Walks**

Mrs Chadwick-Bell clarified that the reported walks were only a small snapshot of all the walks that were undertaken, as informal visits by Executives were not recorded. She reported that she had recently visited pharmacy and theatres. Technological innovations in pharmacy had led to workforce changes and pharmacists undertaking clinical work, with pharmacy technicians no longer based in pharmacy but on wards undertaking medicine management. No significant issues had been raised by the department, and the team had been very welcoming, enjoying their jobs and the training they were given.

EDGH theatres also had a fantastic team.. Anaesthetic rooms were in the process of being improved, but overall facilities were good when compared to other organisations. There were challenges with patient flow, including capacity in recovery areas, and this was being addressed by improving awareness of the issue with the site team, and ensuring that beds were available to improve the flow out of theatres.

007/2019 **Board Committees' Feedback**

1. Audit Committee

Mrs Wells reported that the Audit Committee had met on 31st January. Clinical audit had been discussed, and while the planning of clinical audits had improved, closing the loop on actions remained a concern. The Chair of the Clinical Effectiveness Committee would be asked to attend the Committee to provide assurance that this was being addressed. Cybersecurity in the organisation had been reviewed and were being well managed within the TrustIt was noted that internal audit serviceswere being tendered..

2. Finance and Investment Committee

Mr Nealon reported that the Finance and Investment (F&I) Committee had also met on 31st January. He explained that the financial position of the Trust was encouraging, with clear evidence of grip and control. He anticipated that the 2018/19 £19m CIP target would be reached, and was confident that the budget target for the year would be achieved despite an existing £5m risk. The Trust's 3+2 plan had a defined trajectory, with an ambition of eradicating the Trust's existing deficit. Work was ongoing to identify further savings opportunities in 2019/20 and a control total was close to being agreed. Mr Nealon noted that he felt that there was clear evidence that the Board was acting in a more unitary fashion and working hard to deliver financial results for the organisation. Mr Langley agreed with Mr Nealon's comments.

3. People and Organisational Development Committee

Miss Green explained that the People and Organisational Development (POD) Committee had met on 24th January. She explained that the Committee looked at workforce related matters across the Trust. The Trust workforce plan and leadership portfolio had been reviewed and a report had been received from the Guardians of Safe Working.

She presented the Committee's annual report noting that this considered the

Committee's effectiveness. Concerns that the Committee was too operational were being addressed.

4. Quality and Safety Committee

Mrs Churchward-Cardiff advised that the Quality and Safety (Q&S) Committee had met on 24th January. The agenda for the meeting had been very full and would be reviewed for future meetings. The CQC action plan had been reviewed, and assurance had been given about progress that was being made. Despite some areas of good practice there was a lack of consistency in closing the loop on actions from reports, reviews and audits and the Committee would continue to seek assurance on this. The Quality Account and Quality Account Priorities had been reviewed to ensure that they were aligned.

Falls in the Trust were reported to have increased, and a new assessment tool had been introduced. Essential care standards would go live on 1st April, and a masterclass would be given to Q&S in advance of this.

The Board noted the Committee Reports.

008/2019 **Board Assurance Framework**

Mrs Wells reported that the Board Assurance Framework (BAF) had been amended to show the latest updates first. She explained that three areas on the BAF were rated red; cancer metrics, the Trust's financial position and capital constraints.

A self-assessment of seven day working would be undertaken and would be presented to the Board in the future. Dr Bull added that the introduction of the nerve centre system would help the Trust towards seven day working by giving a real time update on the status of patients across in-patient beds, and of workflow across the Trust. This was anticipated to make significant improvements to patient flow and would be introduced by April.

She proposed an addition to the BAF concerning the development of an accountability framework for the organisation following the Deloitte report and this was endorsed by Board members.

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.

The Board approved the addition to the BAF of the development of an accountability framework.

009/2019 **Chief Executive's Report**

Dr Bull reported that leadership briefings had been undertaken in the organisation during the previous week, with a focus on quality and safety. Work on the reduction of pressure ulcers and falls continued. Compliance with the falls assessment tool was above 90%, and a reduction in secondary falls was being realised, while pressure ulcers had reduced. Excellence in care dashboards were being developed and were already being actively used on wards. Work on mortality and sepsis continued to have a high impact, and mortality standards were being maintained.

Recruitment continued to be a challenge and international recruitment of hard to fill positions was being pursued, while retention of existing staff would be a focus over the coming year. Staff survey results had seen an increased rate of

return to above 50%, with a full report to come to the Board once analysis had been completed. The Trust had been one of the top five in the country for frontline staff having flu vaccinations.

There had been recent visits to the Trust from the Secretary of State for Health, Secretary of State for Work and Pensions and the Leader of the Opposition. All had met with both acute and community teams during their visits.

Dr Bull reported that the Trust anticipated reaching its financial control total for 2018/19. He noted that his report erroneously said that the Trust would reach financial plans for the first time in a number of years, explaining that the Trust had met financial plans in 2016/17.

The healthcare system was in the process of moving from East Sussex Better Together to a health and care integrated approach for the whole of East Sussex, alongside the introduction of new CCG arrangements. The integration of health and care was being looked at on a county-wide basis by all three CCGs in the county. Joint governance of this process had been re-established, and processes had gained good momentum with a strong five year plan developed in conjunction with all partner organisations.

010/2019 **QUALITY, SAFETY AND PERFORMANCE**

Integrated Performance Report Month 9 (December)

Quality & Safety

Mrs Carruth reported that the newly introduced falls assessment tool continued to be assessed following feedback from staff. Reduced numbers of pressure ulcers were being seen, but four had been reported in November and December with no obvious trends identified.

The limit of 40 Clostridium Difficile cases for 2018/19 had been reached in December when seven cases had been identified. Following investigation, no obvious concerns or lapses in care had been identified. Dr Bull explained that the increase was not thought to represent a deterioration in standards of care, and could have been as a result of increased antibiotic prescribing.

Work was being undertaken on reducing rates of catheter associated urinary tract infections (UTIs). Documentation was being improved and the issue was a focus for associate practitioners in the infection control team; an STP group was due to meet in March to discuss the issue.

Mrs Carruth reported that a slight increase in the number of Friends and Family surveys completed in A&E had been seen. A new patient information booklet would be launched shortly. The Trust had seen a reduction in complaints. A program of work to ensure the accuracy of data being reported to the Board had commenced..

The Trust was extremely busy with additional capacity remaining open due to winter pressures. Some substantive staff had been moved to escalation areas to ensure that these were not staffed by agency and bank staff alone.

Mrs Carruth reported that the Trust's first cohort of nurse associates would be starting in September, which was a very positive step for the organisation. Dr Bull explained that the introduction of nurse associates would build upon the Trust's successful associate practitioner programme. Associate practitioners

undertook some clinical responsibilities and formed a significant part of the Trust's workforce. Miss Green explained that both the nurse associate and associate practitioner roles offered significant career opportunities for staff joining the organisation.

Mrs Chadwick-Bell asked for further information about being unable to contact a department being the highest cause of patient contact with PALS. Dr Bull noted that a new digital switchboard system was being introduced to the Trust and it was anticipated that this would lead to improvements.

Access and Delivery & Activity

Mrs Chadwick-Bell reported that A&E performance against the four hour standard during December had been 90.6%, an improvement on the previous year's performance. System-wide performance, which included walk in centres, had been 93.1%, amongst the top twenty in the country. Mrs Chadwick-Bell praised the performance of staff during the very busy period.

Activity continued to be higher than the previous year, with A&E attendances up 7.6% and non-elective attendances up by 11% compared to 2017/18. Numbers of patients being conveyed to hospital had reduced, reflecting improved support for patients in the community. A system improvement programme, focussed on improving performance and quality in urgent care, would be introduced, including reviews of frailty pathways, high intensity services and same day emergency care.

Mrs Chadwick-Bell reported that 18 week Referral to Treatment (RTT) performance during December had been 89.9% against the 92% standard, the same as the previous year. The Trust was performing well in comparison to peer organisations.

Numbers of reported super stranded patients had increased. An issue with timely recording of patient discharges over the Christmas period had been identified and would be addressed. Acute length of stay in December was 0.7 days shorter than the previous year, and a 10% reduction in the use of non-elective bed days was being realised. Length of stay in community beds had reduced by 2.2 days from the previous year. Mrs Chadwick-Bell anticipated that reported delayed transfers of care would increase as validation of this data was being undertaken due to concerns about accuracy.

December had proved challenging for diagnostic performance, largely as a result of limited stenographer capacity impacting on the Trust's capacity to deliver. A wide-ranging improvement program had been introduced, but Mrs Chadwick-Bell anticipated that performance would remain challenging in the short to medium term.

Cancer performance against the 62 day standard in November had been 69.87%, but had improved to over 80% in December. A reduction in performance was anticipated in January as some patients chose not to receive treatment during this period. A number of measures had been introduced which had led to the improved performance, and it was anticipated that performance would continue to improve during 2019. A detailed recovery plan had been completed, widely shared and was well supported. The Trust was also working with the Cancer Alliance to identify how other organisations had addressed the issues being faced by the Trust. In response to a query from Mr Phoenix, Mrs Chadwick-Bell anticipated that the Trust would meet the 85% standard by July 2019.

Mrs Chadwick-Bell reported that work was being undertaken to ensure that reporting of community data was as accurate as possible. District nursing services continued to be busy, and had seen an increase in contacts but a reduction in referrals. The Speech and Language Therapy team remained under pressure due to capacity issues. The HIT team, frailty team and crisis response team were all providing support to out of hospital services in reducing the number of patients attending hospital.

Mrs Churchward-Cardiff noted that two metrics within the IPR, for the percentage of patients admitted from A&E and for admissions via A&E were exactly the same. Mrs Chadwick-Bell agreed to clarify the data with the Performance team. **JCB**

Mrs Churchward-Cardiff asked whether the delays reported in non-obstetric ultrasound were the result of staffing issues. Dr Bull confirmed that this was the case, explaining that a recovery plan was in place. A review of the banding of stenographers was being undertaken which should lead to improved recruitment and retention of staff.

Mrs Churchward-Cardiff noted that the average waiting time for referrals to the Joint Community Rehabilitation team was 22 days. Mrs Chadwick-Bell explained that she was not confident that the data was correct, noting that patients in hospital were not discharged without a Joint Community Rehabilitation start date.

Mrs Churchward-Cardiff queried the increase in acute referrals to podiatry and Dr Bull explained that the introduction of a new pathway had led to the increase.

Mrs Churchward-Cardiff noted concern that patients took three months on average to be seen by the Hastings and Rother musculoskeletal (MSK) team. Mrs Chadwick-Bell explained that for some pathways, particularly spinal, this waiting time was accurate due to capacity issues. A review of the MSK pathway was being undertaken, and had led to a reduction in waiting times. Dr Bull added that the Trust's MSK team had been inundated with referrals when MSK services had been transferred from the previous supplier. He stressed the importance of getting waiting times below 13 weeks.

Leadership & Culture

Miss Green reported that temporary workforce spending had reduced for three consecutive months, with bank usage reducing to 7.6%, and agency usage reducing to 1.2%. Improved recruitment to difficult to fill posts, including in urology, had been key to these reductions.

The Trust's vacancy rate remained fairly static, but was below plan at 8.9%. More applications were being received for advertised roles, reflecting the improving reputation of the organisation. Turnover remained static at 11%, which was positive compared to national metrics. A lot of work was being undertaken to encourage staff to remain in the Trust, including comprehensive leadership development plans and the introduction of stay interviews to find out what incentives staff had for continuing to work for the organisation.

Sickness levels among staff had fallen slightly and were below plan. The Trust had launched a Health and Wellbeing Strategy to address ongoing issues. A slight increase in appraisal rates had been seen but Miss Green explained that

divisions were challenged on their performance in IPRs in order to realise further improvement. Staff survey responses had improved to above 50% and the detailed results would be presented to the Board when available. Miss Humber noted that it was reassuring that sickness had reduced, reflecting the work being undertaken to improve the health and wellbeing of staff.

Mrs Churchward-Cardiff noted that despite the reduction in agency expenditure, the Trust had only met its monthly staffing budget on one occasion during the year, and asked how this overspending was being addressed. Mr Reid explained that the Trust's staff spending plans would be reviewed to look at how they flexed during the year. The money saved on agency staff had been reallocated to bank and substantive staff. He noted that additional money had also been spent as a result of increased payments due to agenda for change during this year.

Mrs Wells asked whether the data reported for End of Life Care training was correct. Miss Green explained that the criteria for training had recently been changed, and that the Trust was adjusting to this. She anticipated that metrics would be rated as red for some time while the Trust caught up with the requirements for new criteria.

Finance

Mr Reid reported that the Trust and wider East Sussex system were both anticipating meeting their financial plans for the year. He explained that the Trust had agreed to deliver a £44.9m deficit for the year and reported that in addition to meeting this target the Trust's ambition was to create £4.5m of reserves during the year. At the end of month 9 the Trust remained confident about delivering the deficit target, and was confident of delivering £2.5m of reserve. A number of risks to delivery existed, which were being carefully controlled. The Trust was in the process of agreeing funding for 2019/20 with commissioners.

Cost Improvement Programmes (CIP) were delivering and Mr Reid anticipated that these would deliver on plan for the year. Non-recurrent CIPs were being moved into recurrent savings reflecting a strong foundation for continued savings during 2019/20. Cash flow was greatly improved from 2018/19 and the Trust had ended December cash levels above plan. Management of the capital budget for the remainder of the year continued to be a significant concern, with a forecast overspend of just over £500k. All capital spending was subject to a high level of scrutiny and planning.

The Board noted the IPR for Month 9.

011/2019 **Winter Planning and Christmas Review**

Mrs Chadwick-Bell reported that winter and Christmas planning had been undertaken a number of months in advance, with lessons learned from previous winters incorporated. Christmas and New Year were generally the most challenging times of year for the organisation. Despite an increase in activity of 3% in A&E during the Christmas period in 2018/19 compared to the previous year, the Trust had improved performance by 6%. A focus on reducing length of stay had led to improved patient flow. The Trust had performed well compared to peer organisations, reflecting the hard work of staff and effectiveness of planning.

23% of patients attending had been seen in the ambulatory care unit at EDGH, and the Trust was looking to extend the working hours for the unit as well as

building a further unit at the Conquest Hospital. An app had been built which allowed ward staff to record patients who were medically fit for discharge. This information was reviewed in combined system meetings and drove patient discharges, ensuring that support packages were in places for complex patients, making a significant difference and changing how staff managed discharges.

Mrs Chadwick-Bell reported that primary care streaming, which had been initiated in 2018, was now fully staffed and was enabling patients to see the correct clinician in the correct department, making a huge difference to A&Es. Planning for Easter would be undertaken, and Mrs Chadwick-Bell reported that adaptations to plans had been identified as a result of winter performance.

Dr Bull reported that elective performance had been maintained throughout the winter period, with no operations cancelled expect for on a couple of occasions when post-surgical critical care beds had been unavailable. The importance of ward rounds in improving the management of patients on wards had been emphasised, and staff found these to be valuable.

Mr Reid reported that across the system £2m less had been spent over winter than the previous year.

The Board noted the Winter Planning and Christmas Review.

012/2019 **STP Population Health Check**

Dr Bull reported that the document being presented had previously been discussed by the Board as the STP Case for Change. The paper had been developed by the STP Clinical and Professional Cabinet and provided an assessment of the priorities for the system. It also provided useful context for some of the work that was being undertaken across the STP. Once the plans had been formally approved then the next step would be the development of a clinical strategy for the STP, taking conclusions and recommendations from the presented document.

Dr Walker explained that he had found the proposal to be a good base line assessment of the position of the STP. He noted that it formed an excellent starting point in deciding the future plans of the STP.

Mrs Churchward-Cardiff said she was surprised that levels of hospitalisation were reported on page 42 of the report as being almost four times higher in coastal West and East Sussex than in other areas of the STP. Mr Phoenix asked what conditions the figures referred to and Mrs Chadwick-Bell agreed to investigate and report back to the Board. **JCB**

Ms Ashton noted that the STP provided a platform for commissioners and providers to come together and that strategies being developed needed to meet the needs of commissioners, providers and clinicians. Dr Bull explained that the work would be supported by the Director of Strategy for the CCGs, but would be chaired by a clinical chair. Concerns had been raised with the STP about the need to ensure that the strategy was provider and clinician led.

The Trust Board reviewed and endorsed the STP Population Health Check, taking note of the planned next steps and timeframes.

013/2019 **Financial Planning for 2019/20**

Mr Reid explained that the paper being presented had been discussed by the

F&I committee, and in other forums within the organisation. The Trust's plan was compliant with national planning processes, as well as local system financial planning processes. The Trust and CCG had submitted a 3+2 financial plan to NHSI in December 2018, and the paper presented refreshed the assumptions within that document, driving a collaborative approach to financial planning across the system.

Control totals had been issued to the Trust and CCG and an £8.5m shortfall in resources had been identified across the East Sussex healthcare system. The Trust's plan had shown a £41.7m deficit against a proposed control total of £34m; plans would be developed to bridge the gap in funding. Financial plans would continue to be updated until the end of the financial year, and business plans for 2019/20 would be presented to the Board on 28th February.

Mr Reid explained that the Trust had set a CIP target of £20m for 2019/20, noting that assurance around the delivery of this target was more robust than in the past. £15m of CIPs had already been identified and he anticipated that the remainder would be identified prior to 31st March. Cost pressure assumptions were reviewed by the Executive team on a weekly basis. Further updates to the plan would be presented to the F&I Committee and the final plan would be presented to the Board for approval.

Mrs Churchward-Cardiff asked whether the variable element of emergency care tariffs could pose a financial risk to the organisation. Mr Reid explained that contractual risks had been considered within the draft plan.

Mrs Churchward-Cardiff asked about non-contracted community services which had not been included within the plan. Mr Reid explained that the Trust was in the process of trying to rebase the community contract with the CCG with the support of external consultants and NHSI, in order to accurately represent services that were being delivered. It was hoped that this would be resolved during the system financial planning process. Dr Bull added he hoped that the rebased contract would better reflect the services that were being provided by the Trust.

014/2019 **ENT Reconfiguration**

Mrs Chadwick-Bell explained that ENT services within the Trust had been pressurised due to recruitment challenges for a number of years. Urgent changes had been made to emergency ENT services in 2018 as a seven day rota could no longer be maintained due to staff levels. BSUH had been very supportive of the Trust's position, and their trainees supported the Trust's rota on a voluntary basis. Some successful junior doctor requirement had taken place during recent months, but recruitment at consultant level had not been possible. Work was being undertaken with BSUH to jointly recruit to consultant roles. The Trust had been unable to provide training for junior doctors due to limited consultant numbers.

Discussions had taken place with the ENT team about the future of the service for some time and it had become clear that maintaining the service as it was would not be possible. Different options for the service had been reviewed and scored by staff, and the highest scoring proposal had been that elective inpatient services were primarily delivered from the Eastbourne site. Emergency ENT surgical cases were already treated at EDGH and the ENT surgical ward was based there. ENT emergency patients attended both sites, and this would continue to be the case, and outpatient services would continue on both sites.

The most significant change to services would be for elective procedures, where patients would attend EDGH. Paediatric day case surgery would continue to be undertaken on both sites, with the majority undertaken at EDGH. Children requiring an overnight stay post-surgery would be treated at the Conquest, and any post-surgical emergency would be managed at the Conquest. Non-post-surgical emergencies, anticipated to be 6-10 patients a year, would be treated at Brighton Hospital.

The proposal had been approved by the Health Oversight Committee (HOSC). A gateway review was due to be undertaken during February to ensure that individual staff concerns about the plans had been addressed and that engagement with staff was as full as possible.

Dr Bull reported that discussions had taken place with the Trust's ENT consultants who had unanimously concluded that the ENT service should be single sited, but not about which site they should be on. A number of concerns had been raised about the safety of the proposed service, which were being addressed. Dr Bull explained that around 2,000 patients a year had emergency ENT surgery at EDGH, with around 500 a year having emergency ENT surgery at the Conquest. A relatively small number of adults would be affected by the changes, and patient safety had been prioritised throughout the planning process.

Mr Phoenix asked whether patient safety could be guaranteed if services were not changed. Dr Bull explained that the service relied on the good will of doctors in Brighton, and as such could not be guaranteed to be sustainable in the future.

Mrs Churchward-Cardiff asked whether the proposed model been operated elsewhere by a multi-sited trust. Dr Bull noted that the Trust's current model saw elective care being provided on one site and emergency care on another. The proposed changes would lead to all ENT services being offered on a single site, which would be safer for patients. The only complicating factor was that 24 hour children's services were only available at the Conquest. Mrs Chadwick-Bell explained that many emergency ENT patients were already managed within A&Es, but were transferred to EDGH if they required admission and this arrangement would be maintained.

Mr Nealon asked whether outside appraisal of the proposal would be undertaken. Dr Bull explained that the change would be subject to STP approval, and that he would be happy to ask for external validation of the plans if necessary.

Dr Bull asked the Board whether they endorsed the proposed direction of travel for the ENT service. Mr Phoenix explained that he was happy that the Board supported the plans, subject to the results of February's gateway review. He asked that an update be presented to the Board in the future to provide further assurance about the plans.

015/2019 **EU Exit Preparation**

Ms Ashton explained that she was Brexit lead for the organisation. The Trust was maintaining a focus on planning for a no deal scenario, as this presented the greatest risk to the organisation. Work was being undertaken to ensure that the Trust's supply chain was as robust as possible and seven key areas had been considered:

- Supply of medicines and vaccines. Nationally, all suppliers had been asked to increase stock levels. Trusts throughout the country had been instructed not to stockpile medications. The Trust's Pharmacy lead sat on a national group, so was well sighted on potential issues.
- Supply of medical devices and clinical consumables. The Trust had also been instructed not to stockpile these provisions. The top five hundred suppliers to Trust have been asked about their continuity plans.
- Supply of non-clinical consumables, goods and services. Supplies of medical supplies and food would be a priority for the country.
- Workforce. It was not anticipated that significant levels of EU staff would leave on Brexit. EU staff were being supported by the Trust.
- Reciprocal healthcare. This would remain in place, as agreement had been reached with the EU in a separate piece of legislation.
- Research and clinical trials. The Trust has contacted national bodies to ensure that it remained fully compliant with guidance.
- Data sharing, processing and access. A review has been undertaken and had not identified any risks.

Brexit planning events had taken place and a communications plan was being developed. Key areas of concern, including pharmacy, procurement and consumables had been prioritised as they had the greatest potential to be impacted by a no deal Brexit. A Brexit planning group was meeting on a weekly basis and a business continuity planning event was taking place on 28th February.

016/2019 **Board Subcommittee Minutes**

The following sub-committee minutes were reviewed and noted:

- Audit Committee 25th July 2018
- POD Committee 7th November 2018

The Minutes were received by the Board

017/2019 **Use of Trust Seal**

Two uses of the Trust Seal since the last Board meeting were noted. These concerned contracts between Reds10 (UK) Limited and East Sussex Healthcare NHS Trust for building the MRI Facility at Conquest Hospital and between Wealden District Council and East Sussex Healthcare NHS Trust for the lease of Third Floor Offices, Amerhurst Road, Bexhill between for a period of five years.

018/2019 **Questions from Members of the Public**

Reception at EDGH

Mrs Walke reported that the reception team at EDGH had not known whether a patient had been discharged from hospital. Dr Bull explained that the Trust's patient administration system recorded where patients were as they moved around the Trust. Ward Clerks updated this information and sometimes this didn't happen immediately as they only worked from Monday to Friday. The introduction of live bed states should address this issue, enabling HCAs to update patient information and should also lead to improvements in reporting and the Trust's ability to track patients through the hospital in real time.

Signpost outside EDGH
Mrs Walke reported that a sign outside EDGH needed replacing as it was no longer legible.

Longest stay patient
Mrs Walke asked whether information about the patient whose stay in the Trust was the longest could be added to the Board papers, along with information about patients who had been in hospital for more than 30 days. Mrs Chadwick-Bell noted that the patient whose stay was the longest remained medically unfit for discharge, so the information would not be that useful. The top 15 longest staying patients were regularly reviewed. Mrs Wells noted that the Trust looked to pursue legal action in rare cases where patients refused to leave hospital.

Board Papers
Mrs Walke asked whether the public could have Board papers printed in colour. Mrs Wells explained that it was the Trust's policy to print papers in black and white. The Trust would work to make the information clearer for future Board meetings.

ENT Services
Mrs Williams noted that ENT services were likely to be largely moving to EDGH in the future, subject to future assessment. She asked when this was likely to take place. Dr Bull explained that it was hoped that the move would be completed in April. The Trust were satisfied about the safety of the proposed changes, but needed to ensure that all the details of the operational plan were correct and that concerns raised by medical staff were fully addressed prior to the move taking place.

Potential Serious Incident
Mrs Williams asked about a serious incident that she had been made aware of, concerning a patient's admission on to a ward. Dr Bull explained that the incident had been fully reviewed by the Serious Incident Review Group and had been categorised as a level one incident and not a Serious Incident.

Transport between sites
Mr Hardwick asked whether progress had been made on the potential provision of patient transport between the Conquest and EDGH. Dr Bull explained that the issue continued to be discussed, and that the recent merger of two colleges has led to a new opportunity for public transport between the hospitals with Stagecoach proposing a direct bus link. A staff survey was being undertaken to look at whether a shuttle service between sites might be viable. Park and Ride options had been explored, but there were no viable sites for this close to either hospital.

Mr Phoenix thanked everyone for attending the meeting.

019/2019 **Date of Next Meeting**
Tuesday 2nd April, Manor Barn, Bexhill

Signed ……

Position ……..

Date .....

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 5th February 2019 Trust Board Meeting

Agenda item	Action	Lead	Progress
010/2019 – Month 9 IPR	Mrs Chadwick-Bell agreed to clarify data in the IPR showing that the percentage of patients admitted from A&E and for admissions via A&E were exactly the same.	**JCB**	The IPR has been updated.
012/2019 - STP Population Health Check	Mrs Chadwick-Bell agreed to clarify which conditions were being reported on in a statistic about hospitalisation rates being almost four times higher in coastal West and East Sussex than in other areas of the STP included on P42 of the STP's report,	**JCB**	Mrs Chadwick-Bell has requested clarification from the STP. A response will be chased.

Quality Walks November 2018 – February 2019

Meeting information:			
Date of Meeting:	2nd April 2019	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

52 services or departments have received visits as part of the Quality Walk programme by the Executive Team between 1st November 2018 and 28th February 2019. In addition to the formal programme the Chief Executive has also visited 17 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, NOVEMBER 2018 - FEBRUARY 2019

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 November 2018 and 28th February 2019. In addition the Chief Executive also visited several departments and staff groups.

Date	Service/Ward/Department	Site	Visit by
5.11.18	Mortuary	EDGH	Catherine Ashton
7.11.18	Ophthalmology & Day Surgery	Bexhill	Jackie Churchward-Cardiff
8.11.18	Speech and Language Therapists	EDGH	Jonathan Reid
13.11.18	Health Visitors	High Weald Children's Centre Ticehurst	Miranda Kavanagh
12.11.18	Rapid Assessment and Discharge Service (RADS)	EDGH	Jonathan Reid
12.11.18	Crisis Response Team	EDGH	Jonathan Reid
12.11.18	Theatres	EDGH	Joe Chadwick-Bell
14.11.18	Podiatry	EDGH	Lynette Wells
21.11.18	Emergency Department	EDGH	Jackie Churchward-Cardiff
21.11.18	Endoscopy Department	EDGH	David Clayton-Smith
26.11.18	Speech and Language Therapists	Conquest	Lynette Wells
26.11.18	Hailsham 3 Ward	EDGH	Catherine Ashton
3.12.18	MacDonald Ward	Conquest	Monica Green
3.12.18	Infection Prevention Control Team	Conquest	Joe Chadwick-Bell
3.12.18	Out patients and Radiology	Bexhill	Vikki Carruth
11.12.18	Community Dietetics	Avenue House Eastbourne	David Clayton-Smith
11.12.18	Sexual Health Clinic	Arthur Blackman Clinic St Leonards	Lynette Wells
12.12.18	District Nursing Team	Eastbourne Park Primary Care Centre	Lynette Wells
14.12.18	Medical Outpatients	Conquest	Catherine Ashton
19.12.18	Gardner Ward	Conquest	Jonathan Reid
19.12.18	Maternity Department	Conquest	David Walker
19.12.18	Rapid Assessment and Discharge Service (RADS)	Conquest	Jackie Churchward-Cardiff
20.12.18	Endoscopy Administration Team	EDGH	Monica Green
02.1.19	Outpatients Department	Bexhill Hospital	Catherine Ashton
08.1.19	Joint Community Rehabilitation Team	Eastbourne	Catherine Ashton
08.1.19	Urology Investigation Suite	EDGH Site	Lynette Wells/Nicki Webber/Karen Manson
08.1.19	Clinical Coding Team	Eastbourne	David Clayton-Smith
08.1.19	Friston Ward	Eastbourne	Monica Green
15.1.19	Kipling Ward	Conquest	David Walker
17.1.19	Pharmacy Department	Conquest	David Clayton-Smith
23.1.19	Benson Ward	CQ Site	Benson Ward
21.1.19	Judy Beard Unit	Conquest	Monica Green
24.1.19	Joint Community Rehabilitation Team	Bexhill	Jackie Churchward-Cardiff

31.1.19	Mortuary	Conquest	Catherine Ashton
1.2.19	Bowel & Bladder Service	Hailsham Health Centre	Vikki Carruth
5.2.19	DeCham Ward	Conquest	Jackie Churchward-Cardiff
7.2.19	PICC Line Team	Conquest	Monica Green
7.2.19	Frailty Team Irvine Unit	Bexhill	Catherine Ashton
11.2.19	Muscular Skeletal and Rehabilitation classes	Amberstone	Lynette Wells
12.2.19	Cuckmere Ward	EDGH	Jonathan Reid
12.2.19	Urology Investigation Suite	EDGH	Jonathan Reid
12.2.19	Muscular Skeletal Service	Newhaven Poly Clinic	Karen Manson
14.2.19	Podiatry	Bexhill Hospital	Karen Manson
14.2.19	Litlington Ward	Eastbourne	Monica Green
14.2.19	Cookson Devas Ward	Conquest	Vikki Carruth
19.2.19	Health Visitors	Lewes and Newick	Karen Manson
20.2.19	Outpatients	EDGH	Catherine Ashton
21.2.19	Firle Unit	EDGH	David Walker
25.2.19	District Nursing Team	Bexhill	Lynette Wells
25.2.19	Glynde Ward	EDGH	Catherine Ashton
25.2.19	Muscular Skeletal Service	Lewes	Karen Manson
28.2.19	Post & Waste Team	EDGH	Jackie Churchward-Cardiff

All of these visits were pre-arranged and the Ward or Department 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

- Some teams feel they would like more involvement with those making decisions when changes to resolve unmet needs and delivery options are being considered, and for groups of staff to be able to be involved resolving problems that affect them directly rather than have decisions imposed. They felt this would lead to more efficient working and less duplication and confusion.
- Some areas are producing newsletters for staff on a regular basis, and it was clear that this helped staff feel more involved in decision making.
- Positive relationships with service managers and with senior management was reported, both of which were seen as supportive and visible.

Incidents, Risks and Safety Issues

- In the Emergency Departments patients regularly face delays getting home or transferred if transport is required, and there is sometimes difficulty discharging patients back to care homes after 6pm. These patients are often in the department for diagnosis, assessment or simple treatment such as re-catheterisation, and would be better served by primary or community care attending the residential home.
- Mental health support is insufficient to support the number and needs of people attending the Emergency Departments with a mental health issue.
- Clinical Decision Units are functioning more as a ward but with limited facilities and inadequate space and patients there are often prevented from being discharged due to social and housing issues.
- A health visiting Team that had co-located with social services didn't feel that the move had been beneficial as they had felt 'taken over' by the council which had made them feel disempowered and isolated.
- Some wards still lack sufficient storage facilities making areas feel generally cluttered with every available space taken for stores and equipment.
- In the community nursing service there is significant capacity issues in trying to meet the increasing demand on the service.
- The number of people attending the Emergency Department continues to increase, many of who could be treated and cared for by primary and community services.

Environment, Equipment and IT

- Some departments at Bexhill Hospital lack amenities and have a general lack of functional space for all elements of the various patient pathways. In the Dowling Unit the facilities are cramped and difficult for patients to navigate particularly if they require the use of a mobility aid.
- Staff continue to report that IT systems are very slow with old equipment in many areas and in the community settings there is often poor Wi-Fi access.
- Some services are still using paper referral systems which are more time consuming and they would find electronic systems much more efficient with less duplication.

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Staffing

- Staff were observed to be friendly enthusiastic and passionate about their work and very patient focused
- Staffing levels remain a challenge, and many areas reported having difficulty achieving the required staff cover which they felt impacted negatively on staff that are otherwise committed and supportive of each other.

Good Practice / Service redesign

- The Emergency Department has worked hard to improve the recruitment and retention of newly qualified nurses. Newly recruited Band 5 staff now receives a week induction followed by an Emergency Department training day, technical skills training and a two week supernumerary period prior to commencing their post. They are also supported by the Practice Educator for clinical practice.
- The Speech and Language Therapy Team are innovative and have been nominated for and won several prestigious awards.
- Podiatry teams demonstrate excellent multidisciplinary working with vascular and orthopaedic colleagues.
- The role of the matron's assistant continues to be highlighted as being really crucial and beneficial
- Friston Children's Unit have examples of developing new roles, such as trainee Advanced Nurse Practitioners and they are also developing Assistant Nurse Practitioner roles.
- Excellent housekeeping was observed in some areas and staff were clearly proud of their environments
- The podiatry service has developed a foot tool (checklist) which is being adopted nationwide and will be presented at a national conference.
- A WhatsApp group for staffing issues has been implemented in one area so that uncovered shifts are offered to permanent staff first before being requested through the Temporary Workforce Service.

Education and Training

- Leadership classes for team leaders and service managers are reported as being helpful for staff development and management skills which then benefits the teams.
- In oncology new treatments are constantly being introduced and staff attend external training and receive training from drug companies in the department.

Patient feedback

- Podiatry patients with diabetes who have accessed the podiatry service for many years felt they had a really positive relationship with the staff.
- The ophthalmology services at Bexhill receive positive FFT scores and patients reported they felt there is a friendly and supportive environment.
- Patients using the MSK service gave positive feedback and valued the service stating that it helps people to restore function, increase activity and reduce pain. One patient mentioned that it had helped them to retain their independence.

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.

Board Assurance Framework

Meeting information:			
Date of Meeting:	2 April 2019	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? Yes	

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 to the BAF however, it is recommended that 2.1.3 "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" is removed as a robust system is in place,

There remain three areas rated red

- 2.1.1 in respect of delivery of the 62 day cancer metrics
- 4.1.1 in relation the to the Trust's financial position and
- 4.2.1 in relation to capital constraints.

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

Quality and Safety Committee – 21st March 2019
Audit Committee – 27th March 2019
Finance and Investment Committee also review risks related to finance and People and Organisational Development workforce metrics.

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. The Trust Board is asked to agree the removal of the gap in control 2.1.3 related to the system monitoring and following up appointments.

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

Date by arrows indicates date that assurance levels increased or decreased

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 Safety 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 effectiveness and terms of reference Effective processes in place to manage and monitor safe staffing levels iFIT introduced to track and monitor health records EDM being implemented 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' a number of areas rated Good in March inspection. "Safer" ward rounds in place

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-19 Quality Strategy reviewed and quality account priorities developed. Ongoing preparation for CQC inspection.** **Jan-19** Positive feedback following internal reviews of both A&E departments. Continued roll out of Health Assure and monitoring of CQC action plan. Effective programme of quality walks in place. **Nov-18** Ongoing work to develop framework as outlined above. "HealthAssure" module being piloted across the Trust to support evidencing compliance with CQC core standards. Mock reviews planned for both A&E departments in November/December. **Jul-Sep 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. Framework being developed in respect of what constitutes "outstanding" - review being undertaken to ensure consistency and strengthen divisional governance structures. **Mar-May 18** CQC inspection 6/7 March core services and 20/21 Mar Well Led. Draft report received May and factual accuracy checks taking place **Nov 17 -Jan 18** Inspection anticipated early 2018. Tracker being strengthened and prep group meeting. Community mock planned for Nov. Ongoing preparation for inspection. CQC information request completed Dec 2018. CQC first focus groups also taken place. **Jan-Sep 17** CQC Report published Jan 17, Trust rating moved to 'Requires Improvement' Good progress evidenced in a number of areas - 2 must do actions and 34 should do actions to address. Programme of improvements in place. . Mock inspections planned for May-17. Effective progress in implementing CQC actions.	end Jul-19	◄► 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 divisions 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 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.	**Mar-19 Comprehensive update provided to March Board seminar. Achievement of 62 day standard remains challenging, recovery plan being progressed and further analysis undertaken.** **Jan-19** Revised recovery plan submitted to NHSI/CCG in Dec. Currently developing the plan further and embedding it within the new weekly PTL meeting format. New AD of Performance taken over responsibility for PTLs and Cancer Services team. Cancer 62 day performance expected to show a gradual improvement for Oct, Nov and Dec - due to the number of patients deferring treatments over the Christmas/New Year period expecting Jan and Feb to be very challenging. Allocated 3 days p/wk Project Management support until end of financial year by Sussex Cancer Alliance. Enabling Trust to focus on delays in the 62 day pathways and assist n reducing the 104 day breaches. **Nov-18** Revised recovery plan being drafted for submission to NHSI and will be reviewed by Q&S committee. PTL formats being revised, capacity and demand analysis being undertaken as well as re-design of patient pathways. Sep-18 NHSI High Impact Actions reviewed and being incorporated into a revised recovery plan. Urology service has re-designed pathways and capacity to meet Cancer and RTT targets, full implementation due Mar-19, but will require completion of the UIS. Colorectal implementing new 'straight' to test' pathway from Sept. 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. **Jul-18** 62 day remains challenged particularly for colorectal and urology; additional adhoc activity continuing. Cancer Matron appointed 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 July. **Mar-May 18** – 62 day performance challenging, 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. Demand for colorectal, breast and urology 2ww has been exceptional and is impacting delivery across all cancer standards in these specialties. Governance systems in place, with demand analysis being undertaken. Twice weekly meeting is in place with ADOs and CCGs, with the COO.	end-Dec 19	Oct-18 ◄►	COO	Cancer Operational Board and IPRs

Strategic Objective 2: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.							
Risk 2.1 Continued - We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.							
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.1.2	C	Effective controls are required to ensure increasing numbers of young people being admitted to acute medical wards with mental health and deliberate self harm diagnoses are assessed and treated appropriately.	**Mar-19 HoN attended Practice development group 30.01.19 overview of CAMHs Transformation Plan. 2 risks in hours and out of hours risk are now on the divisional risk register. Young people in crisis meeting held with SPFT and CCG 05.02.19 Service specification for in hours nurse provision will be reviewed** **Jan-19** Independent review taking place pan Sussex into mental health provision as there is delay in assessment and inequity of service provision cross county in hours. Inadequate OOH service. Assessment delays by CAMHS tracked and recorded as incidents escalated for COO/COO discussion (ESHT – SPFT) Paeds track and record all inappropriate ward admissions and SPFT recharged if appropriate. Reviewing previous 12 months risks for CAMHS for trend and themes. Safeguarding to revisit audit with refreshed ToR. 2 separate risk to go on divisional risk register. **Sep-Nov 18 N**umber of mitigations in place including on site MH (CAHMS) Liaison on both sites Monday to Friday 9am – 5pm which has significantly improved access for MH reviews, Ongoing discussions with SPFT regarding provision of on-site support until 22.00hrs. 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 business case for increased on-site provision from 17.00 – 22.00hrs, ESHT have not seen 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. Continual monitoring and concerns being flagged with commissioners **Jan-Jul 18** Audit presented and shared with CAMHS confirmed children with mental health difficulties primarily present after 4pm and these children require a hospital bed until assessment is undertaken. Acknowledged there is a need for CAMHS 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. Trust applying for the HEE "we can talk" project to further enhance the skills and competencies of the ward staff. **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 to review issues and audit of children	end Apr-19	◄►	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-19 Robust systems in place to able to identify and report on all follow up patients in the acute sector. As previously noted high risk patients have specific processes. Propose to remove from BAF** **Jan-19** FU database has been rolled out to all specialties and enables us to quantify the number of FU patients un-appointed by specialty and clinically indicated target date. The system does require data entry therefore is subject to human error and this creates the need for additional validation but has proved useful in understanding and management of risk. For high risk services, such as AMD & cancer patients additional patient level tracking exists to minimise the risk of delay**.** **Nov-18** No longer reliant on paper system - all specialties that should be are on the system and all patients requiring follow up appointment on system. Currently validating and risk stratifying follow up lists. Propose to move to Green **Sept-18** Database developed and populated except Oncology (interim system already in place),T&O, Haematology & cardiology. Transition period to clear backlog in all specialties and link patient who's FU has been booked and then cancelled, expected completion Spring-19. **Mar 17-Jul 18** Trust unable to formally extract data from Oasis PAS to report on patients follow up by time period. Local systems in place but requires 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.	end Mar-19	Dec-18 ◄►	COO	SLF Q&S

Risk 2.2 There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.	
Key controls	Clinical Unit Structure and governance process provide ownership and accountability to Clinical Units Clinicians engaged with clinical strategy and lead on implementation Job planning aligned to Trust aims and objectives Membership of SLF involves Clinical Unit leads Appraisal and revalidation process Implementation of Organisational Development Strategy and Workforce Strategy National Leadership and First Line Managers Programmes Staff engagement programme Regular leadership meetings Succession Planning Mandatory training passport and e-assessments to support competency based local training Additional mandatory sessions and bespoke training on request
Positive assurances	Effective governance structure in place Evidence based assurance process to test cases for change in place and developed in clinical strategy Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Training and support for those clinicians taking part in consultation and reconfiguration. Outcome of monitoring of safety and performance of reconfigured services to identify unintended consequences Personal Development Plans in place Significant and sustained improvement in appraisal and mandatory training rates

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.2.1	C	A more explicit accountability framework is required which sets out expectations regarding roles, responsibilities and accountabilities; including the leadership model at all levels and the Trust operating structure down to ward level	**Mar-19 Overview of framework considered at Trust Board Seminar March-19 and direction of travel agreed. Ongoing work to develop plan and agree milestones.** **Jan-19** The governance and accountability framework is being reviewed and developed to ensure it is fit for purpose and that expectations in respect of roles, responsibilities and accountabilities are communicated and understood throughout the organisation.	end Jul-19	◄►	DHR/ DCA	POD

Strategic Objective 3: We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.	
Risk 3.1 We are unable to develop and maintain collaborative relationships based on shared aims, objectives and timescales with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.	
Risk 3.2 We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.	
Key controls	Develop effective relationships with commissioners and regulators Proactive engagement in STP and ESBT Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work. Relationship with and reporting to HOSC Programme of meetings with key partners and stakeholders Develop and embed key strategies that underpin the Integrated Business Plan (IBP) Clinical Strategy, Workforce Strategy, IT Strategy, Estates Strategy and Organisational Development Strategy Effective business planning process
Positive assurances	Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. 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 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 STP and ESBT programmes

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.2.1	A	Assurance is required that the Trust will be able to develop a five year integrated business plan aligned to the Challenged Health Economy work.	**Mar-19 A further iteration of the system plan was submitted to NHSI in February 19 and we continue to work closely with commissioners and NHSI to produce our final submission for the beginning of April. There is an ongoing dialogue on investment and activity assumptions to ensure that the internal plans are aligned with the system plan** **Jan-19** The integrated system recovery plan was approved for submission to NHSI at a joint ESHT and CCG Board meeting on the 13th December . Submission made on 20-Dec-18; awaiting feedback from NHSI. **Jul-Nov 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. Draft integrated (ESHT and CCGs) sustainability plan submitted to NHSI and NHSE beginning of Sept 2018 and a further more detailed iteration of this is being prepared for submission in Dec. 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. **Jan-May 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 **Jul-Dec 17** Our System wide placed based plans (ESBT) align commissioners and providers in health and social care. Significant work undertaken 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.	end Apr-19	◄►	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.	**Mar-19 Self Assessment template completed and submitted. Update to April Board and Quality and Safety Committee.** **Jan-19** New 7 day working board self-assessment to be completed March for submission to NHSI. 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. **Nov-18** April 18 Audit showed improvement in standards 5,6 and 8 but deterioration in standard 2 (69 to 58%) Raising awareness of documentation requirements and ensuring clinical staff identified in case notes. NHSI/E site visit 31 Oct **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 strengthened, 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 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. Teams continue with acuity assessment and review delegation on ward whiteboards. • Bidding for funds to enable electronic whiteboards with real time patient tracking. Exploring whether these can also be used to document acuity and delegation of review. • Procurement process to replace 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.	end Apr-19	◄► 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 by senior management 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-19 At Month 11, Trust forecasting delivery of the financial plan. Month 11 run-rate was higher than planned, but reflects a growth in the run-rate on elective care as the organisation is moving towards delivery of the 92% RTT standard with an attendant cost. The Trust will deliver the planned deficit, with some resource set aside to support delivery of the 2019/20 plan as a result of full delivery of the CIP and the agreement of a fair contract offer with clinical commissioners.** **Jan-19** At Month 9, the Trust continues to forecast delivery of the financial plan. Month 8 run-rate was £3.2m (although Month 9 increased as planned), and the net risk to the forecast – including the provision of reserves – is now reduced to £4m from £6m. Executive continue to monitor the recovery plan, with assurance to the Trust Board through F&I Committee. Weekly sessions with Clinical Units through control total meetings or 'confirm and challenge' sessions remain in place, and grip in control measures, including T3, will remain throughout Q4. **Nov-18** At Month 6 run-rate moved from £3.2m to £4.3m. However, this was a planned reduction, reflecting a shorter working month. Overall, the Trust performance against plan improved in month, with an adverse variance of £699k against plan at Month 6. Moving towards a formal agreement on income for the year with clinical commissioners and, as a result, is refreshing the full year forecast. The level of financial risk for the year end position has been calculated at £6m and a full reforecast has been presented to the F&I with identified mitigations to be updated at Month 7. Forecasting full delivery of the financial plan, and will continue to review options and mitigations to ensure this happens. **Sep-18** Further improvement in run-rate to £3.2m deficit, month 5. This is behind plan but consistent with delivery of the financial plan with continued focus through remainder of year. Recovery Director is supporting 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 is considerably above baseline plan, due to significant growth in non-elective activity; this represents both a challenge to delivery of efficiency schemes and a payment risk. 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. DoF holding CU control total review to monitor overall financial performance, with issues from both streams escalated to the Executive as appropriate. **Jul-18** NHSI provisionally accepted refreshed plan for 2018/19, which aims for a deficit of £44.9m and requires minimum efficiency challenge of £19.2m. Working closely with PA Consulting and the Clinical Units to secure up to £23m of efficiency savings, and ensure delivery of the £19.2m. As at M3, the identified pipeline is £29m, but only £15.5m of schemes identified as green; 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. **May-18** – Submitted initial 2018/19 financial plan with £47.9m deficit. CIP target of £23.5m but identified a minimum ask of £18.2m and no contingency to deliver the plan. Plan has not been accepted by NHSI who are requiring as a minimum a deficit of £40m for 2018/19. 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	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.	**Mar-19N HSI have indicated that the fire capital bid is now being reviewed by the Department of Health. The other bids remain under review. The Trust is continuing to carefully manage the capital resource limit and to deliver this statutory target, with CRG meeting every two weeks in the run-up to the financial year end. The focus of attention is now developing a robust and deliverable financial plan for 2019/20.** Jan-19 No further news on capital bids to NHSI has been received, although anticipate a decision post the national Month 9 capital forecast refresh. CRG continues to closely monitor capital expenditure, which remains under tight control. Monthly updates to F&I Committee. Additional capital spend above the CRL (capital resource limit) will default to being charged to revenue budgets, which will in turn threaten delivery of the financial plan. The Trust is receiving support with bid submission from NHSI, and is anticipating delivering the capital budget in 2018/19. This will leave a significant challenge into 2019/20, which is being addressed through the capital planning workshops now in train. **Nov-18** The Trust is holding all capital programmes, other than those with immediate clinical impact, without further investment until the outcome of the capital review process is completed. The Trust has made a number of iterations of the business cases with NHS Improvement and continues to work closely with regulatory colleagues All capital budget-holders are reviewing their full year forecasts in detail and are seeking to minimise future capital spend over the remaining months of the financial year. The Trust remains committed to delivering the capital plan, but there are significant risks to the overall budget being carefully managed within the Capital Review Group. On-going review and monitoring to end Mar-19. Proposal to move gap in assurance to red. **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. **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. **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. **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	On-going review and monitoring to end Mar-19	Dec-18 ▼	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	**Mar-19** As below update meeting with ESFRS has been deferred to allow for an update on contract documentation and post NHSi funding application. Additional works referred to by ESFRS notice are subject to further funding and the business case to NHSI for this funding was submitted in Dec 2018 and following dialogue with NHSi colleagues, further refined in Mar 18. **Jan-19** Update meeting with ESFRS deferred to allow post contract documentation to be issued by the Main Contractor; now planned for late Jan 19. Additional works referred to by ESFRS notice are subject to further funding. Business case to NHSI for funding was submitted in Dec 2018. **Nov-18** Initial works completed as planned and meeting to update ESFRS on progress to date is due early Nov 18. Business case to NHSI for funding being submitted. Sept - Dec 17 Programme behind schedule as unable to decant wards and asbestos issues. Fire doors replaced and stairwells upgraded. Meeting with ESFRS 6 Nov. **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 ESFRS "project closure" meeting will be held. **May-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. Fire stopping works being carried out to reduce the size of the Seaford and Hailsham fire compartments in line with the recommendations by ESFRS on track for completion by the end of June18 when the risk of fire spread will be considerably lower. Business case drafted, approved by F&I and submitted in the STP wave 4 bids @ £11.16m. **Jan-Mar18** Full survey and supporting information provided to ESFRS. Business case presented at the board seminar in Dec, resulting amendments to be incorporated. 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 commissioned to identify the breaches and pictorial evidence sourced. ESFRS visited Feb-18 to check on progress, advised that breaches in both areas will be rectified by the end of May 2018. As	end Apr-19	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 Data Security and Protection Toolkit (DSPT)				
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.	**Mar-19 Information Security Strategy drafted, crictical success factors and priorities identified. Strategy approved through IPR and will be tabled at Information Steering Group.** **Jan-19** New quarterly security status report produced for Q3 2018-19 – threat level HIGH. Report will be reviewed at IG Steering Group, Audit committee and IPR - annual summary to Trust Board Additional 2 WTE resource approved in principle to support improvements in compliance levels with the aim to move threat level from high to medium to low as a normal state Associate Director of Digital approved in principle for ESHT Digital to aim to certify to the information security standard ISO27001 for hosting service in 2019. Meeting Jan to review opportunities for a joined up STP approach to improving security as most recent proposal not gaining sufficient support from the group ESHT Cyber incident response plan - workshop to produce a local plan arranged Feb. New secure disposal contract for IT waste agreed **Nov-18** Information Security Paper presented to Audit committee/Execs. Funding approved to initiate structured approach to addressing the Information Security Agenda; to be known as the ESHT Information Security Maturity Programme and implemented as part of the Trusts Digital Strategy. Third party engaged to carry-out an initial assessment with the aim to plan a 18-24 month programme of work. Same approach is being presented to STP Digital Steering group to create STP wide approach. TIAA audit commissioned to include assessment of - Information Risk Management Regime; Home/Mobile Working & Removable Media Controls, in particular the Mobile Device Management controls; User education and awareness; Incident Management & Managing User Privileges; Security Monitoring & Configuration; Malware Protection & Network Security. Advanced Threat Protection (ATP) deployment 100% complete STP wide joined up approach to assess Information security maturity not agreed by all members. Facilitated successful workshop for CCG Alliance to develop Cyber Incident Response plan; will be repeated at ESHT to improve local Cyber Incident planning processes. **May-Jul 18** Workstreams to ensure adequate controls in place. STP wide Cyber security framework being proposed. Patching policy developed and approved; more aggressive patching regime for PCs/laptops in place. Process introduced to manage Carecert security alerts to improve response and action. Signed up to National Windows 10 licencing agreement, requires implementation of Microsoft advanced threat protection (ATP) to monitor for threats on PCs and Laptops. Threats reported locally and nationally to NHS digital. **Jan-Mar 18** Action plan published Jan-18. Reviewing IT Security Systems. Phishing email simulation software in place and simulation being undertaken. Funding approved by Sussex COIN board to implement DNS security. Long term sustained programme of work required to deliver assurance that threats from cyber-attacks are adequately controlled. Ongoing development and implementation of action plan, progress presented to IG Steering Group.	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. Paeds and A&E 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-19** Relationship with Medacs continues with 5 candidates having started .Two middle grade Paeds, Consultant Radiology and Stroke and Middle Grade Obstetrics and Gynaecology. A further 6 offers of employment are in process. International recruitment continues with a planned visit to India for Band 5 Nurses, and monthly skype Interviews for both Band 5 nurses and Radiographers **Jan-19** To date, Medacs have made 12 offers of employment.Two Paeds Middle Grades are now in post. Of the balance of 10 offers, 2 are pending applicant acceptance; 3 Doctors have withdrawn, and the Trust withdrew one further offer. **Nov-18** International recruitment continuing for Band 5 Nurses and Radiographers. Social media activity undertaken to support targeted recruitment campaigns for A and E, Radiology and Endo and Diabetes. Medacs (RPO- Recruitment Practice Optimisation) now on site and assisting to recruit against 50 Hard to Fill vacancies. To date 7 offers have been made including 3 at Locum Consultant and Consultant for Stroke, Orthodontics and Rheumatology. Successful recruitment and on boarding of July and Oct intake of Junior Doctors. **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. **Jul-18** Continued Headhunter activity to address Hard to Recruit posts, 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. **Mar- May 18** Medical workforce vacancy rate 4.1% - decreased by 10% over the last 12 months, 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. New starters offered the opportunity to auto-enrol on the bank. Workforce Resourcing Group established, will develop a longer term strategy to meet workforce requirements, taking into account the age profile of the population and will look at new roles and skill mix to meet patient demand. Work continues on driving roster efficiency and job planning.	end Apr-19	◄►	HRD	POD

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
Positive assurances	Clinical Units fully involved in developing business plans Organisation values embedded across the organisation Staff Engagement Action Plan Leadership Conversations National Leadership programmes Surveys conducted - Staff Survey/Staff FFT/GMC Survey Staff events and forums - "Unsung Heroes" Medical engagement score showed great improvement in all area

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
5.2.1	A	The CQC staff surveys provide insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others.	**Mar-19 Staff Survey results published and Tryst results have largely remained static. Survey is currently being shared with divisions and a presentation to the Trust Board will take place in April to agree Corporate priorities** **Jan-19** Final response rate for staff survey 53%. Results will be published end of Feb/early Mar. Planning how we share results with staff and identifying actions. Next staff family and friends test will take place before the end of March Following feedback from staff exploring how we can improve levels of engagement and staff satisfaction with some of our community staff, includes a range of interventions - improved communication , leadership development programme for community leaders and quick wins linked to IT and equipment Piiloting "Stay interviews" with some teams to identify what they enjoy working with ESHT and what further support and development they would like to undertake. Continuing to support staff health and wellbeing . Achieved our 75% target for frontline staff to have flu jab. Currently preparing on how we can provide additional support to staff during winter pressures. **Nov-18** Seeking feedback through staff FFT and the National Staff survey. Q2 Staff FFT response rate 22% – a 1% Increase on previous quarter. National average response rate 13%. 79% of respondents would recommend the Trust for care and treatment to a friend/ family member which is consistent with previous response. 56% would recommend the trust as a good place to work a decrease of 3% compared to Q1 This information will be included in divisional retention plans. Response rate for National staff survey 36%staff being actively encouraged to complete it. Approach to medical engagement is being further developed and ongoing work linked to GMC survey results. Range of health and wellbeing activities continue to be rolled out including managing stress ,healthy weights, menopause clubs **Sep-18** Refreshed approach to Staff retention, divisions received workforce information about why staff are leaving /dissatisfied and deep dives with staff groups/specific work areas to identify how we can improve retention/recommendations for ESHT as a place to work. Launching Staff Health and Well Being plan that sets out 7 priorities; focusing on proactively supporting physical and emotional wellbeing. **Mar-May 18** CQC report highlighted positive engagement had supported cultural change. Continuing to increase our response rate to Staff FFT. 80% of respondents would recommend the trust as a place to work. 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. Drill down identified areas that require further review and will be locally reviewed, 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	end Apr-19	◄►	HRD	POD SLF

Chief Executive's Report

Meeting information:			
Date of Meeting:	2nd April 2019	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:

Introduction

The Trust remains on track to meet its year-end financial target. The capital programme is being tightly managed but work has commenced on the Urology Investigation Suite and has been commissioned for the extension of the Ambulatory Care unit at Conquest. Quality standards are being maintained – in particular as reflected in the latest mortality and sepsis indicators. Participation in national audits, and performance against national standards remains generally good. The Trust continues to perform well on constitutional standards, particularly relative to other Trusts. There was a very good response to the NHS staff survey at ESHT, with early analysis showing continued improvement in key areas. We continue to identify and address counter-cultural behaviours in specific areas.

Quality and Safety

Infection Prevention and Control

Clostridium difficile Infection (CDI): There have been 49 hospital acquired CDI cases to date against a limit of 40 for 2018/19. The majority of cases are in patients over the age of 65 years as expected and have >/= 2 risk factors for developing CDI. The Post Infection Review (PIR) of each case shows that one case may be related to cross infection on Folkington ward. The most significant risk factor for our patients developing infection is broad spectrum antibiotics used to treat sepsis, respiratory tract infection and urinary tract infection without early review and switch to more targeted antibiotics. A recovery plan has been agreed targeting antimicrobial stewardship. One MRSA bacteraemia against ESHT was assessed as not preventable.

Over 380 patients have been diagnosed with influenza at ESHT this season. Influenza A H1N1 is most common and is having high impact on hospital admissions and treatment in ITU/HDUs.

The increase in cases during week commencing 4/2/19 was indicative of an outbreak of hospital acquired (HAI) influenza mainly related to Berwick ward, Cuckmere ward, Seaford 3 and Seaford 4 at EDGH. This has required careful management by the operational and IPC teams to safeguard others from the infection while also supporting patient pathways during a period of escalation at OPAL 3. The outbreak ended on 13/02/18.

To date 10 patients have required admission to ITU. Six patients who are thought to have had hospital acquired infection have died with Influenza A identified on part 1 of their death certificate. A serious incident investigation is being undertaken by IPC with the support of the clinical teams.

Testing for Influenza was extended to Conquest site to assist with the increased demand this year. The Trust has achieved vaccination of over 75% of staff.

Additional communication was required to discourage people from visiting our hospitals while they were symptomatic of Influenza infection. Since last year ESHT has invested in large pull up signage to inform visitors of good practice to limit spread of Influenza.

Serious Incidents
Completing actions that have been identified from incident investigations is an important part of embedding learning identified. Through the monitoring of the progress of actions, there was a concern over the number of overdue actions. To address this there has been a focus on supporting Divisions to review their overdue actions and although further work is required, good progress has been made. A monthly closing the loop report outlining action status for Serious Incident is provided but if no assurance has been provided for an action then this will now transfer to an action tracker to continually monitor any overdue actions.

Mortality
The latest SHMI remains 1.00, the lowest level the Trust has achieved.
The RAMI and HSMR from CHKS (Nov17 to Oct18) are 78 and 83 respectively, both at our lowest level ever, and better than the average of our peers.

People, Leadership and Culture

Recruitment
The substantive staff fill rate is 89.8 % as at the end of January 2019, there are now 693 permanent vacancies across the Trust. Key actions being undertaken include:

- International recruitment is continuing in the Philippines and Indian sub-continent with a planned visit to India and monthly Skype interviews
- Targeted recruitment campaigns to support radiology and urgent care departments
- Social media activity continues with very positive results
- 12 International nurses due to join the Trust by June 2019
- Positive relationship with Medacs continues with 5 candidates in post and a further 6 offers of appointment in the pipeline.

Staff Engagement and Wellbeing

Staff Survey
The staff survey results have been published and on the whole our results show that previous improvements have been maintained, with further improvements in some areas. A presentation of the summary of results will be presented at a Board seminar on 2nd April 2019 and the three corporate priorities agreed. Each division has received their results and is working with staff on their priorities, which will be monitored via the IPR process.

Education
The number of Apprenticeship programmes continues to grow and is being adopted in more areas. The spend committed on apprenticeships to date is £1,084,320.00

Access and Delivery

We continue to maintain our 4 hour performance above 90% and in the top group of Trusts in the country. We have achieved 91.9% against a target of 92% for the eighteen week standard. The 62 day cancer target performance remains a challenge but actions taken are resulting in month by month improvement with a recovery trajectory to July of this year.

System partners are developing plans to utilise existing services and develop new models of care with a view to avoiding duplication, increasing productivity thereby supporting more patients in their own homes. One of the health and social care priorities is to reduce the growth in non-elective demand, increase weekend discharges and increase the number of patients on a same day emergency care basis.

Key schemes include

- Development of the acute frailty model
- implementation of a high intensity user service model
- enhanced training for care home staff
- enhancing integrated health and social care teams at locality level
- simplifying discharge processes and decision making
- extending ambulatory care services to 7 days a week

Communication and engagement

In December we launched the new staff extranet. The focus of the new extranet is "How Do I", and all new material will be written with that question in mind. Analytics show how well our extranet is used, with on average 3000 members of staff accessing the extranet every day. In the month since launch, we saw page views almost double. The extranet is also accessed over 24 hours, making it an important tool to communicate with colleagues out of hours. We now want to encourage a move away from the culture of communication by email, to one where the extranet is front and centre of our internal communications.

In February we highlighted the improvements that we have made in the most recent staff survey. We published materials including an infographic showing the change at ESHT over the last three years. Since 2015 we have seen a 23% increase in those saying care of patients is our top priority; a 25% increase in those saying they would recommend care at ESHT; and a 47% increase in those who would recommend ESHT as a place to work.

In February we also held one of our regular member forums. Forty ESHT members came together in Bexhill to hear more about our plans to transform outpatients and the coming year's quality priorities. As part of the session, members of the public took part in two lively sessions offering their thoughts about our plans.

We have also recently launched our new video and material to raise awareness amongst members of staff about the introduction of ReSPECT. This is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning.

Finance

We are continuing to forecast delivery of our challenging 2018/19 financial plan. We will end the year with a deficit of £44.9m, having delivered on our efficiency requirement and agreed a sensible and fair contract with commissioning contracts. This is testament to the dedication and hard work of colleagues across the organisation, working to manage increased demand, improve performance against national targets and provide good care within constrained budgets.

Our run-rate (the difference between income and expenditure) is quite volatile from month to month – in Month 9, it was a £2m deficit, and in Month 11 it was a £4m deficit - but our underlying run-rate trend continues to improve. In the early months of the 2016/17 financial year, it was consistently above £5m, and as we end this year, it is now consistently at £3.1m deficit each month. This is still too high, but it shows what we can achieve. For next year, we will aim to end the financial year with a monthly deficit of £2m.

Planning for 19/20

Colleagues across the Trust have been finalising their business plans for 2019/20 within the framework developed and set out by the Executive Team. The quality of the plans is high again this year. Over the final weeks of the year we will be signing off budgets and activity plans ensuring that these are fully aligned with the Trust plan. Some of the significant investments we have made in recent months will have a transformational effect on quality and service delivery – the new Urology Investigation Suite, the Ambulatory Care Unit, and the new MRI unit are three key examples.

The Trust plan is to reduce the operational deficit from £44.9m to the control total that we have been set of £34.03m. If we achieve this target, we will earn an additional £25m from central Sustainability & Transformation and Financial Recovery Funds (STF and FRF) .

Strategic Development and Sustainability

Clinical Research

I am delighted to report that two member of our Clinical Research Team received awards from the Kent Surrey and Sussex Clinical Research Network; Jude Tidbury received 'Highly Commended' in the 'Best Contribution to non-commercial research' category and Liz Still received 'Highly Commended' in the 'Involving Patients in research award' category.

East Sussex Healthcare NHS
NHS Trust

Month 11 – February 2019

TRUST INTEGRATED PERFORMANCE REPORT

East Sussex Healthcare NHS Trust

Contents

QUALITY AND SAFETY

DIRECTOR OF NURSING & MEDICAL DIRECTOR

Indicators

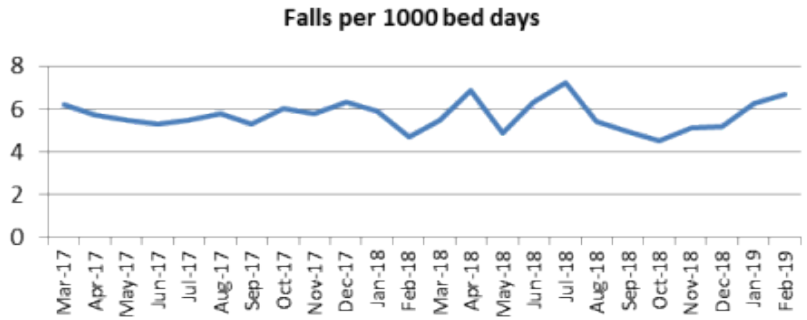
East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Feb-18	Feb-19	Var	2017/18	2018/19	Var		
Total falls	M	105	137	30.5%	1475	1367	-7.3%	125	
Number of no-harm falls	M	79	104	31.6%	1091	1003	-8.1%	93	
Number of minor/moderate falls	M	25	33	32.0%	375	356	-5.1%	32	
Number of major/catastrophic falls	0	1	0	-1	9	8	-1	1	
All patient falls per 1000 Beddays	5.5	4.6	6.4	1.8	5.7	5.7	-0.07	5.5	
All patient falls with harm per 1000 Beddays		1.1	1.6	0.4	1.5	1.5	0.02	1.4	
Falls assessment compliance	M	51.2%	91.4%	40.2%	84.6%	91.4%	6.8%	90.2%	
Total grade 2 to 4 pressure ulcers per 1000 Beddays	M	2.0	2.1	2.7%	2.1	2.2	6.2%	2.2	
Number of grade 2 pressure ulcers	M	43	44	2.3%	498	522	4.8%	48	
Number of grade 3 to 4 pressure ulcers	M	3	0	-3	35	9	-26	1	
Pressure ulcer assessment compliance	M	0.0%	75.0%	75.0%	82.9%	81.5%	-1.3%	78.4%	
VTE Assessment compliance	95.0%	95.3%	96.3%	1.0%	95.7%	95.8%	0.1%	95.8%	

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.

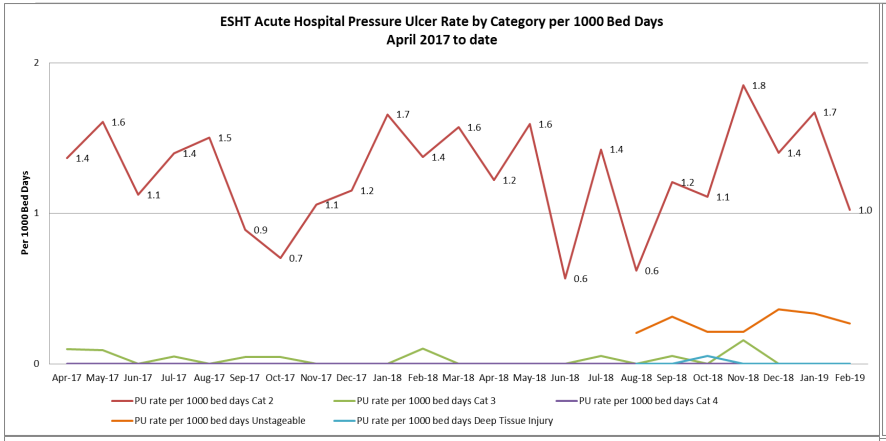
- The percentage of no harm/near miss patient safety incidents for January is 77% (national figure 73%).

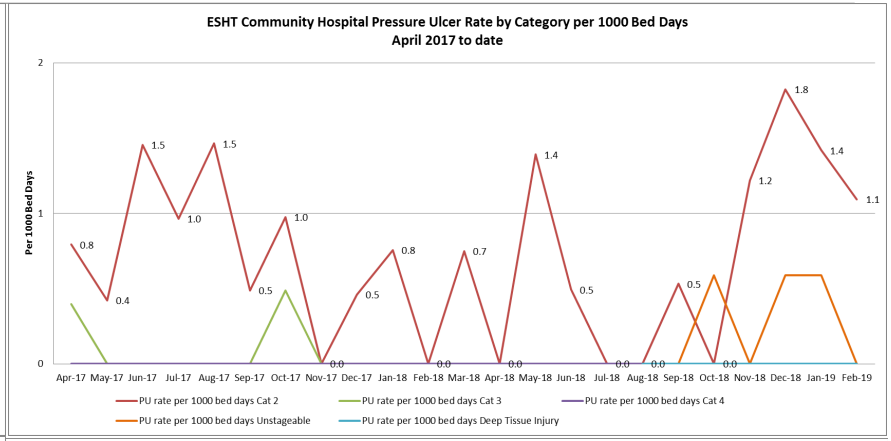
- The rate of falls in February has increased slightly although the actual number decreased. There were 2 x severity 3 falls incident in February.

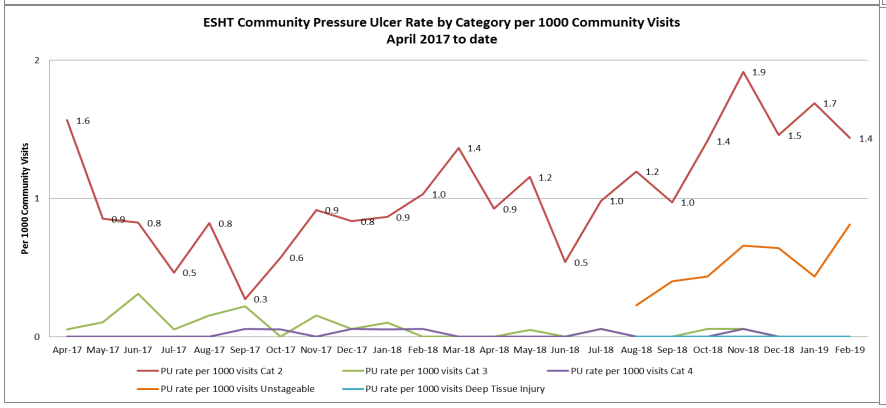


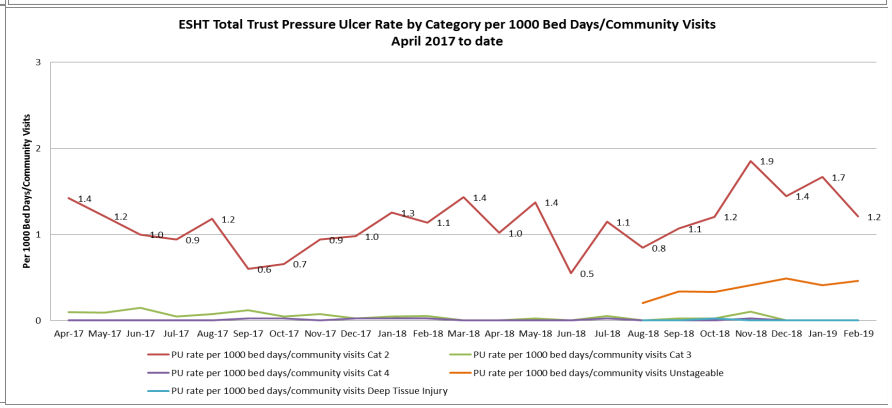
Pressure Ulcer Incidents – February 2019

East Sussex Healthcare NHS Trust









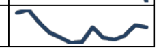
Community Hospitals have continued to report no category 3/4 pressure ulcers since April 2018. The acute setting has also not reported any category 3 or 4 pressure ulcers since December 2018.

There has been a rise in unstageable pressure ulcers in the community setting for February. A ‘deep dive’ will be going to the Patient Safety and Quality Group this month and details themes and trends with an accompanying action plan. These include the issue of non-concordance and the importance of assessing, documenting and reporting skin integrity on admission to ESHT services.

Category 2 damage has shown a significant decrease in all areas across the Trust for February.

East Sussex Healthcare NHS
NHS Trust

Infection Control

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Feb-18	Feb-19	Var	2017/18	2018/19	Var		
Number of MRSA Cases	0	0	0	0	3	1	-2	0	
Number of Cdiff cases	4	1	4	3	31	49	18	4	
Number of MSSA cases	M	0	0	0	9	14	5	1	
Emergency Re-Admissions within 30 days	10.0%	9.5%	7.6%	-1.9%	10.1%	10.6%	0.5%	10.6%	
Crude Mortality Rate	M	2.0%	1.6%	-0.4%	1.7%	1.4%	-0.3%	1.4%	

MRSA bacteraemias - Zero in February

C. Difficile – Limit of 40 cases for 2018/19 has been exceeded.

- 4 cases in February. Two sporadic ribotype identified on the same ward, no obvious source of transmission but awaiting subtyping results to assess if transmission occurred.

MSSA bacteraemias - Zero in February.

Seasonal Influenza

400 Influenza positive cases diagnosed this season, of which 16 patients required ITU care. Cases considered possibly hospital acquired are being investigated with exec oversight by the DoN/DIPC as part of a detailed Root Cause Analysis investigation.

Gram negative bacteraemia

Organism	Total	UTI source	CAUTI source	Biliary	Other	Unknown
E. coli	2	1	0	0	0	1
Klebsiella sp.	1	0	0	0	1	0
Pseudomonas	1	1	(1)	0	0	0
Total (%)	4	2	(1)	0	1	1

1 possible avoidable Klebsiella bacteraemia: RCA undertaken on CAUTI that occurred in a patient with spinal injury, identified possibly avoidable due to lack of documentary evidence of catheter care.

East Sussex Healthcare NHS
NHS Trust

Serious Incidents (SI) reported in February

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Feb-18	Feb-19	Var	2017/18	2018/19	Var		
Number of Serious Incidents	M	3	3	0	42	41	-1	4	
Number of Never Events	0	0	0	0	4	1	-3	0	
Number of medication administration incidents	M	36	32	-11.1%	390	338	-13.3%	32	

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

- 1 x Unexpected complication following thrombolisation procedure
- 1 x Outbreak of Influenza A
- 1 x Unexpected Intra-uterine death

All details are scrutinised at the Weekly Patient Safety Summit and the Patient Safety & Quality Group.

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

There are currently 29 Serious Incidents open in the system all within the correct timescales (10 of which are with the CCG for review). The Amber incident backlog is at 39. A full breakdown of those overdue by number of days is presented to the Patient Safety and Quality Group on a monthly basis with updates from ADoN colleagues for those open longest.
Duty of Candour compliance for all moderate and above harm incidents is at 98% informed verbally, 97% followed up in writing and 93% findings shared with patient or family upon completed investigation.

Patient Experience

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Feb-18	Feb-19	Var	2017/18	2018/19	Var		
Inpatient FFT response rate	45.0%	40.3%	44.9%	4.6%	40.0%	43.7%	3.7%	43.6%	
Inpatient FFT score	96.0%	97.8%	97.7%	-0.1%	97.2%	97.5%	0.3%	97.5%	
A&E FFT response rate	22.0%	4.5%	5.5%	1.0%	8.7%	5.2%	-3.6%	5.1%	
A&E FFT score	88.0%	94.1%	90.1%	-4.0%	89.6%	92.7%	3.1%	92.3%	
Outpatient FFT Score	M	97.1%	97.6%	0.5%	96.1%	97.2%	1.1%	97.1%	
Maternity FFT response rate	45.0%	30.6%	11.6%	-18.9%	32.3%	14.1%	-18.2%	14.8%	
Maternity FFT score	96.0%	100.0%	11.6%	-88.4%	98.4%	66.8%	-31.6%	69.4%	

NHS Choices

- Overall rating at EDGH = 4.5 Stars (an increase from 4) and Overall rating at Conquest = 4.5 Stars
- FFT inpatient rate has decreased slightly to 44.9% in February. Eastbourne ED has decreased to 10.2% and Conquest ED has decreased to 1.3%. % of patients recommending remains in the 90s.

Examples of FFT/ questionnaire comments in February:

Positive comments

- The staff in the room kept reassuring me and the other lady held my hand which made me feel a bit better.
- Friendliness and professionalism of staff comforting relaxed atmosphere.
- All staff who assisted with my care were informative and friendly.

Negative comments

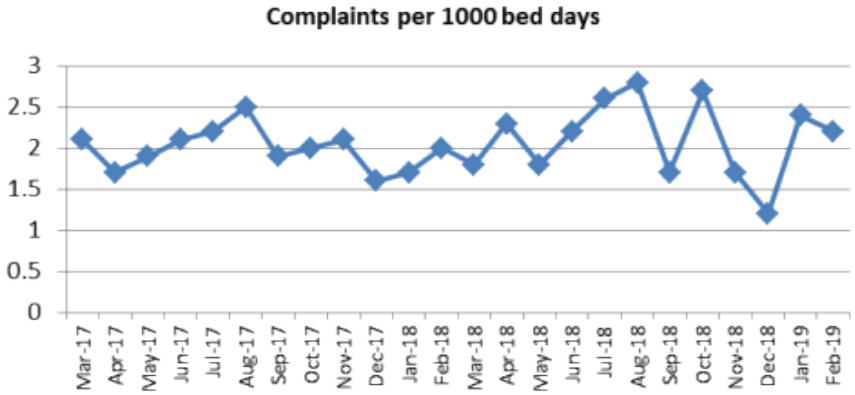
- Maybe for me more pain relief. There was an oxygen mask on me but no one really asked me if I wanted gas.
- I knew there are going to be waiting times but cannot understand why I was asked to come in earlier than the planned time - there seems to have been no need for that.
- The buzzer/call button for side room needs to be looked at as a couple of time I needed help and had to wait for 30 minutes for anyone to come because they hadn't heard the buzzer.

The lowest scoring questions from the inpatient experience questionnaire (part of FFT data) are as follows:

- Were you bothered by noise at night?
- Were you informed as to why you had to repeat clinical information when asked by a nurse or doctor?
- Did you receive written information about your condition (patient information leaflet and discharge letter)

Complaints

East Sussex Healthcare NHS
NHS Trust



47 new complaints were received in February and no overdue complaint responses. The complaints for the Divisions are as follows:

- Medicine – 0.9 per 1000 bed days (12 complaints)
- DAS – 2.6 per 1000 bed days (13 complaints)
- Women, Children and Sexual Health – 6.1 per 1000 bed days (4 complaints)
- Urgent Care - 7 complaints
- Out of Hospital – 4 complaints

The Parliamentary and Health Service Ombudsman (PHSO) had 1 contacts and 1 outcome in February:

- 1st contact - concerning poor communication and arrangements between all organisations following a patient's transfer to London causing a delay for therapy assessment at home. The Local Government Ombudsman reviewing the case had initially asked the Trust to respond to the complaint via them as the complaint had not been sent to us.
- 1st outcome - partially uphold a complaint relating to nursing care provided during a hospital admission. The complaint was multifactorial and the PHSO felt there was failure in record keeping regarding aspects of personal care and have requested an apology and evidence of steps to be taken regarding the importance of record keeping.

Mixed Sex Accommodation

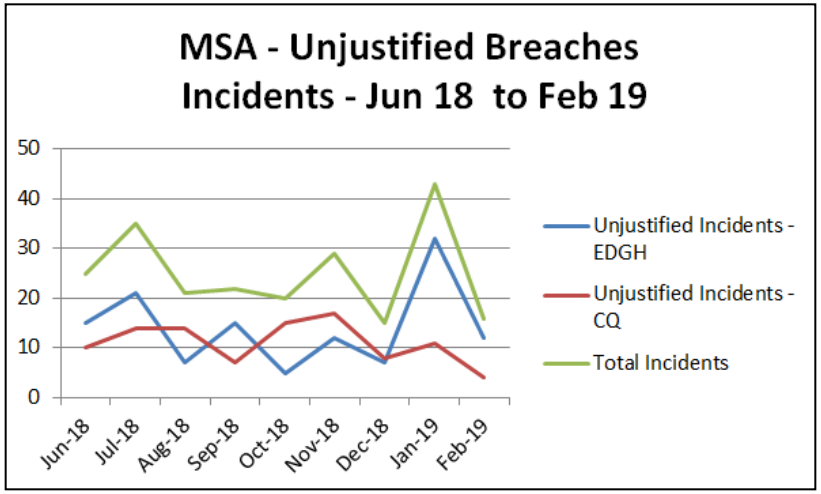
East Sussex Healthcare NHS
NHS Trust

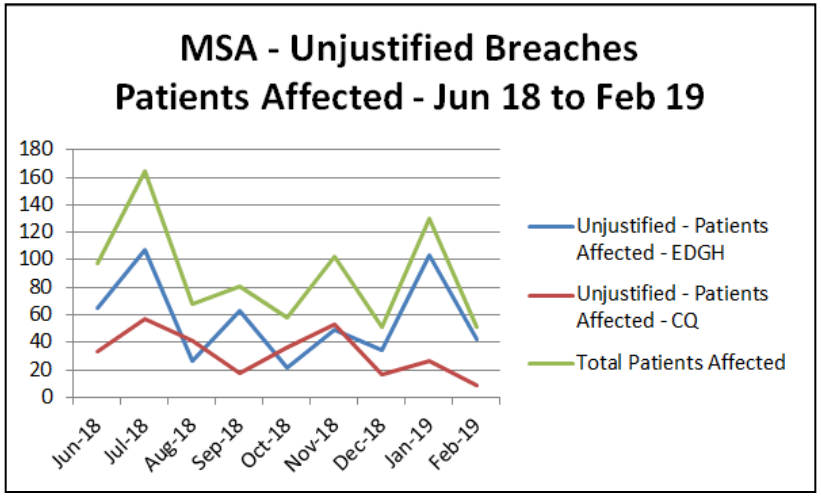
In February the total number of validated and reportable unjustified incidents for the Trust was 16, affecting 51 patients.

Breaches continue to be associated with the following areas:
Conquest – ITU/HDU
Eastbourne – Coronary Care/Coronary Step Down Unit

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

No complaints or concerns were raised regarding any mixing in February.





East Sussex Healthcare NHS
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Safer Staffing and Workforce – February 2019

Fill Rate and CHPPD by Site - Feb-19	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
BEXHILL HOSPITAL	83.3%	117.2%	100.7%	116.3%	9.87
EASTBOURNE DISTRICT GENERAL HOSPITAL	88.2%	95.6%	87.9%	107.8%	8.02
CONQUEST HOSPITAL	93.7%	106.1%	84.7%	109.1%	8.32
Totals	90.9%	101.8%	86.6%	108.9%	8.24

Fill Rate and CHPPD by Division - Feb-19	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
Medicine	83.4%	103.3%	88.7%	117.1%	7.54
Out-of-Hospital	87.0%	109.9%	98.1%	110.9%	5.80
Surgery Anaesthetics & Diagnostics	89.6%	89.9%	84.5%	95.3%	8.69
Women Children & Sexual Health	120.6%	127.4%	82.1%	86.1%	17.08
Totals	90.9%	101.8%	86.6%	108.9%	8.24

- Exceptions to the 100% fill rate continue to be driven by additional duties for escalation beds, risk assessed and authorised enhanced care for individual patients and HCA usage to support some RN gaps.
- The twice daily site staffing meetings review all staffing by ward, including skill mix, and agree redeployments of staff to mitigate any risks between the site team and divisional senior nursing teams.
- Trust CHPPD has decreased slightly to 8.24 in February from 8.6 in January. The latest national median CHPPD (December 2018) was 8.0.
- Divisionally, WSCH CHPPD has reduced from 20.98 in January to 17.08 in February. WCSH division contain a number of highly specialised areas with specific staffing ratios e.g. SCBU and obstetrics. A review identified some data issues for January which are being resolved.
- We are seeking support from Model Hospital/NHSI to further investigate and compare our CHPPD per day for WSCH to understand how we compare against others in this specialist area.

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

Workforce

- The planned establishment reviews for Nursing and Midwifery are underway and will report in the next quarter.

- Planned Winter Escalation beds and wards (opened late in December) remained open in February, as well as some ad-hoc beds which flex up and down according to operational demand (Cookson – Devas ward, Cookson Attenborough ward, Polegate ward & the Annex in A&E EDGH). Although less beds are open this continues to pose significant challenges in relation to staffing resources and is monitored and managed carefully through the twice daily safer staffing meeting for nursing and by the Clinical Site teams out of hours.

- Workforce challenges remain one of our biggest risks which is exacerbated by significant and sustained operational pressures.

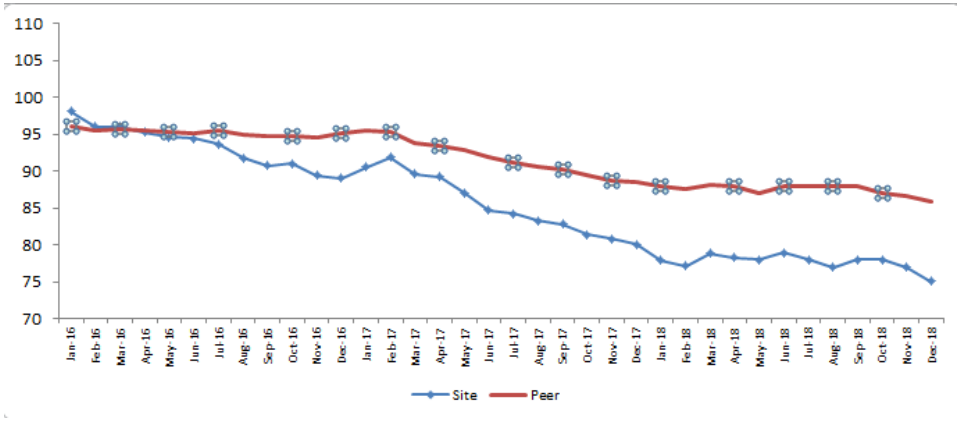
- Nursing recruitment visit to India planned for April 2019.

- The Director of Nursing has some concerns regarding an increased number of falls and pressure ulcers in recent months, being in some part related to significant additional capacity being open and an increased reliance on temporary staff and/or staffing gaps.

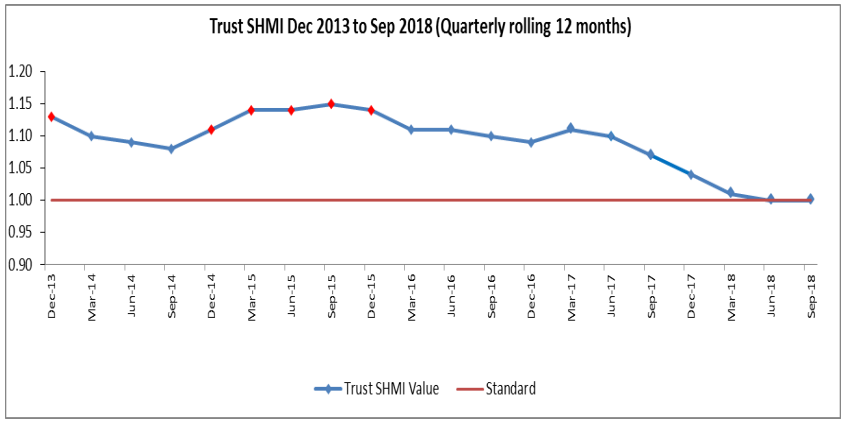
Mortality Metrics

East Sussex Healthcare NHS Trust

RAMI 17 (Rolling 12 months)



SHMI (Rolling 12 months)



SHMI for the period October 2017 to September 2018 is **1.00**. The Trust remains within the EXPECTED range.

RAMI 17 - January 2018 to December 2018 (rolling 12 months) is **75** compared to 80 for the same period last year (January 2017 to December 2017). December 2017 to November 2018 was 77.

RAMI 17 shows a December position of 65. The peer value for December is 97. The November position was 68 against a peer value of 82.

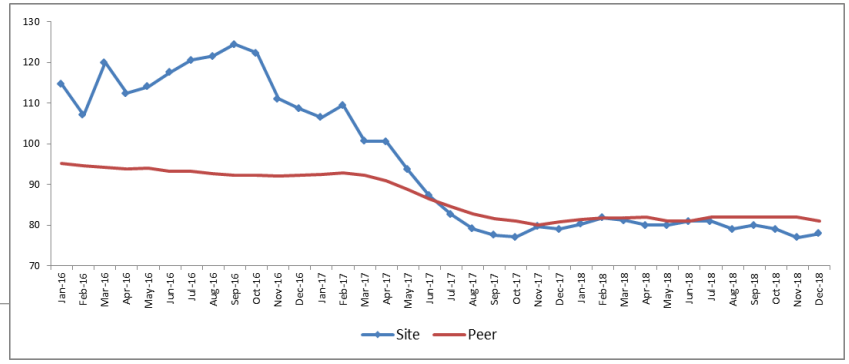
Crude mortality shows January 2018 to December 2018 at 1.59% compared to 1.79% for the same period last year.

The percentage of deaths reviewed within 3 months was 76% in November 2018, October 2018 was also 76%.

SHMI (NHS Digital) Top 5 diagnostic groups by Volume Oct 17 to Sep 18	Observed deaths	Expected deaths	SHMI
Septicaemia (except in labour), Shock.	486	504	0.96
Pneumonia (except that caused by tuberculosis or se	390	405	0.96
Acute cerebrovascular disease.	142	143	0.99
Congestive heart failure; nonhypertensive.	109	94	1.16
Fracture of neck of femur (hip).	82	64	1.28

Main causes of death during February 2019 (Mortality Database)	
Pneumonia	42
Cancer	19
Sepsis/Septicaemia	11
Myocardial Infarction	8
Community-acquired Pneumonia	6

RAMI 17 Septicaemia CCS Group (Rolling 12 months)



Access & Delivery

ACCESS AND DELIVERY

East Sussex Healthcare NHS Trust

URGENT CARE

Access and Delivery

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Feb-18	Feb-19	Var	2017/18	2018/19	Var		
Four hour standard	95.0%	86.8%	83.8%	-3.1%	87.7%	90.7%	3.1%	90.3%	
A&E Minor Performance	98.0%	97.1%	96.3%	-0.9%	97.6%	98.9%	1.3%	98.8%	
Four hour standard (Local System)	95.0%	90.0%	87.7%	-2.4%		92.8%			
12 Hour DTAs	0	0	0	0	0	0	0	0	
Unplanned re-attendance to Emergency Department	5.0%	2.5%	2.7%	0.2%	2.8%	3.5%	0.7%	3.4%	
% Patients waiting less than 15 minutes for assessment in ED	M	78.7%	77.3%	-1.4%	82.7%	85.8%	3.1%	85.6%	
% Patients waiting less than 60 minutes for treatment in ED	M	52.6%	38.3%	-14.3%	46.3%	47.9%	1.6%	47.7%	
% Patients waiting less than 120 minutes for treatment in ED	M	83.0%	70.5%	-12.5%	75.9%	79.9%	4.0%	79.5%	
% Patients that left without being seen in ED	M	1.7%	2.1%	0.4%	1.7%	2.1%	0.4%	2.1%	
% Patients admitted from ED (Conversion rate)	M	33.0%	30.1%	-3.0%	28.9%	30.0%	1.0%	30.1%	
Emergency Department attendances	M	8651	10137	17.2%	108275	117997	9.0%	10714	
Ambulance conveyances	M	2944	3063	4.0%	35343	35104	-0.7%	3208	

The Trusts' 4 hour performance was 83.8% for February 2019.

The system 'Walk-In' centres and the Acute Trusts combined performance for February was 87.7%. This performance ranked ESHT 47th out of 136 (Acute trust footprints) in the country.

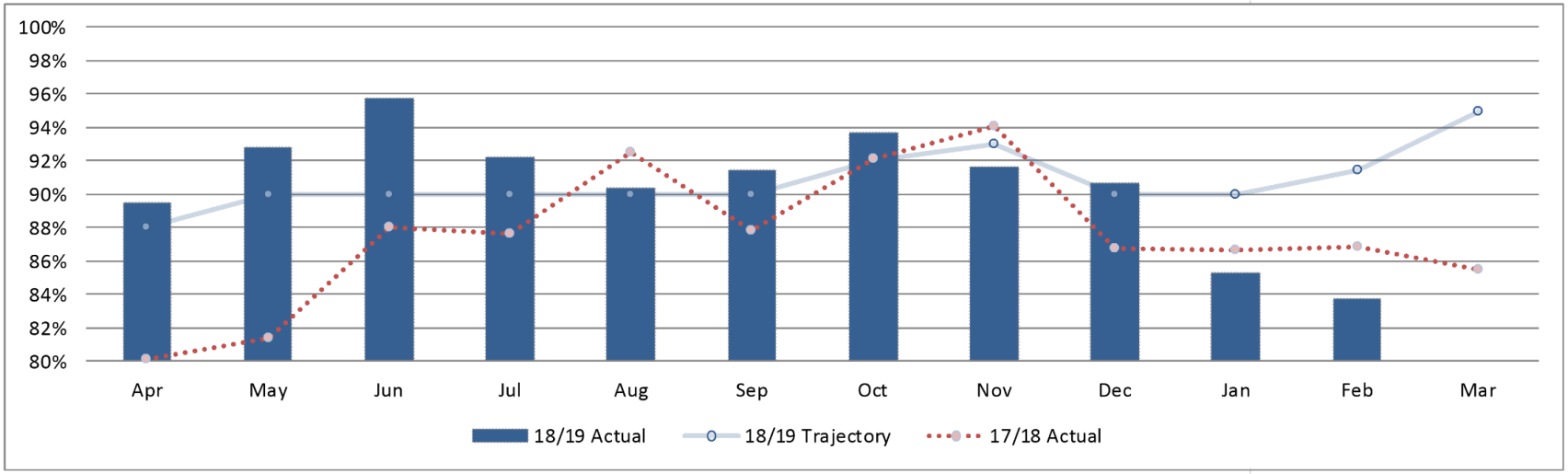
Activity continues to be higher than previous years, A&E attendances are up 9.0% year to date and non-elective spells are up 10.4% year to date.

The system has some key schemes in place focusing on reducing non-elective demand, with a particular focus on reducing frequent attenders and supporting frail elderly patients in an out of hospital setting.

A&E Trajectory

East Sussex Healthcare NHS
NHS Trust

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



	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%	92.2%	90.4%	91.4%	93.7%	91.6%	90.6%	85.3%	83.8%	
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%
National Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

The Trusts' 4 hour performance for February 2019 was 83.8% (Conquest 88.2% and EDGH 79.5%)

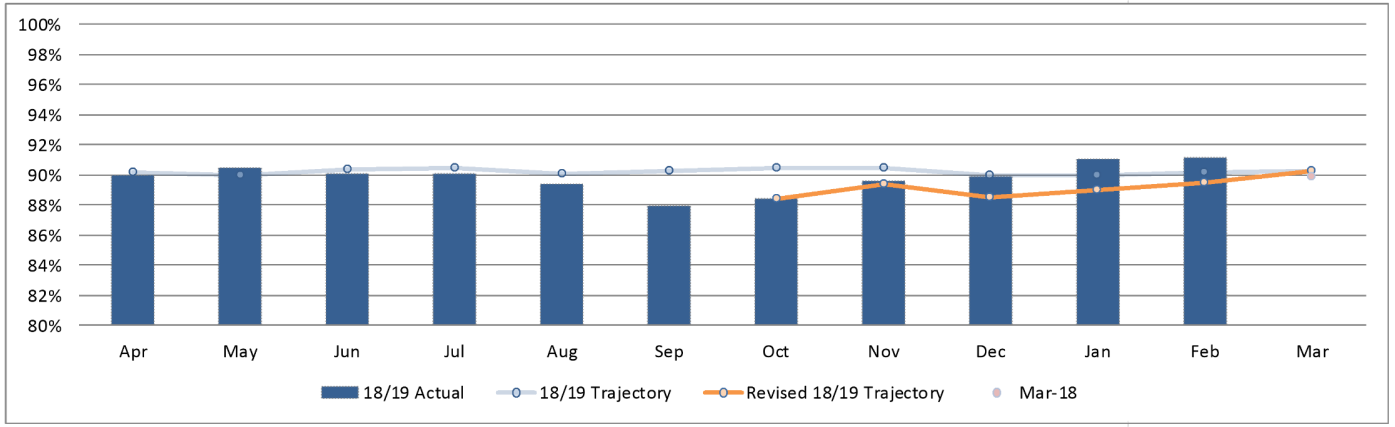
- Minors performance for February 2019 decreased to 96.3%.
- Attendances in February were up 17.2% against the corresponding month last year.
- Ambulance conveyances have decreased by 0.7% year to date.

East Sussex Healthcare NHS
NHS Trust

RTT

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Feb-18	Feb-19	Var	2017/18	2018/19	Var		
RTT Incomplete standard	92.0%	90.2%	91.1%	0.9%	91.3%	89.8%	-1.5%	89.8%	
RTT Backlog (Number of patients waiting over 18 weeks)	M	2777	2366	-411	2777	2366	-411	2862	
RTT Total Waiting List Size	28221	28348	26721	-1627	28348	26721	-1627	28219	
RTT 52 week waiters	0	0	0	0	2	0	-2	0	
RTT 35 week waiters	M	165	163	-1.2%	165	163	-1.2%	185	

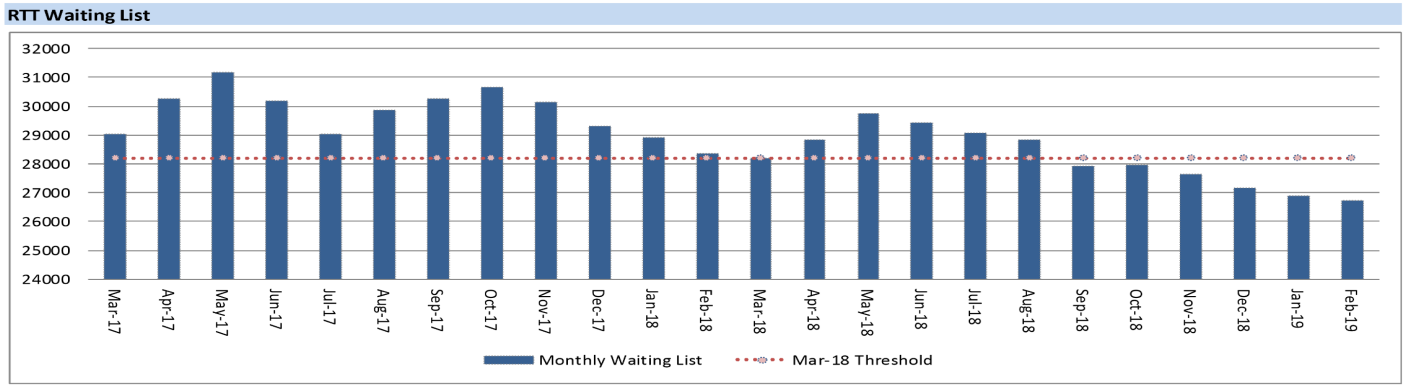
RTT (Referral to Treatment 18 Weeks)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	90.2%	90.0%	90.4%	90.5%	90.1%	90.3%	90.5%	90.5%	90.0%	90.0%	90.2%	90.3%
Revised 18/19 Trajectory							88.4%	89.4%	88.5%	89.0%	89.5%	90.3%
18/19 Actual	90.0%	90.5%	90.1%	90.1%	89.4%	87.9%	88.4%	89.6%	89.9%	91.1%	91.1%	
Mar-18												89.9%

- The Trust performance for February 2019 was 91.1%, with performance 1.6% above the revised trajectory for 18/19.
- Focus continues on out-patient and theatre efficiency in order to manage demand and capacity without additional costs.

RTT Waiting list



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Actual	28853	29767	29426	29066	28818	27942	27983	27652	27150	26904	26721	
17/18 Actual	30284	31188	30179	29053	29886	30260	30655	30149	29302	28909	28348	28221

Surgery: *Performance collectively has remained static from Jan – Feb 19.*

- ENT and Ophthalmology, whilst both recovering steadily have seen rate of improvement slow in February.
- T&O has seen another 2% improvement taking it to 87.37% which is the highest it has been this financial year.

Medicine: *Steady state remains.*

- Gastro has remained at just over 90%, all other specialties are achieving

Women & Children: *Continued overall improvement since Dec 18.*

- Paediatrics continues to deliver over 95%.
- Gynae is improving month on month since Sept 18 and with new consultant and registrar now in place, should see capacity and therein, performance improve. Although now only sitting at 81% with a sizeable backlog to recover position whilst maintaining a steady state. (500 admitted patients and over 2,000 follow ups). Working with ADO and service manager on business plan and recovery.

East Sussex Healthcare NHS
NHS Trust

CANCELLATIONS AND DTC

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Feb-18	Feb-19	Var	2017/18	2018/19	Var		
Super Stranded (Census on last day of month)	M	144	106	-38	68	53	-15	110	
Avg Daily Super Stranded Beddays (single month metric)	142	175	166	-9	196	156	-40	160	
Avg Daily Super Stranded Beddays (rolling 3 month avg NHSI metric)	142	174	160	-14	201	159	-42	161	
Delayed transfer of care national standard	3.5%	1.7%	4.9%	3.3%	3.9%	3.0%	-0.9%	2.8%	
Cancellations									
Urgent operations cancelled for a second time	0	0	0	0	1	4	3	0	
Proportion of last minute cancellations not rebooked within 28 days	0.0%	0.0%			0.7%	1.0%	0.3%	1.5%	

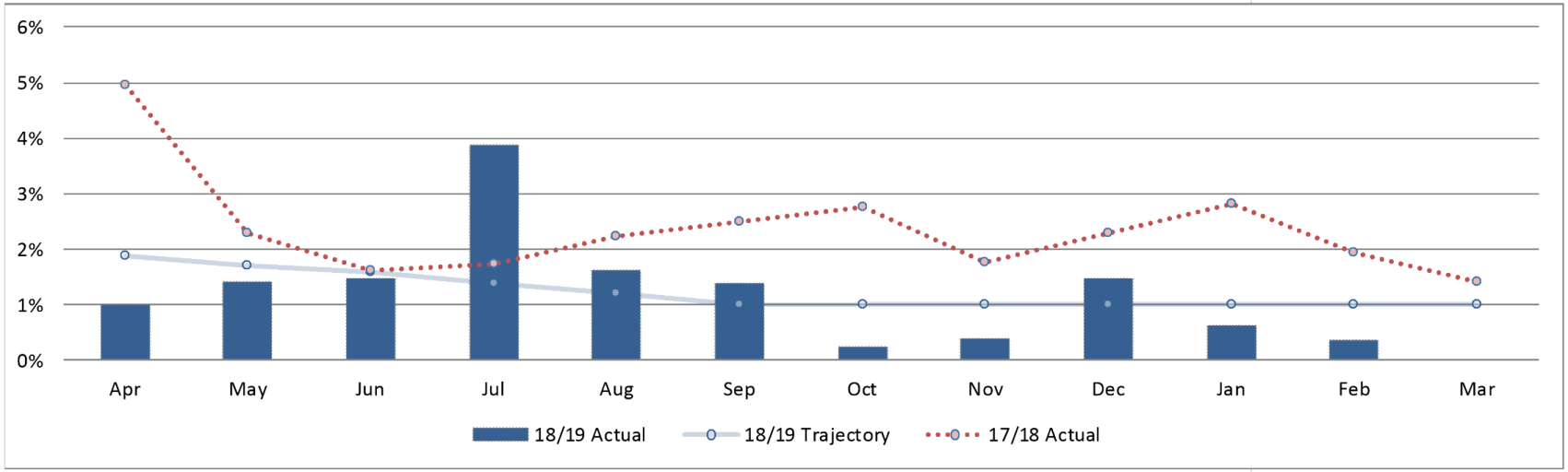
- DTC performance for February has declined to 4.9%, not meeting the 3.5% target.
- Although super stranded patient numbers have declined over the past 12 months, we have seen a slight increase over the winter period and this has resulted in non-achievement of the rolling 3 month NHSI metric
- An improvement plan and trajectories are in development with the aim of meeting the NHSI standards of achieving a 40% reduction in the superstranded patients and an increase in weekend discharges.

Diagnostics

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Feb-18	Feb-19	Var	2017/18	2018/19	Var		
Diagnostic standard (% patients waiting more than 6 weeks)	1.0%	1.9%	0.4%	-1.6%	2.4%	1.3%	-1.2%	1.3%	

Diagnostic waiting times (over 6 weeks)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	1.9%	1.7%	1.6%	1.4%	1.2%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
18/19 Actual	1.0%	1.4%	1.5%	3.9%	1.6%	1.4%	0.3%	0.4%	1.5%	0.6%	0.4%	
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%
National Target	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%

February met the 6 week diagnostic target with a final position of 0.4%.

A total of 7 breaches occurred in February 2019 - Non-obstetric ultrasound (1), Audiology - Audiology Assessments (2), Respiratory physiology - sleep studies (3), Cystoscopy (1)

East Sussex Healthcare NHS
NHS Trust

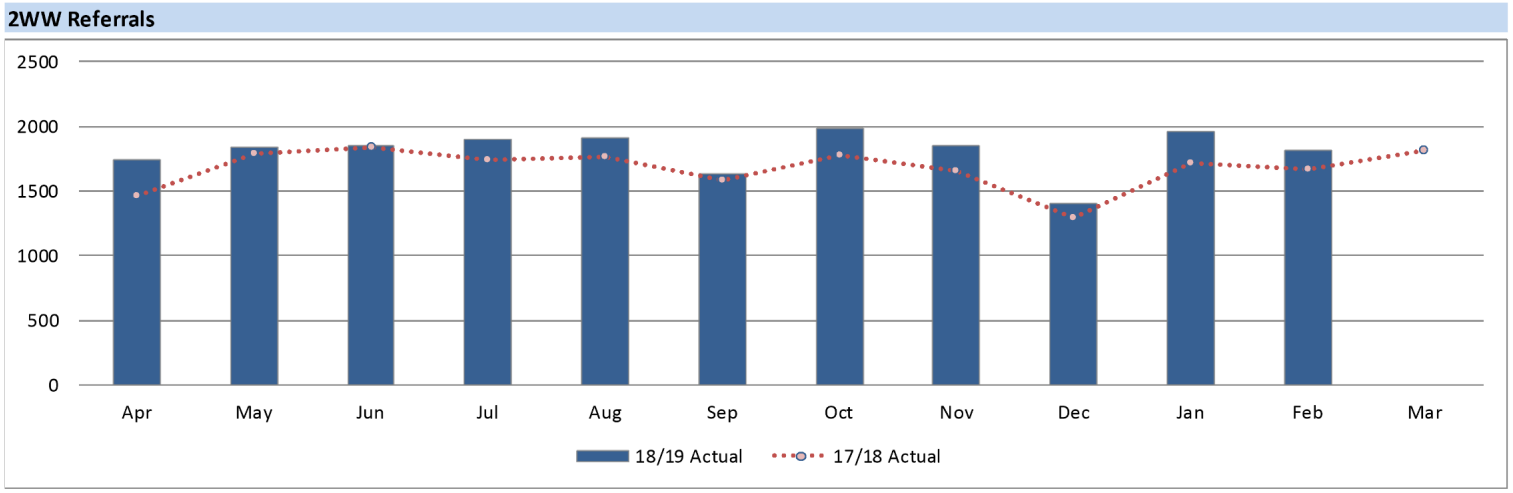
CANCER STANDARDS

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jan-18	Jan-19	Var	2017/18	2018/19	Var		
Cancer 2WW Standard	93.0%	95.8%	93.8%	-2.0%	96.1%	93.8%	-2.3%	93.9%	
Cancer 62 day urgent referral standard	85.0%	65.5%	72.9%	7.4%	75.7%	71.2%	-4.5%	71.7%	
Cancer 2WW Standard (breast symptoms)	93.0%	94.4%	95.7%	1.3%	95.9%	95.7%	-0.3%	95.6%	
Cancer 31 day standard	96.0%	95.6%	98.6%	3.1%	97.3%	94.4%	-3.0%	94.5%	
Cancer 31 day subsequent drug treatment	98.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Cancer 31 day subsequent surgery	94.0%	100.0%	100.0%	0.0%	98.4%	86.0%	-12.4%	87.3%	
Cancer 62 day screening standard	90.0%	66.7%	63.6%	-3.0%	71.9%	68.2%	-3.7%	66.0%	

- Performance decreased to 72.9% for January compared to the December performance of 80.7%. Historically performance decreases in January as a result of the impact of Christmas and New Year and the delays that result in the pathways being pushed into January (and February). Performance was still above the Trust recovery trajectory.
- Activity numbers (62 day treatments) for January increased significantly compared to the total treatments reported for November and December, the total figure of 173.5 reported (for January) was the highest total reported by the Trust to date.
- An analysis of all of the 62 day breaches (by the Cancer Services Team) showed that 18 of the 47 breaches were deemed as potentially avoidable breaches e.g. within ESHT's control. If the 18 breaches had not occurred the Trust would have reported 29 breaches out of 173.5 treatments with a compliance of 83.3%.
- Lung, Head and Neck, Haematology, Urology and Gynaecology are the highest breaching specialities this month (January) of the 62 Day Standard.

East Sussex Healthcare NHS
NHS Trust

Cancer 2 Week Wait Referrals



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Actual	1736	1842	1855	1903	1912	1630	1978	1846	1403	1962	1809	
17/18 Actual	1460	1784	1833	1736	1771	1579	1777	1656	1300	1718	1671	1809

Suspected Cancer Site by Date of Decision to Refer

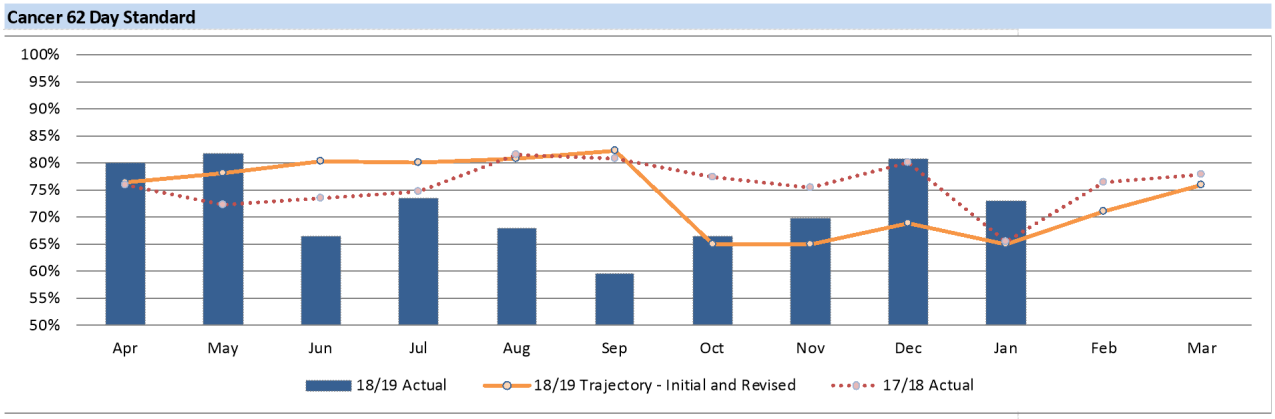
Suspected Cancer Site	Apr 17 to Feb 18	Apr 18 to Feb 19	% Variance
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	1,645	1,595	-3.0%
Other suspected cancers	36	27	-25.0%
Suspected brain/central nervous system tumours	69	72	4.3%
Suspected breast cancer	2,131	2,753	29.2%
Suspected childrens cancer	20	15	-25.0%
Suspected gynaecological cancers	1,428	1,555	8.9%
Suspected haematological malignancies (excluding acute leukaemia)	149	190	27.5%
Suspected head & neck cancers	2,015	1,959	-2.8%
Suspected lower gastrointestinal cancers	2,920	3,628	24.2%
Suspected lung cancer	672	616	-8.3%
Suspected sarcomas	1	1	0.0%
Suspected skin cancers	3,491	3,611	3.4%
Suspected testicular cancers	146	210	43.8%
Suspected upper gastrointestinal cancers	1,762	1,509	-14.4%
Suspected urological cancers (excluding testicular)	1,800	2,135	18.6%
Grand Total	**18,285**	**19,876**	**8.7%**

2WW referrals are currently up 8.7% year to date. This increase continues to add pressure on the system.

As part of the Cancer Recovery plan, the Trust is working with CCG colleagues to review and understand the continued increase in 2WW referrals.

Cancer 62 Days

East Sussex Healthcare NHS Trust



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory - Initial and Revised	*76.5%*	*78.1%*	*80.3%*	*80.0%*	*80.8%*	*82.2%*	*65.0%*	*65.0%*	*69.0%*	*65.0%*	*71.0%*	*76.0%*
18/19 Actual	80.1%	81.9%	66.3%	73.4%	68.0%	59.7%	66.3%	69.8%	80.7%	72.9%		
17/18 Actual	76.0%	72.4%	73.4%	74.7%	81.6%	80.8%	77.4%	75.4%	80.2%	65.5%	76.6%	78.0%
National Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

- Following September's 2018 performance the Trust took steps to realign the focus on the 62 day standard and build a recovery plan with a trajectory to show recovery in July 2019.
- Some key actions and developments from the plan:
    i. 28 day lower GI pathway implemented (FIT and straight to test) with primary care for pathway compliance
    ii. Cancer Alliance support in place 2 days per week
    iii. Working with SES Cancer Alliance and other providers to develop a standardised access policy
    iv. Booking of Radiology appointments straight from clinic
    v. MRI's no longer outsourced which has reduced the pathway timeline
    vi. Scope potential funding opportunities for an additional Breast Care CNS and Colorectal pathway matron
    vii. Development of the Urology Investigations Suite from late May 19

Cancer Summary

January 2019 Summary					
Standard	Total Seen /Treated	On Target	Breaches	Compliance	Target
Cancer Two Week Wait	1,536	1,441	95.0	93.8%	93%
Breast Symptom Two Week Wait	138.0	132.0	6.0	95.7%	93%
31 Day First Treatment (Tumour)	218.0	215.0	3.0	98.6%	96%
31 Day Subsequent Surgery	19.0	19.0	0.0	100.0%	94%
31 Day Subsequent Drug Treatments	10.0	10.0	0.0	100.0%	98%
31 Day Subsequent Palliative Treatments	11.0	11.0	0.0	100.0%	N/A
Cancer 62 Day Standard (Tumour)	173.5	126.5	47.0	72.9%	85%
62 Day Screening Standard (Tumour)	5.5	3.5	2.0	63.6%	90%
62 Day Upgrade Standard (Tumour)	21.5	19.5	2.0	90.7%	N/A

East Sussex Healthcare NHS
NHS Trust

Cancer Standards – Cancer 62 Days

January 2019 2WW Referral to First Treatment 62 Days

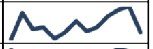
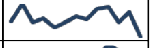
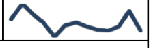
Tumour Site	Total treated	Treated within 62 days	Breaches	% meeting standard
Other	1.0	1.0	0.0	**100.0%**
Upper GI	13.5	12.0	1.5	**88.9%**
Skin	29.0	25.5	3.5	**87.9%**
Colorectal	22.0	19.0	3.0	**86.4%**
Breast	27.0	22.0	5.0	**81.5%**
Gynaecology	9.0	6.0	3.0	**66.7%**
Urology	48.5	30.5	18.0	**62.9%**
Lung	12.0	6.5	5.5	**54.2%**
Haematology	8.0	3.0	5.0	**37.5%**
Head & Neck	3.5	1.0	2.5	**28.6%**
Totals:	**173.5**	**126.5**	**47.0**	**72.9%**

Activity

ACTIVITY

Acute Activity

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Feb-18	Feb-19	Var	2017/18	2018/19	Var		
Emergency Department attendances	M	8651	10137	17.2%	108275	117997	9.0%	10714	
Ambulance conveyances	M	2944	3063	4.0%	35343	35104	-0.7%	3208	
Admissions via A&E	M	33.0%	30.1%	-3.0%	28.9%	30.0%	1.0%	30.1%	
Elective spells	M	590	503	-14.7%	6590	6052	-8.2%	559	
Day Cases	M	3712	3741	0.8%	43073	43244	0.4%	3926	
Elective Beddays	M	1503	1942	29.2%	17500	18492	5.7%	1714	
Total Non-Elective Spells	M	4126	4376	6.1%	46166	50984	10.4%	4658	
Number of Emergency spells	M	3563	3850	8.1%	39439	44503	12.8%	4064	
Number of Maternity spells (ante and post partem)	M	308	276	-10.4%	3629	3427	-5.6%	314	
Number of other non-elective spells (Births/Transfers from other hospitals)	M	255	250	-2.0%	3098	3054	-1.4%	279	
Non-Elective beddays	M	21133	19510	-7.7%	239876	222976	-7.0%	20532	
LOS									
Elective Average Length of Stay	M	2.5	3.9	1.3	2.7	3.1	0.4	3.1	
Non-Elective Average Length of Stay	M	4.9	4.6	-0.3	5.2	4.4	-0.8	4.5	
Inpatient Average Length of Stay at intermediate care units	M	30.1	26.3	-3.8	28.2	25.3	-2.9	25.8	

Leadership & Culture

LEADERSHIP & CULTURE

HR DIRECTORATE
Feb 2019
Version v4.0

East Sussex Healthcare NHS
NHS Trust

CONTENT

East Sussex Healthcare NHS
NHS Trust

TRUST OVERVIEW

TRUST														
WORKFORCE CAPACITY	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend line
Budgeted fte	6,859.8	6,859.1	7,060.0	6,981.2	6,993.4	7,031.1	6,941.3	6,914.1	6,915.7	6,915.1	6,906.1	7,031.9	7,033.8	
Total fte usage	6,716.4	6,875.5	6,910.5	6,681.7	6,707.4	6,755.4	6,667.0	6,679.1	6,622.4	6,737.3	6,655.5	6,575.2	6,682.6	
Variance	-143.4	16.4	-149.5	-299.5	-286.0	-275.7	-274.3	-235.0	-293.3	-177.8	-250.6	-456.7	-351.2	
Permanent vacancies	537.1	527.6	644.6	605.2	651.3	663.5	641.2	611.9	576.4	556.6	595.9	693.2	659.1	
Fill rate	92.0%	92.2%	90.5%	91.0%	90.4%	90.3%	90.5%	90.9%	91.4%	91.7%	91.1%	89.8%	90.3%	
Bank fte usage (as % total fte usage)	6.7%	9.1%	10.1%	7.3%	8.1%	8.3%	7.8%	8.1%	6.8%	7.9%	7.6%	7.7%	7.1%	
Agency fte usage (as % total fte usage)	1.9%	1.9%	1.6%	1.9%	1.8%	1.7%	1.6%	1.4%	1.2%	1.4%	1.2%	1.2%	1.5%	
Turnover rate	11.1%	11.0%	10.9%	11.0%	10.9%	11.1%	11.0%	10.8%	10.7%	11.0%	11.1%	11.1%	10.9%	
Stability rate	91.9%	92.7%	92.1%	91.9%	89.5%	92.0%	92.0%	91.8%	91.4%	91.0%	90.9%	89.8%	91.1%	
SICKNESS ABSENCE														
Annual sickness rate	4.5%	4.5%	4.5%	4.5%	4.5%	4.4%	4.4%	4.4%	4.4%	4.4%	4.3%	4.2%	4.3%	
Monthly sickness rate (%)	4.6%	4.1%	3.6%	3.7%	3.5%	3.8%	3.9%	4.2%	4.4%	4.6%	4.4%	4.7%	4.6%	
Short term sickness (<28 days)	48.4%	57.5%	45.9%	44.3%	46.0%	41.2%	45.0%	42.6%	46.5%	55.1%	51.3%	60.7%	60.7%	
Monthly long term sickness (28 days+)	51.6%	42.5%	54.1%	55.7%	54.0%	58.8%	55.0%	57.4%	53.5%	44.9%	48.7%	39.3%	39.3%	
MANDATORY TRAINING & APPRAISALS														
Appraisal rate	81.3%	79.6%	79.5%	79.2%	78.1%	78.2%	79.7%	80.1%	79.5%	80.6%	81.3%	80.9%	79.8%	
Fire	86.5%	86.6%	86.2%	87.4%	87.1%	86.6%	87.6%	87.2%	88.2%	87.9%	87.2%	87.5%	87.2%	
Moving & Handling	90.3%	90.1%	89.4%	89.9%	89.8%	88.7%	89.2%	89.2%	90.2%	90.4%	90.3%	91.1%	91.2%	
Induction	95.1%	94.8%	94.4%	95.0%	94.3%	94.8%	96.2%	95.5%	91.3%	90.8%	91.1%	92.0%	92.1%	
Infec Control	89.9%	90.2%	89.9%	90.5%	90.1%	89.6%	90.0%	89.7%	90.9%	91.0%	91.0%	90.7%	90.6%	
Info Gov	86.5%	86.3%	85.8%	85.1%	83.8%	84.7%	84.0%	82.5%	82.0%	80.5%	79.3%	79.1%	76.2%	
Health & Safety	87.4%	88.0%	88.8%	89.1%	88.6%	89.4%	88.7%	88.2%	88.3%	87.6%	88.2%	87.6%	88.0%	
MCA	95.3%	95.8%	95.8%	96.1%	96.1%	96.5%	96.5%	95.7%	95.7%	95.1%	95.6%	95.6%	95.5%	
DoLs	96.3%	96.4%	96.4%	96.8%	96.9%	97.2%	96.7%	94.9%	94.9%	93.9%	94.4%	95.0%	95.0%	
Safeguarding Vulnerable Adults	85.2%	84.7%	84.2%	85.8%	86.0%	86.7%	86.6%	86.3%	87.2%	86.8%	87.2%	87.6%	87.5%	
Safeguarding Children Level 2	85.4%	85.3%	84.7%	86.4%	87.4%	87.6%	87.8%	87.5%	88.2%	88.0%	88.4%	88.5%	87.3%	

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

MONTHLY HEADLINES

- Trust total workforce utilisation for February 6,682.6 fte which is 351.2 fte below the budgeted establishment however actual expenditure (£24,531k) is above budget (£23,520k) by £1,011k

- Substantive expenditure of £21,287k accounts for 86.8% of total expenditure & temporary expenditure of £3,244k which equates to 13.2% of total as follows:
    - Bank £2,212k (9.0%) increase due to cover for escalation wards & an additional financial adjustment (Christmas week)
    - Agency £772k (3.2%) small increase due to escalation & cover for vacancies
    - Overtime £36k (0.1%)
    - Waiting List payments £224K (0.9%) increase of £63k due to ad-hoc clinics (Ophthalmology & Radiology)

- The Trust vacancy rate has reduced by 0.5% to 9.7% (reduction of 34.1fte) due to focussed recruitment for all staff groups. Current vacancies equate to 659.1 fte with continuing focus on high temporary workforce spend and 'hard to recruit' posts

- Annual turnover reduced to 10.9% reflecting 645.5 fte leavers in the rolling 12 months. This is an annual reduction of 0.2% across the rolling 12 month period with February accounting for 51.1fte leavers. The Stability rate, reflecting staff with longer than 12 mths service, has seen an improvement.

- Monthly sickness has reduced by 0.1% against January to 4.6%, but the overall annual sickness rate has increased by 0.1% to 4.3% however this rate is lower that the previous 2 years

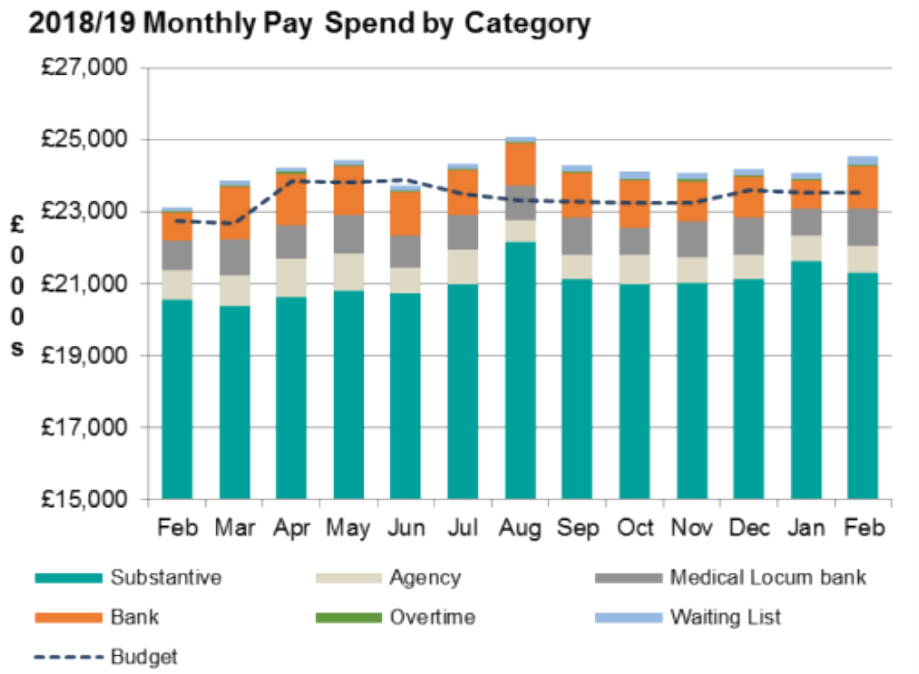
- Mandatory Training rate reduced by 0.5% to 87.9%. Compliance has reduced for all training except for Trust Induction, Health & Safety and Deprivation of Liberties training. Information Governance continues to be an area of focus

- Appraisal compliance is currently at 79.8% showing a small reduction of 1.1% lower than the previous month

East Sussex Healthcare NHS
NHS Trust

WORKFORCE EXPENDITURE

Actuals in Month (£000s)														
Category	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Trend line
Budget	£22,733	£22,657	£23,830	£23,824	£23,875	£23,490	£23,321	£23,282	£23,228	£23,231	£23,578	£23,528	£23,520	
Substantive	**£20,529**	**£20,354**	**£20,634**	**£20,783**	**£20,727**	**£20,972**	**£22,152**	**£21,117**	**£20,966**	**£21,001**	**£21,109**	**£21,618**	**£21,287**	
Agency	£848	£863	£1,053	£1,037	£697	£954	£604	£667	£833	£732	£687	£727	£772	
Medical Locum bank	£796	£1,014	£911	£1,086	£923	£977	£960	£1,037	£738	£979	£1,017	£731	£1,003	
Bank	£801	£1,448	£1,451	£1,343	£1,210	£1,229	£1,172	£1,244	£1,309	£1,131	£1,144	£799	£1,209	
Overtime	£45	£34	£46	£28	£30	£43	£41	£42	£51	£43	£49	£28	£36	
Waiting List	£108	£135	£110	£151	£128	£136	£156	£183	£225	£196	£180	£161	£224	
Total Temp Expenditure	**£2,598**	**£3,494**	**£3,571**	**£3,645**	**£2,988**	**£3,339**	**£2,933**	**£3,173**	**£3,156**	**£3,081**	**£3,077**	**£2,446**	**£3,244**	
Total Spend	**£23,127**	**£23,848**	**£24,205**	**£24,428**	**£23,715**	**£24,311**	**£25,085**	**£24,290**	**£24,122**	**£24,082**	**£24,186**	**£24,064**	**£24,531**	



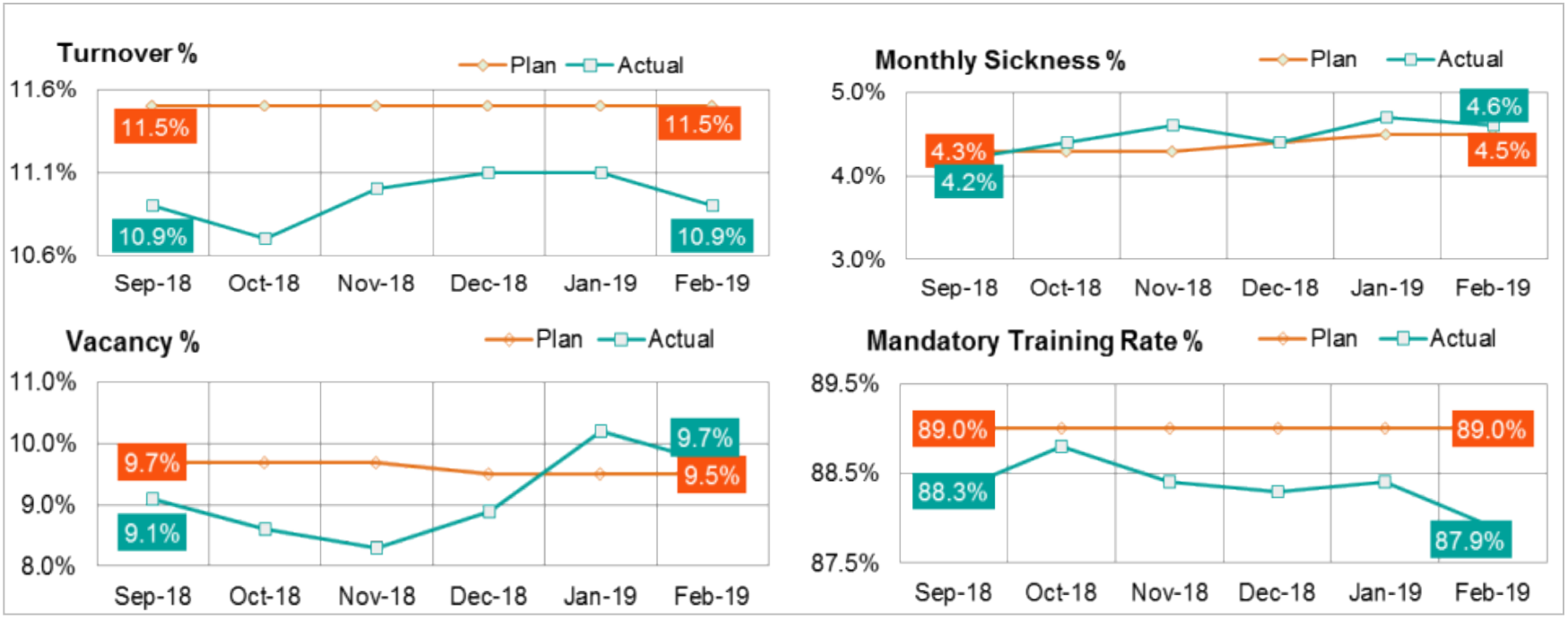
- **SUBSTANTIVE** – Expenditure fell back again, reducing by £331K from last month's high as this included enhancements paid for the Christmas holiday period.
- **BANK/LOCUM** - Expenditure increased by £682K overall this month due the use of locum and bank staff to cover escalation wards. The lag for Christmas week payments due to no weekly payroll impacts this month. In addition, the expenditure has been impacted by backlog locum payments in Respiratory and Womens Health along with bank cover for vacancies in ENT and General Surgery.
- **AGENCY** - Expenditure increased by £45K which included agency medical in Acute Medicine to cover escalation, cover for external secondments on Frank Shaw ward and cover for vacancies in Clinical coding & Facilities.
- **OVERTIME** – Expenditure increased by £8K
- **WLI** - Payments have increased this month by £63k due to extra clinics in Ophthalmology to reduce backlogs, ad-hoc clinics and cross sectional reporting in Radiology.

***Source data**: Finance Ledger*

NHSI KPI'S - PLANNED v ACTUAL

- Workforce KPI's aligned with NHSI submission for 2018/19
- Monthly sickness and vacancy rate reduced but still above plan. Turnover reduced and below plan. Mandatory training reduced and below target.

Category	Plan/Actual	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Annual Turnover %	Plan	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%
	Actual	10.9%	10.7%	11.0%	11.1%	11.1%	10.9%
Monthly Sickness %	Plan	4.3%	4.3%	4.3%	4.4%	4.5%	4.5%
	Actual	4.2%	4.4%	4.6%	4.4%	4.7%	4.6%
Vacancy Rate %	Plan	9.7%	9.7%	9.7%	9.5%	9.5%	9.5%
	Actual	9.1%	8.6%	8.3%	8.9%	10.2%	9.7%
Mandatory Training rate	Plan	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%
	Actual	88.3%	88.8%	88.4%	88.3%	88.4%	87.9%

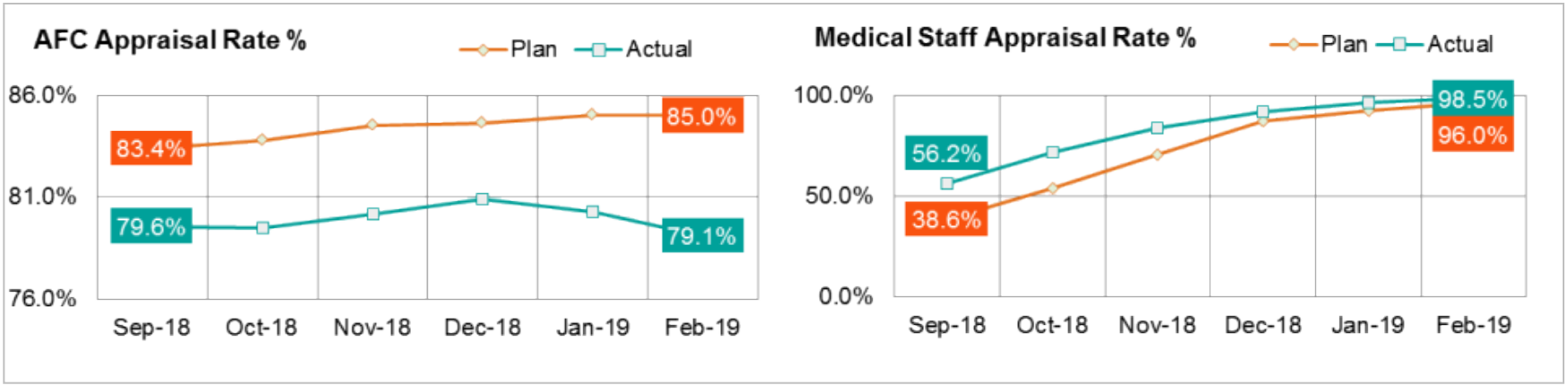


***Source data**: ESR & Finance Ledger*

NHSI KPI'S - PLANNED v ACTUAL (continued)

- Agenda for Change appraisal rate % based on a rolling year whilst the Medical Staff Appraisal rate represents year to date (as per Revalidation reports)
- Medical Appraisal rate continues to increase but the appraisal rate for other staff has reduced over the last two months and is below plan.

Category	Plan/Actual	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
AfC Appraisal Rate (rolling year)	Plan	83.4%	83.8%	84.5%	84.6%	85.0%	85.0%
	Actual	79.6%	79.5%	80.2%	80.9%	80.3%	79.1%
Medical Staff Appraisal Rate (Yr to date)	Plan	38.6%	53.7%	70.2%	87.1%	92.0%	96.0%
	Actual	56.2%	71.4%	83.4%	91.8%	96.5%	98.5%



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

East Sussex Healthcare NHS
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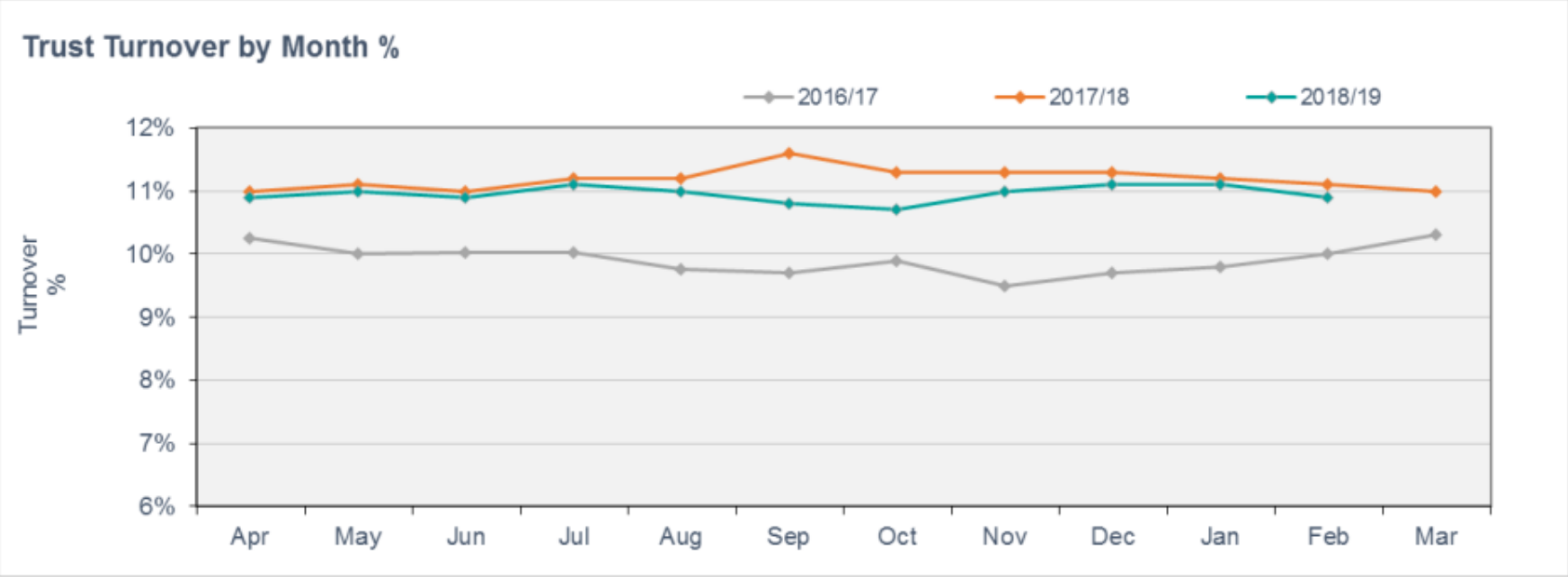
TURNOVER TREND – STAFF GROUP

- Turnover rate does not include junior doctors rotation.
- Turnover rate has reduced by 0.2% to 10.9% in February which equates to 645.5 fte leavers.
- 51.1 fte staff left the Trust in February '19, including 1.9 fte Medical & Dental staff, 7.6 fte Registered Nurses and 7.3 fte Allied Health Professionals. Annually, Registered Nurses are the largest cohort of leavers at 190.1 ftes for the year to 28 Feb '19.
- Latest available benchmark data for Dec 18 when NHS rate was 10.3% and Kent, Surrey, Sussex Trusts 12.1% (ESHT 11.1%)

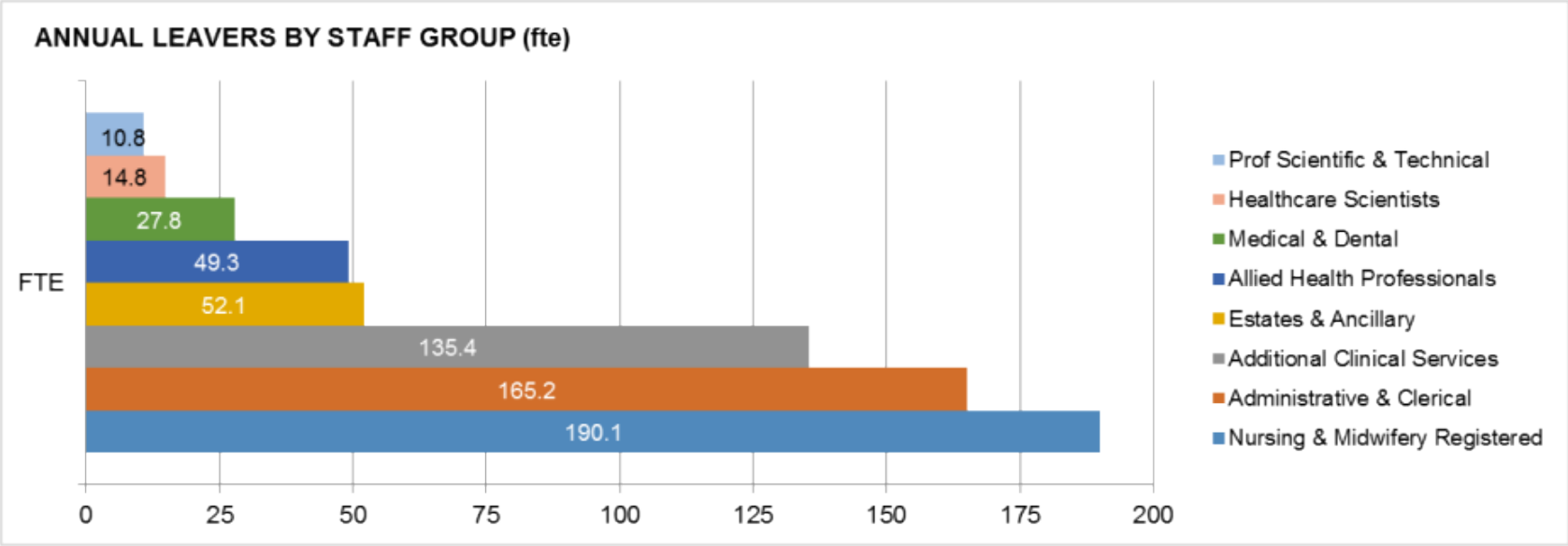
TRUST TURNOVER (%)

Year on Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	10.3%	10.0%	10.0%	10.0%	9.8%	9.7%	9.9%	9.5%	9.7%	9.8%	10.0%	10.3%
2017/18	11.0%	11.1%	11.0%	11.2%	11.2%	11.6%	11.3%	11.3%	11.3%	11.2%	11.1%	11.0%
2018/19	10.9%	11.0%	10.9%	11.1%	11.0%	10.8%	10.7%	11.0%	11.1%	11.1%	10.9%	



***Source data**: ESR*

LEAVERS & STABILITY – STAFF GROUP



STAFF GROUPS	STABILITY > 1YR
Medical & Dental	93.4%
Prof Scientific & Technical	88.1%
Administrative & Clerical	90.8%
Nursing & Midwifery Registered	91.6%
Estates & Ancillary	93.8%
Additional Clinical Services	89.9%
Healthcare Scientists	94.8%
Allied Health Professionals	88.4%
TRUST	**91.1%**

Overview

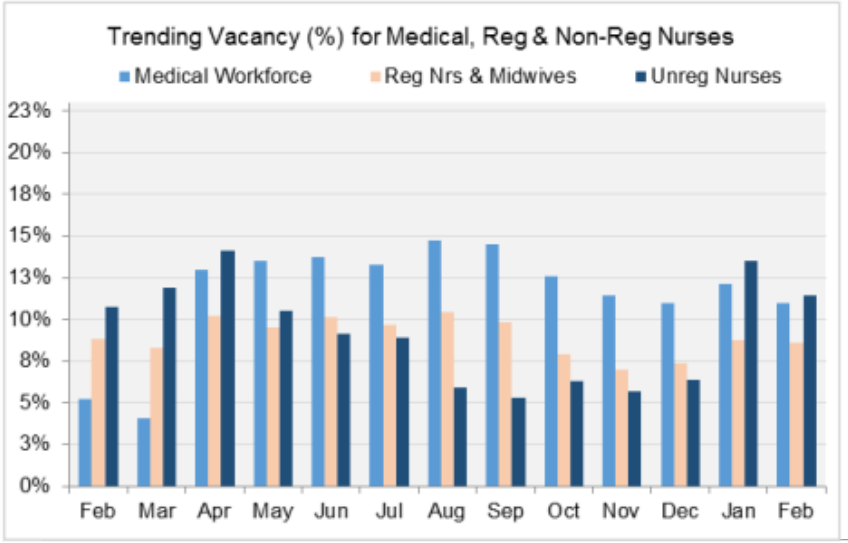
- The Stability Rate measures the number of current staff who have more than 1 year's service with ESHT
- The Stability rate has increased by 1.3% this month
- Professional Scientific & Technical staff (i.e. Pharmacy staff, ODPs, Optometrists and other technical staff) and Additional Clinical Services staff (i.e. unregistered nursing and other clinical support staff) and Allied Health Professionals all have stability rates below 90%.

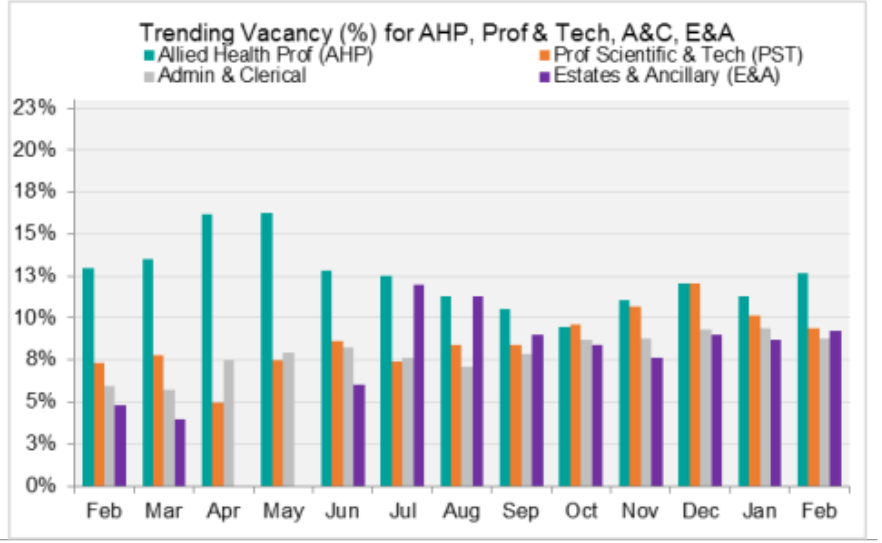
***Source data**: ESR February 2019*

RECRUITMENT – TRENDING NET VACANCIES BY STAFF GROUP (%)

- Trust vacancy rate has reduced by 0.5% to 9.7% (659.1 fte), a reduction of 34.1 ftes.
- Focus on difficult to recruit and high agency spend posts e.g. Radiology, Respiratory, Histopathology, Haematology, Geriatric Medicine, Gastroenterology, Stroke
- Medacs – 5 candidates in post (Obs and Gynae, Rheumatology, Paediatrics and Stroke), with a further 6 offers in the pipeline
- Planned trip to India for Band 5 Nurses, together with planned monthly Skype Interviews.
- No national vacancy rate benchmarking is currently available

FEB 2018 TO FEB 2018	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Trend line
Medical Workforce	5.2%	4.1%	13.0%	13.5%	13.7%	13.3%	14.7%	14.5%	12.6%	11.4%	11.0%	12.1%	11.0%	
Reg Nrs & Midwives	8.8%	8.3%	10.2%	9.5%	10.1%	9.7%	10.4%	9.8%	7.9%	7.0%	7.4%	8.7%	8.6%	
Unreg Nurses	10.7%	11.9%	14.1%	10.5%	9.2%	8.9%	5.9%	5.3%	6.3%	5.7%	6.4%	13.5%	11.4%	
Allied Health Prof (AHP)	13.0%	13.5%	16.2%	16.2%	12.8%	12.5%	11.3%	10.5%	9.5%	11.1%	12.1%	11.3%	12.7%	
Prof Scientific & Tech (PST)	7.4%	7.8%	5.0%	7.5%	8.6%	7.4%	8.4%	8.4%	9.6%	10.7%	12.1%	10.2%	9.4%	
Admin & Clerical	6.0%	5.7%	7.5%	8.0%	8.2%	7.6%	7.1%	7.9%	8.7%	8.8%	9.3%	9.4%	8.8%	
Estates & Ancillary (E&A)	4.8%	4.0%	-1.5%	-2.7%	6.0%	12.0%	11.3%	9.0%	8.4%	7.6%	9.0%	8.7%	9.2%	
TRUST	**8.0%**	**7.8%**	**9.5%**	**9.0%**	**9.6%**	**9.7%**	**9.5%**	**9.1%**	**8.6%**	**8.3%**	**8.9%**	**10.2%**	**9.7%**	





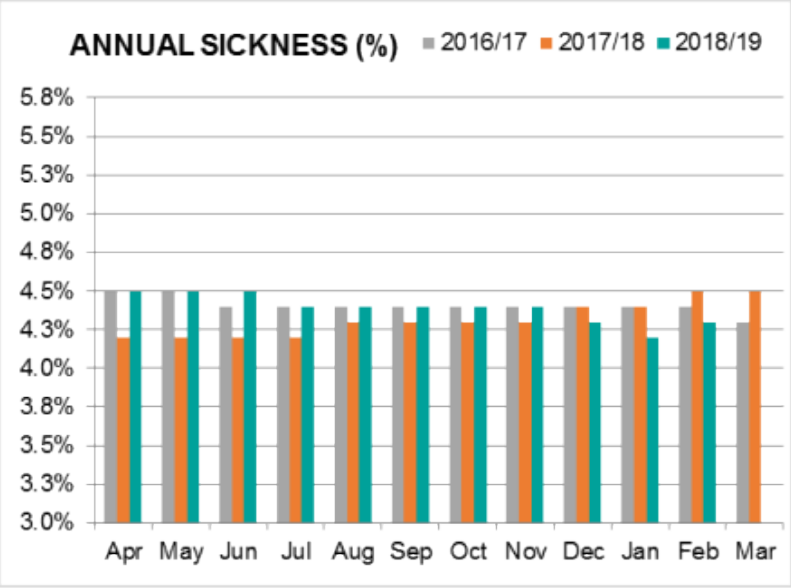
***Source data**: ESR & Finance Ledger*

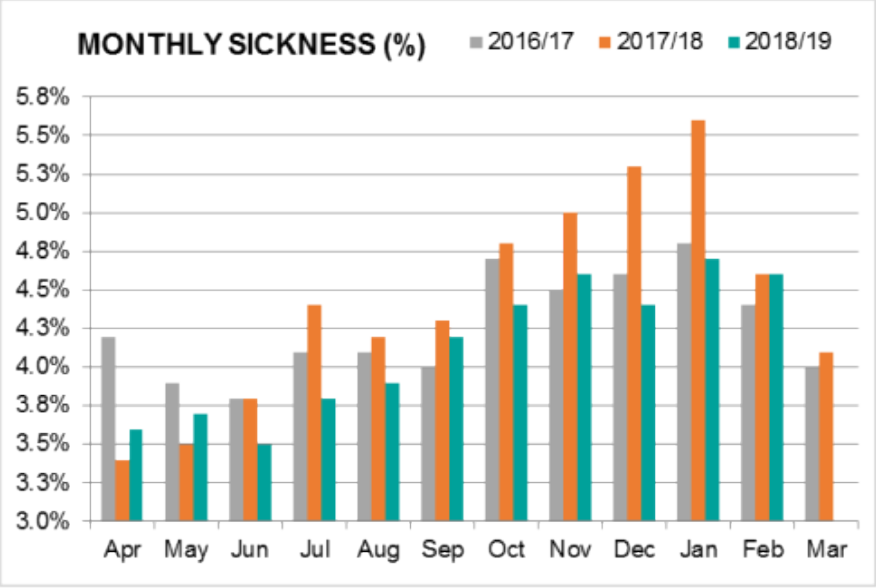
ABSENCE MANAGEMENT – SICKNESS RATES

- Monthly sickness has reduced by 0.1% to 4.6% with seasonal illnesses still high.
- The annual sickness rate has increased by 0.1% to 4.3% but is still lower than for the previous two years.
- Latest comparative figures released by NHS Digital show monthly sickness for the NHS in October 2018 at 4.3% (ESHT 4.4%). The staff group unregistered nurses and other clinical support show the highest monthly sickness rate, nationally, at 6.6% (ESHT comparative group had 5.8% sickness at that time). The monthly rate for Kent, Surrey, Sussex Trusts was 4.1%.

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%	4.4%	4.4%	4.4%	4.3%	4.2%	4.3%	

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%	4.2%	4.4%	4.6%	4.4%	4.7%	4.6%	



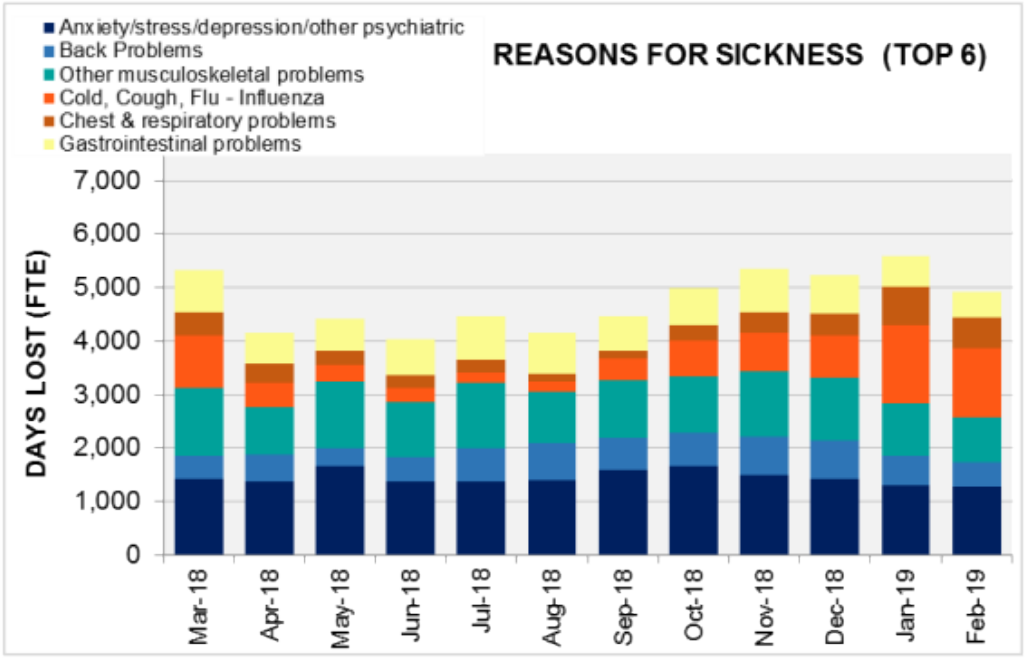


***Source data**: ESR*

ABSENCE MANAGEMENT – SICKNESS REASONS

- Cold, cough, flu remains the highest cause of sickness in February though reduced by 174 fte days lost this month.
- Of the top 6 reasons, non seasonal illness (anxiety, back, other musculoskeletal, gastrointestinal problems) have all been reducing since November

TOP 6	Fte Days Lost by Month												
Reason for sickness	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend line
Anxiety/stress/depression/other psychiatric	1,433.3	1,376.5	1,660.3	1,363.5	1,369.6	1,391.9	1,583.4	1,655.6	1,499.4	1,422.6	1,294.1	1,276.8	
Back Problems	415.1	490.1	346.1	462.9	629.8	691.8	617.0	641.4	708.0	718.3	557.1	455.6	
Other musculoskeletal problems	1,270.8	905.9	1,231.1	1,032.2	1,212.7	977.0	1,058.3	1,031.5	1,219.4	1,179.9	983.6	835.3	
Cold, Cough, Flu - Influenza	990.8	442.9	313.0	275.3	189.2	185.8	410.6	682.5	730.2	788.3	1,474.1	1,300.1	
Chest & respiratory problems	438.6	353.0	264.0	235.8	244.2	132.8	142.1	291.9	371.3	393.2	705.9	568.4	
Gastrointestinal problems	777.1	587.5	604.9	657.3	825.8	782.7	657.3	698.0	829.0	724.7	566.9	485.4	



Feb 2019 - Top 10 in descending order (%)		%
1	Cold,Cough,Flu - Influenza	16.2%
2	Anxiety/stress/depression/other psychiatric illnesses	15.9%
3	Other known causes - not elsewhere classified	11.2%
4	Other musculoskeletal problems	10.4%
5	Chest & respiratory problems	7.1%
6	Gastrointestinal problems	6.1%
7	Back Problems	5.7%
8	Unknown causes / Not specified	5.3%
9	Genitourinary & gynaecological disorders	3.6%
10	Headache/migraine	2.5%
	TOP 10 REASONS	**84.0%**

***Source data**: ESR*

WELLBEING & ENGAGEMENT

Staff Engagement

- Staff survey results circulated to each division. Corporate priorities identified and divisions are sharing results with their staff and developing action plans linked to local issues.
- Over 200 nominations received to date for Pride of ESHT awards – closing date 31st March 2019
- BME and Disability networks met to discuss key issues and action plans developed.

Health & Wellbeing

- Raising awareness of staff experiencing menopause and support required through roadshows and the Menopause cafes
- Health and wellbeing night visits at Eastbourne, Hastings and Bexhill supporting those staff who work different shift patterns
- "Staying well" team based workshops discussing interventions that support physical and emotional wellbeing
- 4 x Schwartz Rounds held

Retention

- 2 Maternity support groups held
- Supporting with specific teams going through change to maximise retention
- Facilitating flexible working requests
- Promotion of all staff benefits including Eye Care Service
- Leading Community Together programme planning an event for 2nd May to share their work and the importance of working together

East Sussex Healthcare NHS
NHS Trust

TRAINING & APPRAISAL COMPLIANCE BY DIVISION

MANDATORY TRAINING

- Overall mandatory training compliance has reduced by 0.5% to 87.9%
- Following the notification of Black status in early February all Divisions were asked to review training and decide whether to cancel over the next 3 weeks taking into account risk and impact. We have seen a slight drop in compliance across most subjects during February.
- Information Governance – compliance with this subject has dropped from 84% to 76% over the last 6 months despite ongoing support and reminders sent out to all areas. A targeted plan is being put in place to offer further support and, where staff are confident in their knowledge of information governance, they can now go straight to the assessment which takes approximately 15 minutes. Sanctions are being considered if there is not an improvement in the next month.

APPRAISAL OVERVIEW

- The overall appraisal rate for the Trust has reduced again by 1.1% to 79.8%.

DIVISION	APPRAISAL COMPLIANCE	
	12 mth	16 mth
Urgent Care	75.4%	83.8%
Medicine	78.9%	87.0%
Out of Hospital	75.3%	86.4%
Diag/Anaes/Surg	80.8%	89.9%
Womens, Child, S/Health	83.8%	88.1%
Estates & Facilities	84.4%	90.5%
Corporate	79.6%	87.5%
TRUST	**79.8%**	**88.0%**

										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	79.3%	87.8%	84.6%	82.2%	69.6%	81.9%	91.3%	86.4%	22.1%	85.7%	87.0%	76.8%
Medicine	83.8%	87.9%	93.2%	87.7%	74.0%	85.5%	94.6%	90.3%	45.5%	87.7%	85.4%	57.1%
Out of Hospital	89.6%	92.9%	98.5%	92.9%	76.9%	89.1%	98.5%	99.8%	36.6%	88.1%	87.1%	78.0%
Diag/Anaes/Surg	85.7%	89.2%	85.2%	88.0%	71.8%	83.7%	95.8%	94.3%	35.5%	87.0%	86.5%	50.0%
Womens, Child, S/Health	87.1%	92.3%	92.7%	92.3%	79.6%	88.8%	94.1%	94.7%	1.7%	88.2%	93.2%	90.3%
Estates & Facilities	87.5%	92.3%	97.4%	92.6%	70.2%	93.4%	n/a	n/a	n/a	n/a	n/a	n/a
Corporate	93.6%	96.8%	90.5%	96.1%	88.9%	94.7%	96.0%	95.3%	12.7%	84.7%	83.6%	100.0%
TRUST	**87.2%**	**91.2%**	**92.1%**	**90.6%**	**76.2%**	**88.0%**	**95.5%**	**95.0%**	**33.7%**	**87.5%**	**87.3%**	**85.1%**

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

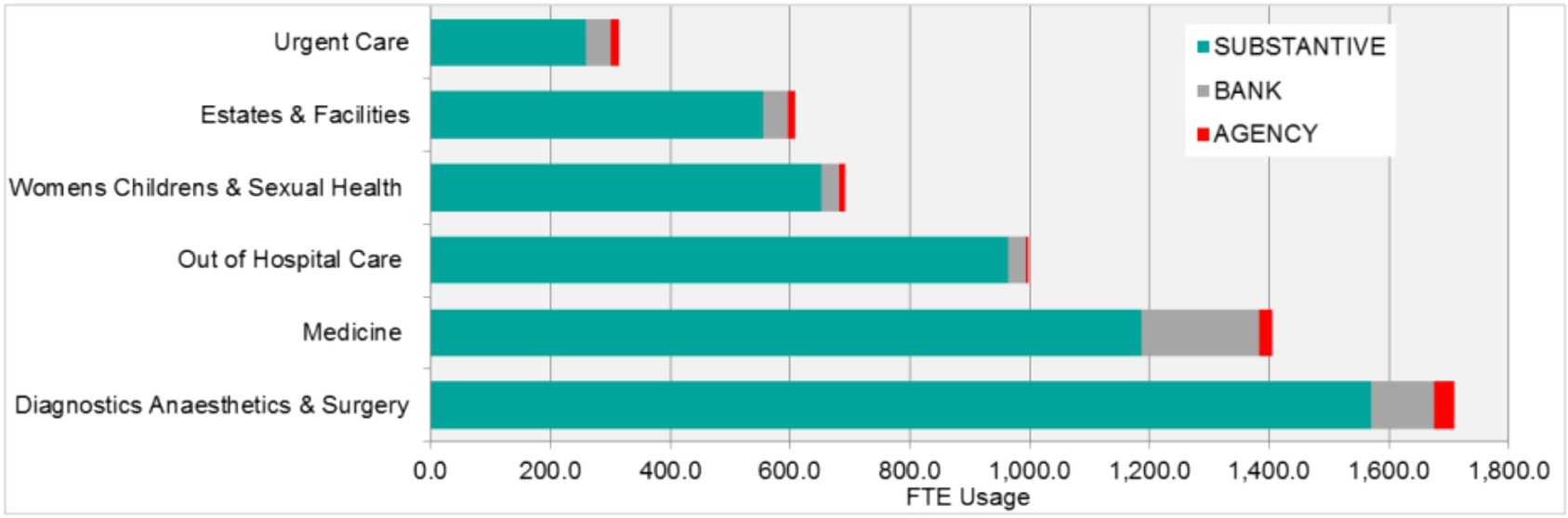
***Source data**: ESR*

APPENDIX

- Supporting documents

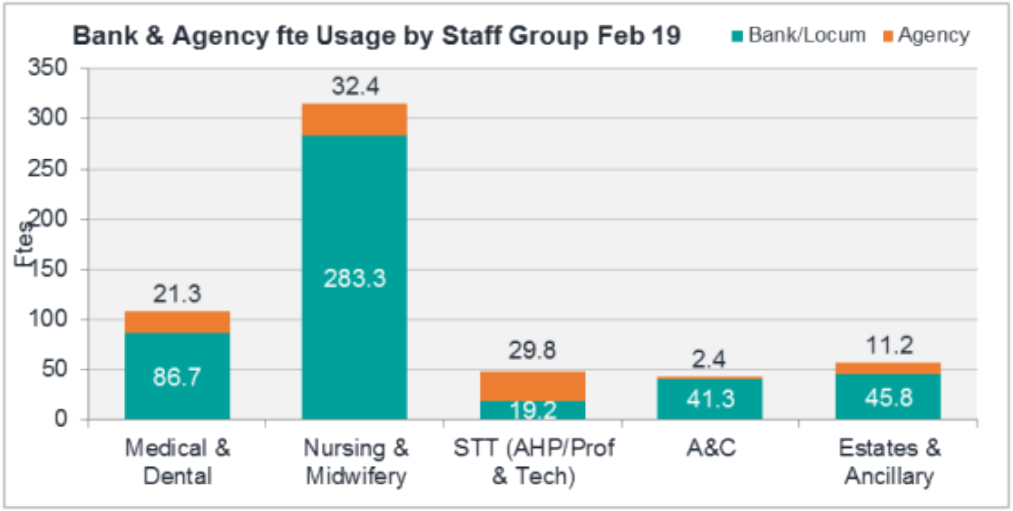
WORKFORCE UTILISATION BY DIVISION (FTE USAGE) – FEB '19

DIVISION	BUDGET	SUBSTANTIVE		BANK		AGENCY		TOTAL
	FTE	FTE	%	FTE	%	FTE	%	FTE
Diagnostics Anaesthetics & Surgery	1,801.4	1,568.8	91.8%	106.4	6.2%	33.1	1.9%	1,708.3
Medicine	1,465.3	1,187.0	84.4%	195.4	13.9%	23.3	1.7%	1,405.7
Out of Hospital Care	1,096.4	963.8	96.7%	30.5	3.1%	2.8	0.3%	997.1
Womens Childrens & Sexual Health	700.6	650.9	94.2%	30.7	4.4%	9.3	1.3%	690.9
Estates & Facilities	641.0	553.5	91.1%	42.7	7.0%	11.2	1.8%	607.4
Urgent Care	323.7	257.6	81.9%	42.2	13.4%	14.8	4.7%	314.6
Corporate	1,005.4	927.7	96.8%	28.4	3.0%	2.5	0.3%	958.6
TRUST	**7,033.8**	**6,109.3**	**91.4%**	**476.3**	**7.1%**	**97.0**	**1.5%**	**6,682.6**



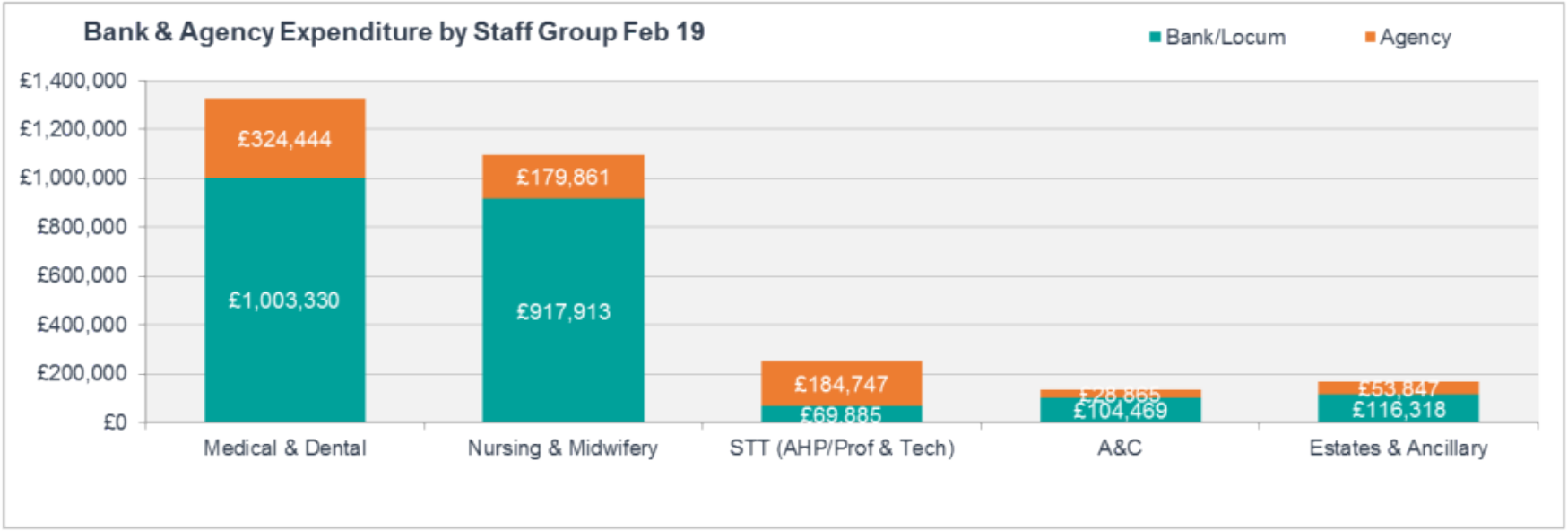
***Source data**: Finance Ledger*

FLEXIBLE LABOUR – FTE & EXPENDITURE FOR FEBRUARY '19



- Total temporary workforce expenditure increased in Feb '19 against Jan '19 by £798K:
  - Bank costs increased by £682K
  - Agency costs increased by £45K
  - Overtime costs reduced by £8K
  - Waiting list costs increased by £63K

(Source data: Finance Ledger M11)



***Source data**: Finance Ledger*

GLOSSARY

No.	TERM	DEFINITION
1	Prof Scientific and Tech	Professional Technical staff including Pharmacists & Pharmacy Technicians, Chaplaincy staff, Theatre Operating Dept Practitioners (this latter is in accordance with current NHS Occupational Code guidelines)
2	Additional Clinical Services	Unregistered staff including unregistered nurses & therapy helpers
3	Administrative and Clerical	All administrative & clerical staff including senior managers
4	Allied Health Professionals	Registered Chiropodists, Dietitians, Occupational Therapists, Orthoptists, Physiotherapists, Radiographers, Speech & Language Therapists
5	Estates and Ancillary	Estates, Facilities, Housekeeping, Catering, Portering, Laundry staff
6	Healthcare Scientists	Biomedical Scientists, Audiologists, Cardiographers, EME Technicians, Medical Photographers
7	Medical & Dental	All medical & dental staff; consultants, career grades & junior doctors
8	Nursing & Midwifery Registered	Registered nurses, midwives and health visitors
9	Students	Students are included within their relevant professions
10	Urgent Care	Also known as Emergency Department
11	Annual Sickness Calculation	Fte days lost to sickness over rolling 12 months divided by fte days available over same period

Finance

FINANCE

Jonathan Reid, Director of Finance

Finance Report Summary - Month 11

	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	(52,838)	(41,330)	(42,874)	(1,544)
Year End Forecast	(68,422)	(45,000)	(45,000)	0

The Trust is £1.5m behind plan YTD due to profiling in previous months, which is a £0.7m improvement against plan in month. The M11 run rate deteriorated by £1.2m from the previous month. The YTD value of the fixed income deal brokered with the ESBT CCGs is included in the financial position. Overspends are primarily in medical pay, WLIs, premium payments and nursing special observations £0.7m. CIP is £0.8m behind plan YTD. YTD non-pay overspends include drugs and NHS Property Services void costs which are offset by non-recurrent benefits from VAT and stock adjustments.

Agency Usage

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(12,936)	(8,616)	(8,764)	(148)
Year End Forecast	(13,799)	(9,305)	(9,305)	0

Agency spend is £148k above plan YTD due to continued requirement for agency in difficult to recruit medical and AHP posts. Overall agency costs remain within the NHSI ceiling for 2018/19. YTD agency spend is a reduction of £4.2m (32%) compared to the same period 2017/18. However, internal bank and locum spend is overspent against YTD plan.

Income

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	353,007	363,989	373,641	9,652
Year End Forecast	387,935	397,467	397,467	0

YTD under performance on elective and day case activity £1.0m is fully offset by increased non-elective activity above planned values. A&E activity was above plan in month, in line with YTD trend. £4.6m national funding for the 18/19 pay award is showing above plan on income, and offsetting increased pay costs. The YTD value of the fixed income deal with the ESBT CCGs is included in the financial position.

Operating Costs

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(399,329)	(398,211)	(409,574)	(11,363)
Year End Forecast	(448,948)	(434,713)	(434,713)	0

Overall costs are reporting £11.4m overspend against plan YTD. 18/19 AfC wage award national deal (£4.6m offset by additional funding in income), medical pay costs including agency (£3.7m) drugs overspend (£2.9m, of which £1.4m is offset within income) and CIP under delivery are partially offset by non-recurrent benefits from stock adjustments and VAT.

Cost Improvement Programme

	Plan £k	Actual £k	Variance £k
Year to Date	18,043	17,199	(844)
Year End Forecast	20,511	19,026	(1,485)

The Trust is £0.8m behind plan YTD but on track to deliver £19.2m. The main adverse variances are: bed modelling (£0.9m), WLI reduction in DAS (£0.3m), Medicine Temporary Staff reductions (£0.2m) and DAS stock controls (£0.1m); this underperformance is partially offset with over delivery on pharmacy drugs, vacancies in Emergency Care as well as the Maternity CNST being received earlier than planned.

Cash

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Current Balance	2,100	2,100	6,041	3,941
Year End Forecast	2,100	2,100	2,100	0

Cash balance above minimum balance at month end, but will return to plan for year end. NHSI has invited ESHT to be part of a pilot for restructruing historical debt.

Capital Plan

	Plan £k	Actual £k	Variance £k
Year to Date	11,931	11,501	430
Year End Forecast	15,455	15,455	0

Current CRL is £15.4m (which includes £0.8m of winter funding, £1.7m EPMA and £0.1m Order Comms). To enable the Trust to deliver its CRL, the capital plan, which is oversubscribed, is being reprioritised. Two submissions for emergency capital funding have been submitted to NHSI. The Trust awaits the outcome of these additional funding requests.

BPPC

	Month Volume	Month Value	YTD Volume	YTD Value
Trade Invoices	93.42%	94.83%	66.74%	74.63%
NHS Invoices	95.32%	99.93%	84.09%	97.74%

93% of trade invoices were paid within 28 days which equates to 94% of the total value paid in month.

95% of NHS invoices were paid within contract or within 28 days of receipt which was 99% 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	1,801.37	1,708.34	93.03	(777)	(1,243)	(466)	(3,564)	(8,850)	(5,286)	(3,764)	(3,764)	0
Medicine	1,465.34	1,405.67	59.67	2,009	2,763	754	29,985	29,306	(678)	32,553	32,553	0
Urgent Care	323.73	314.55	9.18	497	567	71	7,782	8,671	889	8,475	8,475	0
Out of Hospital Care	1,096.36	997.05	99.31	(631)	(555)	76	(6,397)	(6,836)	(440)	(7,023)	(7,023)	0
Women's, Children's & Sexual Health	700.63	690.92	9.71	920	706	(215)	12,050	10,756	(1,293)	13,180	13,180	0
Estates & Facilities	640.95	607.40	33.55	(2,020)	(2,262)	(243)	(21,773)	(23,500)	(1,727)	(23,747)	(23,747)	0
Corporate	1,005.45	958.71	46.74	(4,106)	(3,388)	718	(45,478)	(44,486)	992	(49,720)	(49,720)	0
Central	0.00	0.00	0.00	(850)	(856)	(6)	(13,935)	(7,936)	5,999	(14,954)	(14,954)	0
Total	**7,033.83**	**6,682.64**	**351.19**	**(4,958)**	**(4,269)**	**689**	**(41,330)**	**(42,874)**	**(1,544)**	**(45,000)**	**(45,000)**	**0**

Key Risks

Key Risk 1	Medical pay costs increased by 4% compared to M1-11 2017/18 (£2.4m overspend YTD)
Key Risk 2	Day case and Elective activity £1.0m below plan YTD (gynae, orthopaedics, ophthalmology and dermatology).
Key Risk 3	Unidentified CIP and delivery of CIP YTD £0.8m 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 including working with Medacs to fill hard to recruit roles. T3 pay costs controls were implemented in November over agency and locums and further controls over premium pay and WLIs being introduced. An Internal Audit report has concluded that the Trust could, in some instances, strengthen the processes and controls on WLIs.
Mitigation 2	Ongoing review of elective and day case activity during specialty reviews to understand correlation with costs, waiting list and referral trends.
Mitigation 3	Divisions being held to account via Confirm & Challenge sessions and IPRs. Grip and control has been strengthened across the Trust. Capacity identified as bed modelling CIP remains open in M11 due to high levels of NEL activity.
Mitigation 4	Additional controls in place and number of shifts booked to cover special observations has reduced in month.
Mitigation 5	Annual 18/19 income from ESBT CCGs (including contract challenges) has been agreed at a fixed value income deal (£279m). Discussions with other commissioners is ongoing.

Income & Expenditure Summary - Month 11

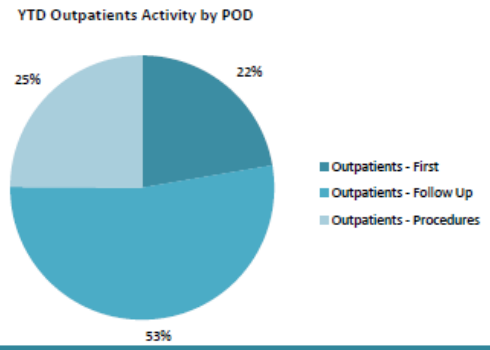
	In Month				Year to Date				Forecast Outturn		
	17/18 Actual (£m)	18/19 Plan (£m)	18/19 Actual (£m)	Variance (£m)	17/18 Actual (£m)	18/19 Plan (£m)	18/19 Actual (£m)	Variance (£m)	18/19 Plan (£m)	18/19 FOT (£m)	Variance (£m)
NHS Patient Income	23.0	26.1	26.9	0.9	284.7	301.3	300.9	(0.4)	329.1	329.1	0.0
Tariff-Excluded Drugs & Devices	2.6	2.8	3.5	0.7	31.0	33.3	33.8	0.5	36.4	36.4	0.0
Private Patient / ICR	0.4	0.4	0.1	(0.3)	2.3	3.3	2.3	(1.1)	3.7	3.7	0.0
Other Non-Clinical Income	3.1	2.3	4.1	1.8	33.7	26.0	36.7	10.6	28.3	28.3	0.0
Total Income	**29.2**	**31.5**	**34.6**	**3.2**	**351.7**	**364.0**	**373.6**	**9.7**	**397.5**	**397.5**	**0.0**
Pay - Substantive	(20.7)	(21.0)	(21.5)	(0.6)	(224.2)	(229.2)	(234.7)	(5.5)	(250.2)	(250.2)	0.0
Pay - Bank	(1.6)	(1.8)	(2.2)	(0.4)	(23.2)	(20.9)	(23.6)	(2.7)	(22.8)	(22.8)	0.0
Pay - Agency	(0.8)	(0.7)	(0.8)	(0.1)	(12.9)	(8.6)	(8.8)	(0.1)	(9.3)	(9.3)	0.0
Total Pay	**(23.1)**	**(23.5)**	**(24.5)**	**(1.0)**	**(260.4)**	**(258.7)**	**(267.0)**	**(8.3)**	**(282.2)**	**(282.2)**	**0.0**
Drugs	(3.4)	(3.5)	(4.2)	(0.7)	(38.9)	(38.7)	(41.6)	(2.9)	(42.2)	(42.2)	0.0
Supplies & Services - Clinical	(2.3)	(2.4)	(2.9)	(0.5)	(31.7)	(31.9)	(31.8)	0.1	(35.3)	(35.3)	0.0
Supplies & Services - General	(0.4)	(0.4)	(0.3)	0.1	(4.0)	(4.4)	(3.9)	0.4	(4.8)	(4.8)	0.0
Purchase of Healthcare (non-NHS)	(0.5)	(0.5)	(0.5)	0.0	(4.8)	(5.3)	(5.2)	0.1	(5.8)	(5.8)	0.0
Services from Other NHS Bodies	(0.8)	(0.6)	(0.7)	(0.0)	(6.3)	(6.9)	(7.4)	(0.5)	(7.5)	(7.5)	0.0
Consultancy	(0.1)	(0.1)	(0.1)	(0.0)	(0.7)	(0.9)	(1.1)	(0.1)	(1.0)	(1.0)	0.0
Clinical Negligence	(1.2)	(0.9)	(0.9)	0.0	(13.4)	(9.6)	(9.2)	0.4	(10.3)	(10.3)	0.0
Premises	(1.7)	(1.3)	(0.9)	0.4	(13.5)	(13.3)	(12.6)	0.7	(14.6)	(14.6)	0.0
Depreciation	(1.1)	(1.0)	(1.0)	(0.1)	(11.7)	(12.9)	(11.4)	1.5	(12.9)	(12.9)	0.0
Other	(1.3)	(1.5)	(1.9)	(0.3)	(14.1)	(14.2)	(18.4)	(4.1)	(18.3)	(18.3)	0.0
Total Non-Pay	**(12.7)**	**(12.3)**	**(13.4)**	**(1.1)**	**(138.9)**	**(139.6)**	**(142.6)**	**(2.9)**	**(152.6)**	**(152.6)**	**0.0**
Total Operating Costs	**(35.8)**	**(35.8)**	**(37.9)**	**(2.1)**	**(399.3)**	**(398.3)**	**(409.6)**	**(11.3)**	**(434.8)**	**(434.8)**	**0.0**
Net Surplus/(Deficit) from Operations	**(6.6)**	**(4.3)**	**(3.3)**	**1.0**	**(47.6)**	**(34.3)**	**(35.9)**	**(1.6)**	**(37.4)**	**(37.4)**	**0.0**
Financing Costs	(0.4)	(0.6)	(0.6)	(0.0)	(6.5)	(7.0)	(6.7)	0.3	(7.6)	(7.6)	0.0
Total Non-Operating Costs	**(0.4)**	**(0.6)**	**(0.6)**	**(0.0)**	**(6.5)**	**(7.0)**	**(6.7)**	**0.3**	**(7.6)**	**(7.6)**	**0.0**
Total Costs	**(36.2)**	**(36.4)**	**(38.6)**	**(2.1)**	**(405.8)**	**(405.3)**	**(416.2)**	**(10.9)**	**(442.5)**	**(442.5)**	**0.0**
Net Surplus/(Deficit)	**(7.0)**	**(5.0)**	**(4.0)**	**1.0**	**(54.1)**	**(41.3)**	**(42.6)**	**(1.3)**	**(45.0)**	**(45.0)**	**0.0**
Donated Asset/Impairment Adjustment	0.1	0.0	(0.3)	(0.3)	0.2	0.0	(0.3)	(0.3)	0.0	0.0	0.0
Operational Surplus/(Deficit)	**(6.9)**	**(5.0)**	**(4.3)**	**0.7**	**(53.9)**	**(41.3)**	**(42.9)**	**(1.5)**	**(45.0)**	**(45.0)**	**0.0**
Sustainability & Transformation Fund	0.0	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0
Net Surplus/(Deficit)	**(6.9)**	**(5.0)**	**(4.3)**	**0.7**	**(52.6)**	**(41.3)**	**(42.9)**	**(1.5)**	**(45.0)**	**(45.0)**	**0.0**

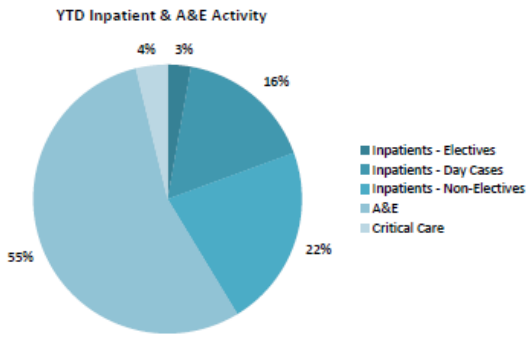
Summary & Next Steps

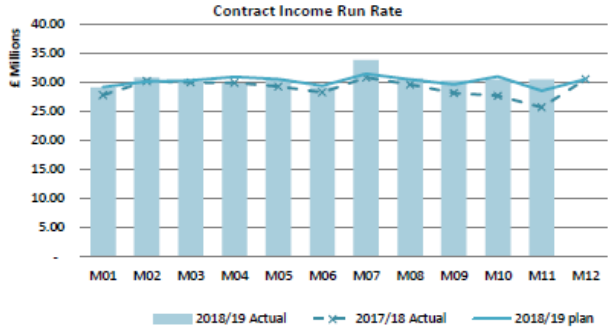
The Trust's YTD performance at M10 is £1.5m behind plan with a CIP underperformance of £0.8m. Income overperformed in month by £3.2m, PBR income is above plan in the month (£0.9m). Elective activity is 0.1m above plan in month with YTD underperformance of £1.0m, YTD effect of 18/19 final income outturn figure for ESBT CCGs has been recognised in the position. Other non clinical income includes over performance on Pharmacy Manufacturing Unit (£0.2m), central funding for the AfC wage award (£4.6m) and Education & Training income above plan. Drugs continue to overspend in month. Pay continues to significantly overspend in M11 with the largest overspend in Medical (£0.6m), largely due to temporary workforce and WLI payments.

Income & Activity Summary - Month 11

	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	588	575	499	(76)	1,717	1,711	1,713	2	6,566	6,675	6,019	(656)	19,309	19,847	19,450	(396)	21,643	21,643	0	
Inpatients - Day Cases	3,109	3,160	3,124	(36)	2,303	2,375	2,444	70	35,906	36,661	35,877	(784)	26,942	27,547	26,943	(605)	30,041	30,041	0	
Inpatients - Non-Electives	3,848	3,769	3,994	225	7,889	7,936	8,872	936	42,710	44,958	47,311	2,353	88,902	94,667	99,287	4,620	103,454	103,454	0	
Outpatients	31,424	32,220	33,051	831	3,300	3,443	3,475	32	362,106	373,638	376,152	2,514	38,096	40,181	39,771	(410)	43,539	43,539	0	
A&E	8,673	9,376	10,209	833	1,190	1,260	1,356	96	108,837	111,843	118,473	6,630	14,624	15,029	16,189	1,160	16,424	16,424	0	
CQUIN	0	0	0	0	379	538	570	32	0	0	0	0	5,781	6,498	6,756	259	7,100	7,100	0	
Critical Care	708	677	942	265	809	743	1,076	333	8,197	8,079	8,217	138	9,058	8,865	8,957	93	9,687	9,687	0	
Direct Access	8,038	8,210	10,295	2,086	333	330	370	40	93,887	95,234	98,681	3,447	3,772	3,833	3,569	(264)	4,180	4,180	0	
ESBT	0	0	0	0	531	588	588	0	0	0	0	0	4,967	6,467	6,467	0	7,055	7,055	0	
Excess Bed Days	725	1,359	792	(567)	172	331	192	(139)	15,752	16,174	8,907	(7,267)	3,835	3,936	2,160	(1,776)	4,301	4,301	0	
Exclusions	0	0	0	0	2,661	2,796	3,539	744	0	0	0	0	30,993	33,339	33,815	476	36,434	36,434	0	
iMSK	0	0	0	0	435	118	118	(0)	0	0	0	0	4,163	1,303	1,303	(0)	1,421	1,421	0	
Maternity Pathway	509	529	505	(24)	548	539	551	12	6,137	6,139	6,234	95	6,284	6,255	6,462	207	6,822	6,822	0	
Other	296,456	281,690	160,309	(121,381)	3,016	5,808	5,614	(195)	3,277,595	3,358,906	3,173,087	(185,820)	60,011	63,429	63,597	168	69,616	69,616	0	
Contract Income Total	354,078	341,566	223,721	(117,846)	25,281	28,516	30,479	1,962	3,957,693	4,058,307	3,878,958	(179,349)	316,736	331,196	334,726	3,530	361,717	361,717	0	
Divisional Income					3,503	2,960	4,154	1,194					36,045	32,793	38,915	6,122	35,750	35,750	0	
Total Income	354,078	341,566	223,721	(117,846)	28,784	31,476	34,633	3,157	3,957,693	4,058,307	3,878,958	(179,349)	352,781	363,989	373,641	9,652	397,467	397,467	0	







Summary & Next steps

Inpatients - Electives & Day Cases (YTD) **£1m behind plan** **-2.1%**

Trauma and Orthopaedics have under performed by £0.8m YTD against plan.

Ophthalmology (£0.7m) and Gynaecology (£0.6m) have under performed YTD against plan.

Inpatients - Non-Electives (YTD) **£4.62m above plan** **4.9%**

The upward trend in NEL activity has continued this month - February 2019 activity is 5% higher than last month and 5% higher than February 2018.

Over performance YTD in General Medicine (£0.6m) and Stroke Medicine (£3.1m), offset by under performance in Geriatric Medicine (£0.8m).

Outpatients (YTD) **£0.4m behind plan** **-1.0%**

Trauma and Orthopaedics (£0.4m) and Respiratory Medicine (£0.4m) have over performed YTD against plan, offset by under performance in Ophthalmology (£0.4m) and Paediatrics (£0.5m) and General Surgery (£0.3m).

A&E (YTD) **£1.2m above plan** **7.7%**

Financial over performance of £1.2m YTD. Activity continues to increase; historically A&E activity decreases in Jan-Mar; this February activity is 0.3% higher than last month, and 0.3% higher than February 2018

Other (YTD) **£0.2m above plan** **0.3%**

The Trust and ESBT CCGs have agreed a fixed income deal for 2018/19 (£2.2m), offset by a prior year dispute resolution with High Weald Lewes Havens CCG resulting in a credit note YTD of (£0.7m).

Under performance YTD in Health Visiting (£0.3m). Ward Attenders has under performed YTD (£0.4m) due to positive coding changes.

Activity under performance due to IT issues in Pathology (71,599) and Ward Attenders (2,868), offset by over performance in Diagnostic Imaging (4k).

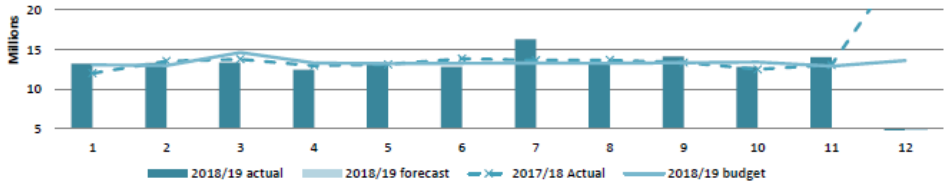
Financial Risks (YTD)

Previously reported financial risks have been mitigated against as a result of the 18/19 fixed income deal brokered with the ESBT CCGs.

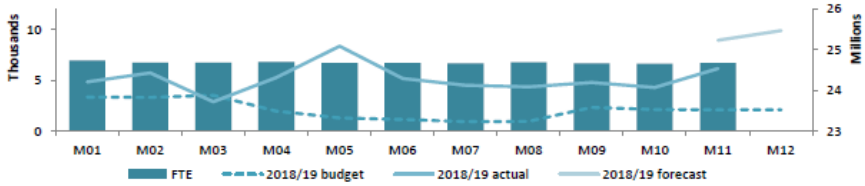
Operating Expenditure & Workforce Summary - Month 11

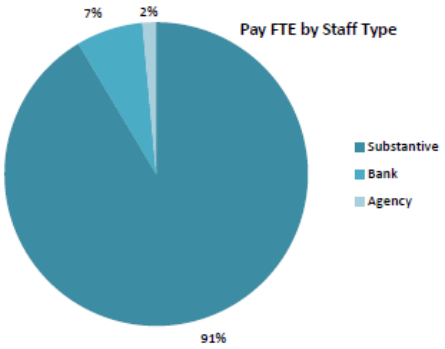
Cost Element	In Month								Year to Date				Forecast Outturn			
	17/18 WTE Actual	18/19 WTE Plan	18/19 WTE Actual	WTE Variance	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	18/19 Expenditure Variance (£k)	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	18/19 Expenditure Variance (£k)	18/19 Plan (£k)	18/19 FOT (£k)	Variance (£k)	
Administrative & Management	1337	1389	1292	96	3,588	3,807	3,591	216	39,909	41,784	39,974	1,811	45,591	45,591	0	
Ancillary	668	710	667	43	1,361	1,555	1,501	55	15,648	16,940	16,557	383	18,495	18,495	0	
Medical	667	713	708	5	5,602	5,642	6,203	(562)	63,422	61,548	65,827	(4,279)	67,354	67,354	0	
Nursing & Midwifery	3073	3163	3034	129	9,336	9,858	9,733	125	104,703	105,638	106,550	(911)	115,475	115,475	0	
Prof, Scientific & Tech	528	538	518	19	1,597	1,733	1,812	(80)	19,394	18,947	19,600	(653)	20,680	20,680	0	
Professions Allied to Medicine	444	530	463	66	1,502	1,735	1,577	158	16,198	19,513	17,267	2,247	21,268	21,268	0	
Other	0	-8	0	-7	141	(810)	114	(924)	1,133	(5,664)	1,244	(6,908)	(6,637)	(6,637)	0	
Total Pay	**6716**	**7034**	**6683**	**352**	**23,127**	**23,520**	**24,531**	**(1,011)**	**260,407**	**258,707**	**267,017**	**(8,310)**	**282,227**	**282,227**	**0**	
Services from Other NHS Bodies					755	620	670	(51)	6,315	6,896	7,415	(519)	7,515	7,515	0	
Clinical Negligence Premium					1,218	877	876	2	13,397	9,393	9,241	152	10,270	10,270	0	
Consultancy					83	62	74	(12)	665	928	1,074	(146)	1,036	1,036	0	
Drugs					1,048	1,014	937	77	11,028	8,600	10,122	(1,523)	9,106	9,106	0	
Drugs - Tariff Excluded					2,386	2,523	3,305	(782)	27,874	30,107	31,476	(1,368)	32,902	32,902	0	
Education and Training					3	132	99	34	919	1,435	838	597	1,567	1,567	0	
Establishment Expenses					520	640	525	115	6,064	6,978	7,654	(675)	7,612	7,612	0	
Premises					1,669	1,298	920	377	13,455	12,497	12,617	(120)	13,752	13,752	0	
Purchase of Healthcare from Non NHS Bodies					465	494	466	27	4,827	5,121	5,153	(33)	5,611	5,611	0	
Supplies and Services - Clinical					2,310	2,556	2,917	(361)	31,663	30,054	31,781	(1,727)	32,836	32,836	0	
Supplies and Services - General					382	337	326	10	3,975	3,656	3,940	(284)	3,995	3,995	0	
Other Non-Pay					11,912	1,731	2,297	(566)	18,739	23,954	21,245	2,709	26,411	26,411	0	
Total Non-Pay					**22,751**	**12,282**	**13,411**	**(1,129)**	**138,922**	**139,619**	**142,557**	**(2,938)**	**152,614**	**152,614**	**0**	
Total Expenditure	**6716**	**7034**	**6683**	**352**	**45,877**	**35,802**	**37,942**	**(2,140)**	**399,329**	**398,326**	**409,574**	**(11,248)**	**434,841**	**434,841**	**0**	

Non-Pay Monthly Run rate



Pay Monthly Run Rate vs FTE





Summary & Next Steps

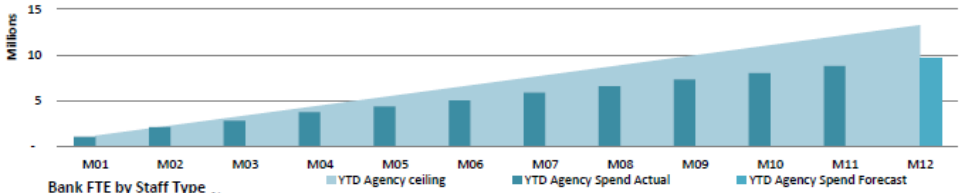
The arrears for AfC national pay award was paid to eligible staff in M5. £4.6m income has been received YTD to offset the additional pay increase. Variances in Other Pay is attributable to unidentified CIP and has increased as a result of the new deal AfC pay award in each staff group. Medical pay is £4.3m overspent YTD (which includes waiting list premium payments, agency covering vacancies and Emergency Care Twilight shifts).

Drugs spend is showing £1.5m overspend due to inflationary pressures and increase in non-elective activity. Tariff excluded drugs are overspent by £1.4m 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 £0.5m of VAT relating to the 2017/18 financial year which was reflected in position in M4. £0.2m Maternity CNST benefit was been reported in M6, linked to Women's and Children's CIP, a further CNST benefit of £0.1m was received in M8. In M7 old year premises costs were received in month relating to NHS Property Services costs for prior years (£0.3m) as well as 18/19 YTD costs (£0.1m).

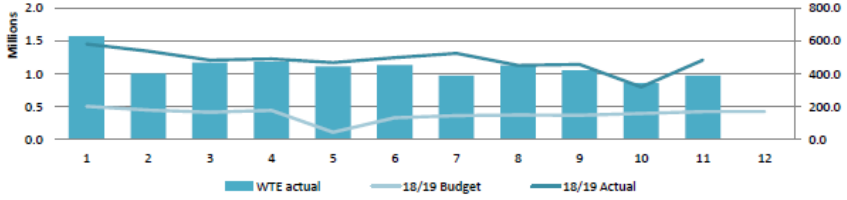
Temporary Workforce Summary - Month 11

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	8	1	2	-1	89	69	29	40	1,171	804	512	291	872	872	0	
Ancillary	25	0	11	-11	77	69	54	15	806	804	642	161	872	872	0	
Medical	16	9	21	-13	263	274	324	(50)	5,386	3,306	3,337	(31)	3,580	3,580	0	
Nursing & Midwifery	37	0	32	-32	175	101	180	(79)	2,612	1,481	2,074	(593)	1,582	1,582	0	
Prof, Scientific & Tech	44	4	30	-26	244	177	185	(8)	2,961	2,222	2,199	23	2,399	2,399	0	
Total Agency	131	14	97	-83	848	689	772	(83)	12,936	8,616	8,764	(148)	9,305	9,305	0	
Bank																
Administrative & Management	56	4	41	-37	98	255	104	151	1,814	3,255	1,393	1,862	3,510	3,510	0	
Ancillary	53	27	46	-19	87	0	116	(116)	1,723	0	1,335	(1,335)	0	0	0	
Nursing & Midwifery	262	110	283	-173	572	1,120	918	202	10,233	10,643	9,731	912	11,763	11,763	0	
Prof, Scientific & Tech	11	0	9	-9	32	58	32	26	356	638	439	199	696	696	0	
Professions Allied to Medicine	4	0	10	-10	12	43	38	5	133	393	342	51	436	436	0	
Total Bank	387	141	390	-249	801	1,476	1,209	267	14,259	14,929	13,241	1,688	16,405	16,405	0	
Total Locum	65	19	87	-68	796	464	1,003	(539)	8,987	5,988	10,360	(4,372)	6,361	6,361	0	
Total Waiting List Initiative	9	0	15	-15	108	14	224	(211)	2,150	150	1,850	(1,700)	164	164	0	
Total Temporary Workforce	591	173	588	-415	2,553	2,643	3,208	(565)	38,332	29,683	34,215	(4,531)	32,235	32,235	0	

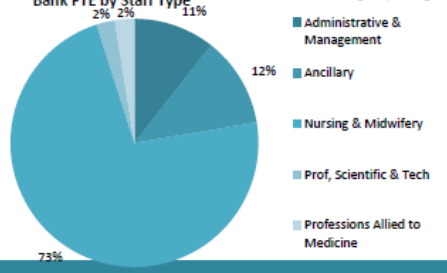
Cumulative Performance vs Agency Ceiling



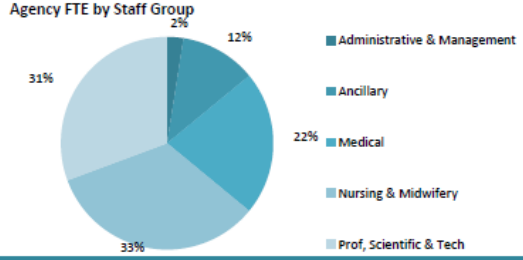
Bank Monthly Run Rate vs FTE



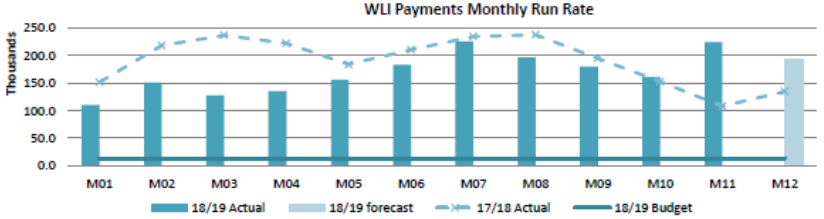
Bank FTE by Staff Type



Agency FTE by Staff Group



WLI Payments Monthly Run Rate



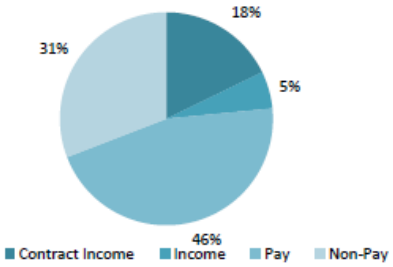
Summary & Next steps

Overall agency is £148k above plan YTD. Medical specialties which are heavily reliant on agency are neurology, rheumatology, pathology, general surgery, radiology and A&E. Agency spend in M1-11 has significantly reduced compared to the previous financial year due to the shift towards utilisation of bank and locum resource. In addition, progress is being made with recruitment to locum or substantive posts through Medacs with a focus on hard to fill vacancies and services looking at alternative staffing models. Administrative and clerical agency has reduced by 56% compared to the same period in 17/18 with Clinical Coding having implemented their plan to stop using agency. Total temporary staffing costs have fallen by 11% compared to the previous year (£4.1m lower). Internal Audit have completed their WLI review and the recommendations are being taken forward to implement further controls on spend.

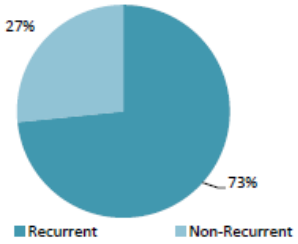
Cost Improvement Programme Summary - Month 11

Category	In Month Plan (£k)	In Month Actual (£k)	In Month Variance (£k)	Year to Date Plan (£k)	Year to Date Actual (£k)	Year to Date Variance (£k)	Forecast Outturn Plan (£k)	Forecast Outturn Actual (£k)	Forecast Outturn Variance (£k)	YTD Rec (£k)	YTD Non-Rec (£k)
Contract Income	300	320	21	2,259	3,059	801	2,610	3,334	724	2,238	821
Income	148	173	26	1,095	974	-121	1,320	1,082	-238	696	278
Pay	1,081	1,079	-2	9,389	7,856	-1,533	10,281	8,670	-1,611	4,977	2,879
Non-Pay	620	434	-185	5,300	5,309	9	6,300	5,941	-360	4,708	601
Total 'Green' schemes	**2,148**	**2,007**	**-140**	**18,043**	**17,199**	**-844**	**20,511**	**19,026**	**-1,485**	**12,620**	**4,579**
Pipeline/Unidentified	0	0	0	0	0	0	3,005	4,490	1,485	73%	27%
Total	**2,148**	**2,007**	**-140**	**18,043**	**17,199**	**-844**	**23,516**	**23,516**	**0**		

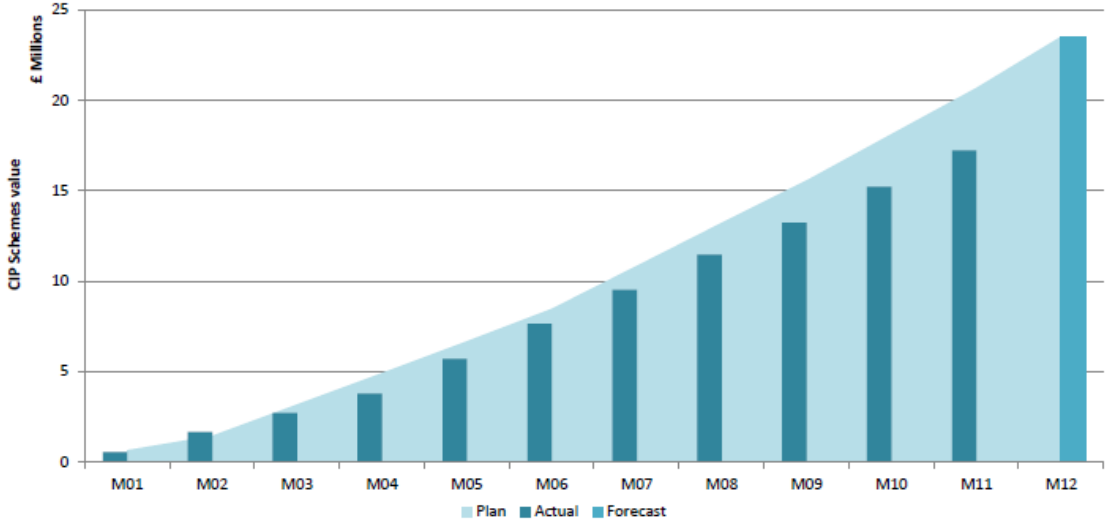
YTD CIP green schemes by category



YTD CIP green schemes recurrent/non-recurrent



CIP Performance



Summary & Next Steps

YTD: The Trust has delivered £17.2m against a plan of £18.0m, with an adverse variance of £0.8m. Bed modelling is the largest contributor with an adverse variance YTD of £0.9m, other adverse variances include DAS WLI (£0.3m), medical temp staff run rate (£0.2m), DAS speciality non-pay stock controls (£0.1m) and outpatient space at Crowborough Hospital (£0.1m). These are partially offset by favourable variances, including emergency care nurse savings from vacancies (£0.5m), Pharmacy drug procurement (£0.4m), CNST maternity improvements (£0.4m), DAS procurement savings (£0.1m), WAC non-recurrent staff underspend (£0.1m) and IT virtualise switchboard (£0.1m).

In Month: M11 has delivered £2.01m against a plan of £2.15m, with an adverse variance of £0.14m. This adverse variance for the month is mainly made up of medicine reduction in temp staff (£93k), emergency care doctor agency spend (£76k), Estates & Facilities senior management team Capex (£44k) - these top three adverse variances are all due to non-delivery. Whilst the Trust is behind plan it is on track for delivering the £19.2m target with delivery of the required £2m in the month.

Forecast: Against 'Process Green Plan' the Trust is forecasting an adverse outturn variance of £1.5m against the £20.5m plan, bed modelling makes up the majority of this (£1.0m) with other variances continuing from the YTD position. Emergency Care, Out of Hospitals and Corporate are all forecasting to deliver favourably against plan for the full year.

By Category: Contract income continues to over perform YTD (£0.8m), with pay schemes showing an adverse variance of £1.5m, mainly due to the impact of bed modelling.

These variances are against the £23.5m plan, if compared to the £19.2m then we are slightly ahead of plan YTD, at £17.2m Actual vs £16.9m Plan.

Finance Report Divisional Summaries - Month 11

Divisional Performance

Division	In the Month						Year to Date			Forecast Outturn			Summary
	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													
Contract Income				8,341	8,212	(129)	97,263	94,984	(2,279)	106,181	106,181	0	YTD contract income underperformance and unidentified CIP are key drivers of YTD underperformance. Pay continues to overspend due to medical agency and WLIs. Theatres non pay costs continue to report an overspend in month and ongoing overspends in pathology are due to send away testing.
Divisional Income				423	531	108	4,435	4,461	25	4,859	4,859	0	
Pay	1,801.37	1,708.34	93.03	(7,043)	(7,301)	(258)	(77,567)	(79,093)	(1,526)	(84,610)	(84,610)	0	
Non-Pay				(2,498)	(2,685)	(186)	(27,695)	(29,202)	(1,506)	(30,194)	(30,194)	0	
Overall	**1,801.37**	**1,708.34**	**93.03**	**(777)**	**(1,243)**	**(466)**	**(3,564)**	**(8,850)**	**(5,286)**	**(3,764)**	**(3,764)**	**0**	
Medicine													
Contract Income				7,651	8,926	1,275	90,124	94,012	3,888	98,428	98,428	0	Key drivers of divisional underperformance are special observations £0.7m overspend YTD, £1.7m medical pay and CIP under delivery, partly offset by NEL activity above income plan.
Divisional Income				148	86	(62)	1,562	1,101	(462)	1,760	1,760	0	
Pay	1,465.34	1,405.67	59.67	(5,060)	(5,346)	(286)	(54,073)	(57,801)	(3,728)	(59,297)	(59,297)	0	
Non-Pay				(730)	(904)	(174)	(7,629)	(8,005)	(377)	(8,339)	(8,339)	0	
Overall	**1,465.34**	**1,405.67**	**59.67**	**2,009**	**2,763**	**754**	**29,985**	**29,306**	**(678)**	**32,553**	**32,553**	**0**	
Urgent Care													
Contract Income				1,967	2,061	94	23,334	24,548	1,214	25,497	25,497	0	A&E activity is on plan in month. Prior month's medical agency and R&R payments to medical staff have caused a pay overspend of £174k YTD. Overspends on discharge and site team offset by underspend on GP streaming £559k and A&E nursing vacancies £566k underspend.
Divisional Income				34	32	(2)	331	350	19	364	364	0	
Pay	323.73	314.55	9.18	(1,441)	(1,450)	(9)	(15,259)	(15,433)	(174)	(16,700)	(16,700)	0	
Non-Pay				(62)	(76)	(13)	(623)	(794)	(171)	(686)	(686)	0	
Overall	**323.73**	**314.55**	**9.18**	**497**	**567**	**71**	**7,782**	**8,671**	**889**	**8,475**	**8,475**	**0**	
Out of Hospital Care													
Contract Income				3,271	3,354	82	36,040	36,346	306	39,316	39,316	0	Drugs overspend £1.2m YTD. £475k Pharmacy Manufacturing Unit overspend due to staff awaiting redeployment and is a stranded cost. Offset by vacancies across Therapies and District Nursing.
Divisional Income				338	333	(6)	3,615	3,488	(127)	3,953	3,953	0	
Pay	1,096.36	997.05	99.31	(3,200)	(3,009)	190	(34,851)	(34,193)	658	(38,050)	(38,050)	0	
Non-Pay				(1,041)	(1,232)	(191)	(11,201)	(12,478)	(1,276)	(12,243)	(12,243)	0	
Overall	**1,096.36**	**997.05**	**99.31**	**(631)**	**(555)**	**76**	**(6,397)**	**(6,836)**	**(440)**	**(7,023)**	**(7,023)**	**0**	
Women's, Children's & Sexual Health													
Contract Income				3,781	3,640	(141)	43,418	42,485	(933)	47,409	47,409	0	Contract income under delivery of Health Visiting contract YTD, lower activity in Paediatrics (non-elective) and Gynaecology (day case/elective). Continued vacancies in Health Visiting offsetting agency usage in midwifery unit and agency medical in month.
Divisional Income				48	73	24	593	884	291	641	641	0	
Pay	700.63	690.92	9.71	(2,635)	(2,741)	(106)	(28,950)	(29,080)	(131)	(31,585)	(31,585)	0	
Non-Pay				(275)	(267)	8	(3,011)	(3,532)	(521)	(3,286)	(3,286)	0	
Overall	**700.63**	**690.92**	**9.71**	**920**	**706**	**(215)**	**12,050**	**10,756**	**(1,293)**	**13,180**	**13,180**	**0**	
Estates & Facilities													
Divisional Income				710	647	(63)	7,705	7,750	46	8,415	8,415	0	£1.4m unidentified CIP is included in the YTD position. £390k of underperformance on ward closure CIPs. Key overspends relate to £156k due to laundry and stock adjustment and £154k catering provisions overspend YTD.
Pay	640.95	607.40	33.55	(1,396)	(1,493)	(97)	(15,525)	(16,152)	(626)	(16,921)	(16,921)	0	
Non-Pay				(1,334)	(1,416)	(82)	(13,952)	(15,099)	(1,146)	(15,240)	(15,240)	0	
Overall	**640.95**	**607.40**	**33.55**	**(2,020)**	**(2,262)**	**(243)**	**(21,773)**	**(23,500)**	**(1,727)**	**(23,747)**	**(23,747)**	**0**	
Corporate													
Divisional Income				1,140	1,576	436	12,652	14,051	1,399	13,792	13,792	0	Training and education income is above plan, primarily due to LDA income. Key overspends are due to unidentified CIP in pay and non pay. Non pay overspend of £0.9m YTD includes EDM cost pressure of £0.9m, offset by CNST maternity benefit of £391k.
Pay	1,005.45	958.71	46.74	(3,173)	(3,117)	56	(35,340)	(35,044)	296	(38,510)	(38,510)	0	
Non-Pay				(2,074)	(1,848)	226	(22,790)	(23,494)	(703)	(25,002)	(25,002)	0	
Overall	**1,005.45**	**958.71**	**46.74**	**(4,106)**	**(3,388)**	**718**	**(45,478)**	**(44,486)**	**992**	**(49,720)**	**(49,720)**	**0**	
Central													
Contract Income				3,505	4,281	777	41,018	42,352	1,334	44,885	44,885	0	YTD divisional income includes national pay deal £4.6m, which offsets increased pay costs in divisions. Tariff Exclusions income is above plan YTD to contra £1.4m overspend on non-pay costs. Central CIP risk adjustment (division target £23.5m allocated vs NHSI plan £19.2m). Identification of CIP in operational divisions has led to central phasing adjustments between Income, Pay and Non Pay in order to ensure alignment to NHSI plan.
Divisional Income				118	876	758	1,900	6,831	4,931	1,965	1,965	0	
Pay	0.00	0.00	0.00	427	(74)	(501)	2,857	(222)	(3,079)	3,447	3,447	0	
Non-Pay				(4,900)	(5,622)	(722)	(59,709)	(56,620)	3,089	(65,251)	(65,251)	0	
Overall	**0.00**	**0.00**	**0.00**	**(850)**	**(539)**	**311**	**(13,935)**	**(7,660)**	**6,275**	**(14,954)**	**(14,954)**	**0**	
Donated assets adjustment				**0**	**(318)**	**(318)**	**0**	**(276)**	**(276)**				
Total	**7,033.83**	**6,682.64**	**351.19**	**(4,958)**	**(4,269)**	**689**	**(41,330)**	**(42,874)**	**(1,544)**	**(45,000)**	**(45,000)**	**0**	

Statement of Financial Position - Month 11

	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	217.0	●	1.2	215.7	215.7	●	0.0
Intangible Assets	1.9	1.9	1.9	◆	(0.1)	1.9	1.9	●	0.0
Other Assets	1.3	1.3	1.8	●	0.5	1.3	1.3	●	0.0
Non Current Assets	**219.0**	**219.0**	**220.6**	●	**1.7**	**219.0**	**219.0**	●	**0.0**
Inventories	7.3	7.3	5.5	◆	(1.8)	7.3	7.3	●	0.0
Trade and Other Receivables	35.3	26.0	27.4	●	1.4	26.0	26.0	●	0.0
Cash and Cash Equivalents	2.1	2.1	6.0	●	3.9	2.1	2.1	●	0.0
Non Current Assets Held for Sale	0.0	0.0	0.0	●	0.0	0.0	0.0	●	0.0
Current Assets	**44.7**	**35.4**	**39.0**	●	**3.5**	**35.4**	**35.4**	●	**0.0**
Trade and Other Payables	(37.7)	(28.6)	(32.0)	◆	(3.4)	(28.6)	(28.6)	●	0.0
Borrowings	(35.7)	(0.4)	(0.3)	●	0.1	(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)	(0.4)	●	0.2	(0.6)	(0.6)	●	0.0
Other Liabilities	(1.7)	(1.7)	(2.6)	◆	(0.8)	(1.7)	(1.7)	●	0.0
Current Liabilities	**(75.7)**	**(31.3)**	**(35.3)**	◆	**(4.0)**	**(31.3)**	**(31.3)**	●	**0.0**
Borrowings	(121.5)	(201.6)	(198.0)	●	3.6	(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**	**24.1**	◆	**(4.2)**	**19.2**	**19.2**	●	**0.0**
Public Dividend Capital	156	156	159	●	3	156	156	●	0
Income & Expenditure Reserve	(187)	(232)	(229)	●	2	(232)	(232)	●	0
Revaluation Reserve	94	94	94	◆	(0)	94	94	●	0
Total Tax Payers Equity	**64.2**	**19.2**	**24.1**	●	**4.9**	**19.2**	**19.2**	●	**0.0**

Summary & Next Steps

Cash above £2.1m minimum cash balance at month end and borrowing in line with planned deficit.

Cashflow & Borrowing Summary - Month 11

Short Term (13 week) Cashflow Forecast

Week Ending (Friday)	Actual (£k) 01-Feb	08-Feb	15-Feb	22-Feb	Forecast (£k) 01-Mar	08-Mar	15-Mar	22-Mar	29-Mar	05-Apr	12-Apr	19-Apr	26-Apr
Balance Brought Forward	**11,173**	**8,204**	**6,007**	**36,596**	**10,337**	**6,873**	**5,823**	**36,078**	**9,562**	**2,100**	**2,642**	**2,068**	**19,328**
Receipts													
WGA Income	678	762	29,317	543	615	717	30,257	421	0	160	160	30,505	160
Other Income	776	152	1,364	128	580	100	1,301	400	220	970	170	1,371	475
External Financing	0	0	5,658	0	0	0	3,670	100	0	0	2,504	0	0
Total Receipts	**1,454**	**914**	**36,339**	**671**	**1,195**	**817**	**35,228**	**921**	**220**	**1,130**	**2,834**	**31,876**	**635**
Payments													
Pay	(253)	(274)	(286)	(23,015)	(249)	(275)	(250)	(23,632)	(250)	(270)	(270)	(11,244)	(14,792)
Non-Pay	(4,168)	(2,787)	(5,392)	(2,723)	(4,355)	(1,593)	(3,127)	(3,090)	(7,432)	(318)	(3,139)	(3,170)	(1,590)
Capital Expenditure	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend	0	0	0	0	0	0	0	0	0	0	0	0	0
Other payments	(2)	(50)	(72)	(1,193)	(55)	0	(1,596)	(715)	0	0	0	(202)	0
Total Payments	**(4,423)**	**(3,110)**	**(5,750)**	**(26,930)**	**(4,659)**	**(1,868)**	**(4,973)**	**(27,437)**	**(7,682)**	**(588)**	**(3,409)**	**(14,616)**	**(16,382)**
Net Cash Movement	**(2,970)**	**(2,197)**	**30,589**	**(26,259)**	**(3,464)**	**(1,050)**	**30,255**	**(26,516)**	**(7,462)**	**542**	**(575)**	**17,260**	**(15,747)**
Balance Carried Forward	**8,204**	**6,007**	**36,596**	**10,337**	**6,873**	**5,823**	**36,078**	**9,562**	**2,100**	**2,642**	**2,068**	**19,328**	**3,581**

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%	13,785	827
2017/18 Loans	50,393	Aug 17 - Mar 18	3	3.50%	50,363	1,781
Prior Years Total	**160,979**				**157,212**	**5,703**
Current Year						
Loan Apr 2018	3,916	Apr 18	3	3.50%	3,916	69
Loan May 2018	3,917	May 18	3	3.50%	3,917	71
Loan June 2018	3,771	Jun 18	3	3.50%	3,771	69
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
Loan September 2018	4,346	Sep 18	3	3.50%	4,346	76
Loan October 2018	2,122	Oct 18	3	3.50%	2,122	0
Loan November 2018	3,061	Nov 18	3	3.50%	3,061	0
Loan December 2018	4,322	Dec 18	3	3.50%	4,322	0
Loan January 2019	3,003	Jan 19	3	3.50%	3,003	0
Loan February 2019	4,958	Feb 19	3	3.50%	4,958	0
Current Year Total	**41,331**				**41,331**	**428**
Total Loans	**202,310**				**198,543**	**6,131**

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

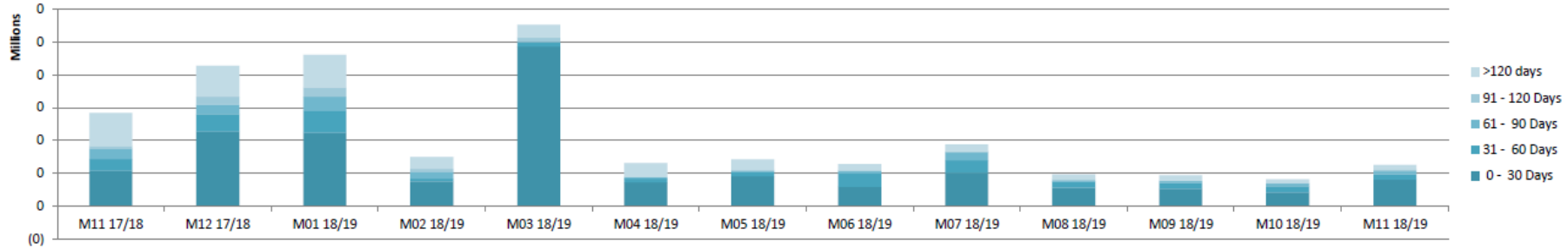
4. All existing loans listed in the table on the left.

5. The "Interim Loan Agreement" for £35.2m was due to be repaid in February 2019. NHSI informally notified the Trust that 'Interim revenue loans expired or expiring in 2018/19 will be extended as per the previous loan extensions in 2017/18. Trusts are not required to request new interim loans to repay expiring loans unless asked by DHSC to do so.' It is expected that formal notification from DHSC will be received shortly.

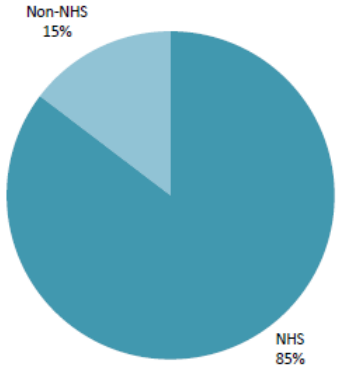
Receivables Summary - Month 11

Receivables Aging Run rate (£k)

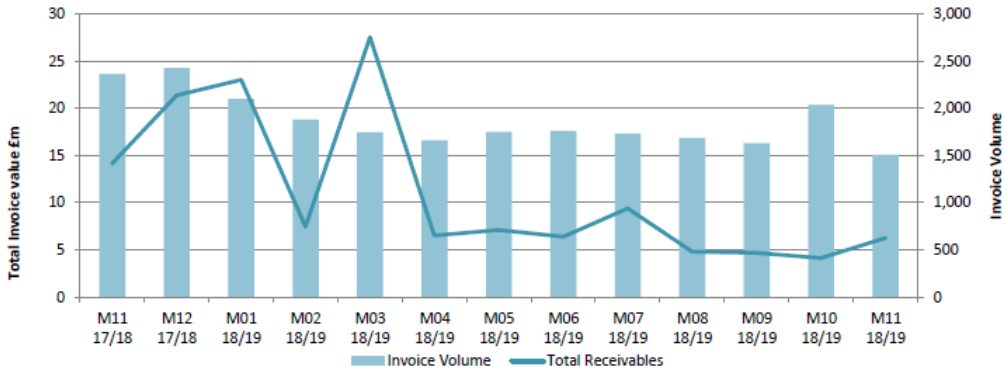
Aging Profile	M11 17/18	M12 17/18	M01 18/19	M02 18/19	M03 18/19	M04 18/19	M05 18/19	M06 18/19	M07 18/19	M08 18/19	M09 18/19	M10 18/19	M11 18/19
0 - 30 Days	5,379	11,332	11,164	3,753	24,337	3,630	4,559	2,924	5,070	2,765	2,639	2,093	4,038
31 - 60 Days	1,745	2,686	3,335	448	696	566	685	2,033	1,918	894	910	896	786
61 - 90 Days	1,573	1,467	2,189	968	(44)	273	161	369	1,248	147	238	406	464
91 - 120 Days	470	1,214	1,316	518	618	(71)	100	95	131	321	101	101	352
>120 days	4,997	4,685	5,048	1,775	1,963	2,111	1,586	988	1,021	698	783	620	632
Total Receivables	**14,164**	**21,384**	**23,053**	**7,461**	**27,572**	**6,508**	**7,091**	**6,408**	**9,389**	**4,825**	**4,670**	**4,116**	**6,272**
Invoice Volume	**2,366**	**2,426**	**2,100**	**1,880**	**1,749**	**1,660**	**1,752**	**1,761**	**1,732**	**1,688**	**1,632**	**2,037**	**1,508**



Current Month % NHS vs Non-NHS by Value



Receivables Invoice Value vs Volume Run Rate



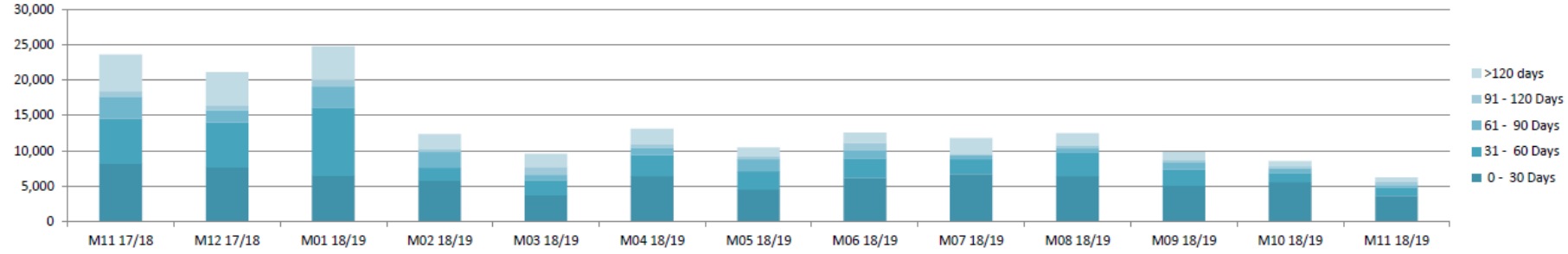
Summary & Next Steps

1. Internal plan for February was to maintain aged receivables under £2.5m. This was achieved in month.
2. Increase in over 90 day debt of £263k in month.
3. Debtor days 26 days (27 days in January).

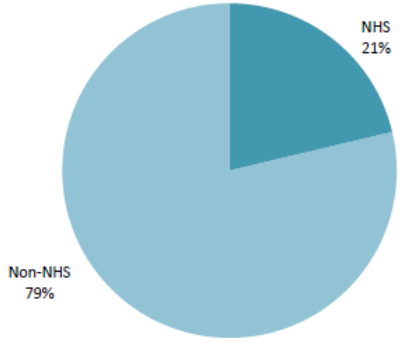
Payables Summary - Month 11

Payables Aging Run rate (£k)

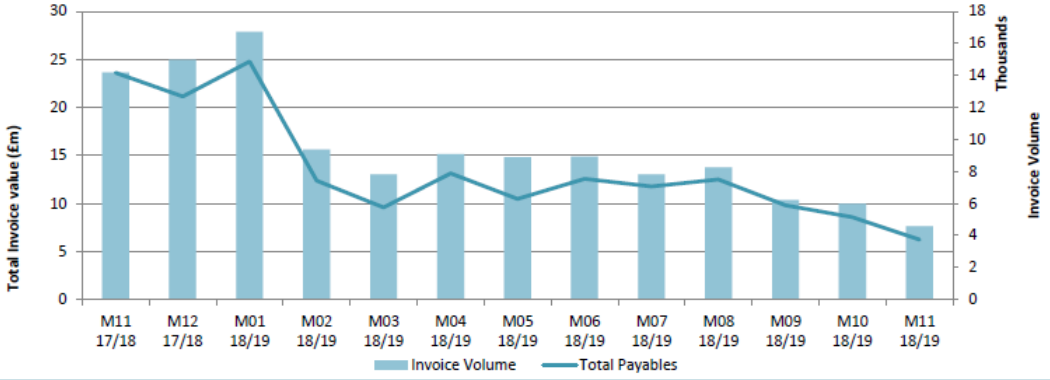
Aging Profile	M11 17/18	M12 17/18	M01 18/19	M02 18/19	M03 18/19	M04 18/19	M05 18/19	M06 18/19	M07 18/19	M08 18/19	M09 18/19	M10 18/19	M11 18/19
0 - 30 Days	8,184	7,668	6,423	5,752	3,711	6,387	4,552	6,153	6,708	6,410	5,109	5,530	3,611
31 - 60 Days	6,341	6,360	9,679	1,843	2,117	3,002	2,547	2,774	2,102	3,301	2,245	1,338	1,135
61 - 90 Days	3,128	1,681	2,969	2,267	766	1,039	1,703	1,099	599	600	986	629	442
91 - 120 Days	729	655	932	367	1,148	452	366	1,078	124	459	301	258	386
>120 days	5,220	4,753	4,762	2,135	1,854	2,249	1,315	1,464	2,233	1,725	1,169	806	675
Total Payables	**23,602**	**21,118**	**24,765**	**12,363**	**9,596**	**13,129**	**10,484**	**12,568**	**11,765**	**12,494**	**9,810**	**8,561**	**6,249**
Invoice Volume	**14,182**	**14,954**	**16,715**	**9,382**	**7,829**	**9,092**	**8,889**	**8,947**	**7,830**	**8,266**	**6,209**	**5,975**	**4,580**



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 84 days in month (88 days in January)
3. Internal KPIs to target elimination of registered > 120 days and creditor days < 60.

Capital Programme Summary - Month 11

YTD Capital Programme Performance	TOTAL PLAN ADJUSTED £000	CRG COMMITTED £000	ACTUAL EXPENDITURE £000	FORECAST EXPENDITURE £000	SYSTEM COMMITTED £000
Brought Forward	**500**	**992**	**1,327**	**1,602**	**275**
External Funding	3,709	250	75	780	5
2018/19 Business Cases	2,370	100	242	750	1,117
Medical Equipment	2,200	362	291	291	0
Digital	2,072	2,505	1,635	2,617	46
Estates	11,005	10,306	6,491	7,851	3,055
Finance	2,000	1,657	1,440	1,564	0
Total Owned	**23,856**	**16,172**	**11,501**	**15,455**	**4,498**
Donated	0	0	1,109	0	0
Less donated Income	0	0	(1,109)	0	0
Total	**23,856**	**16,172**	**11,501**	**15,455**	**4,498**

Capital Resource Limit	Source	£k
Opening Capital Resource Limit		15,455
Closing Capital Resource Limit		15,455

Summary & Next steps

1. The Capital Resource Group has committed £16.1m of this year's Capital Resource Limit (CRL) of £15.5m (updated for Winter Funding, EPMA and Order Coms).
2. To enable the Trust to deliver the target CRL the capital plan, which is over subscribed, is being reprioritised so that it delivers the CRL at year end.
3. Two submissions requesting emergency capital funding have been made to NHSI for £3.9m (medical devices and backlog maintenance) and £13.8m (fire safety). The Trust awaits the outcome on its two submissions.
4. A MRI finance sub-group meets on a bi-weekly basis to review and challenge costs and assumptions.


WHAT
MATTERS
TO YOU
MATTERS
TO US
ALL

Mortality Report – Learning from Deaths (1st April 2017 to September 30th 2018)

Meeting information:			
Date of Meeting:	2nd April 2019	Agenda Item:	10
Meeting:	Trust Board	Reporting Officer:	David Walker

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

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

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 reflects the new review process and all plaudits and care concerns raised by family or carers of the deceased are recorded.
This report details the April 2017 – September 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. A higher percentage of deaths are now being reviewed within the 3 month timescale and the backlog of deaths outstanding for review has decreased. The Mortality Review Audit Group also review the deaths with a much higher likelihood of avoidability on a quarterly basis, to ensure accuracy in reporting.

As per the required national changes for the reviewing of deaths, Medical Examiner posts are being recruited to at both ESHT sites and the new review process will commence in April 2019.

Learning disability deaths are being reviewed externally against the LeDeR (learning disability mortality review) programme however, feedback to individual Trusts from these external reviews is slow. Internal reviews are therefore being continued in order to mitigate against any risk.

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/September 2018-19

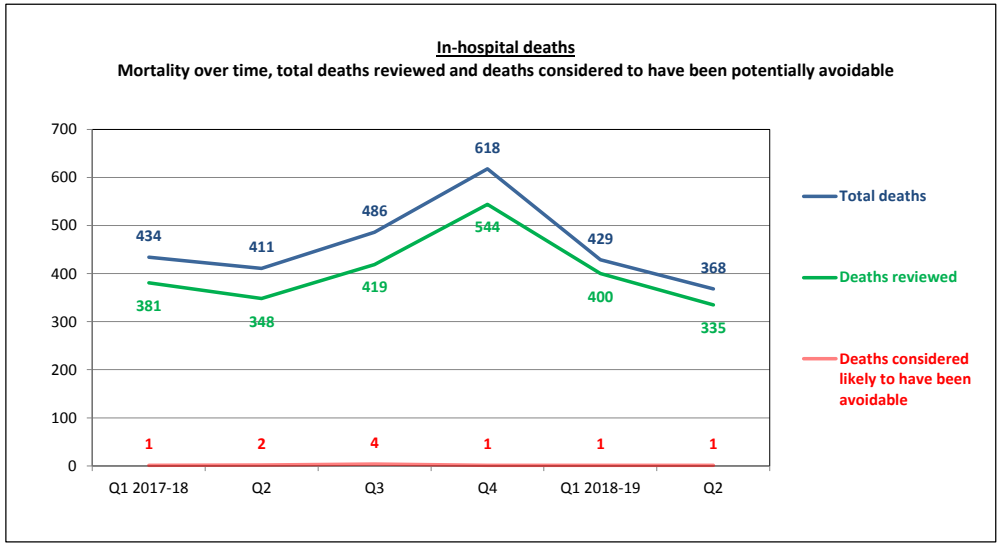
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 04/03/2019)

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

Time Series:	Start date	2017-18	Q1	End date	2018-19	Q2

Total number of deaths in scope		Total deaths reviewed		Total number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
146	110	127	106	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
368	429	335	400	1	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
797	1949	735	1692	2	8



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	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	33.3%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	33.3%	This Quarter (QTD)	1	33.3%	This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%	This Year (YTD)	2	33.3%	This Year (YTD)	0	0.0%	This Year (YTD)	1	16.7%	This Year (YTD)	3	50.0%	This Year (YTD)	0	0.0%

Data above is as at 04/03/2019 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were 7 care concerns expressed to the Trust Bereavement team relating to Quarter 2 2018/19 deaths, one of which was subsequently raised as a complaint.
Complaints - Of the complaints relating to 'bereavement' which were partially or fully upheld during Quarter 2 2018/19, two have overall care ratings of 'poor care' on the mortality database. One was fully investigated as a serious incident and both cases, which relate to Quarter 4 2017/18 deaths, were discussed at the Mortality Review Audit Group where avoidabiity ratings of 4 - 'possibly avoidable but not very likely', were agreed.
Serious incidents - There was one severity 5 incident reported in Quarter 2 2018/19. This death was discussed at the Mortality Review Audit Group, where an avoidability rating of 2 - 'strong evidence of avoidability' was agreed.
As at 04/03/2019 there are 319 April 2017 - September 2018 deaths still outstanding for review on the Mortality database.

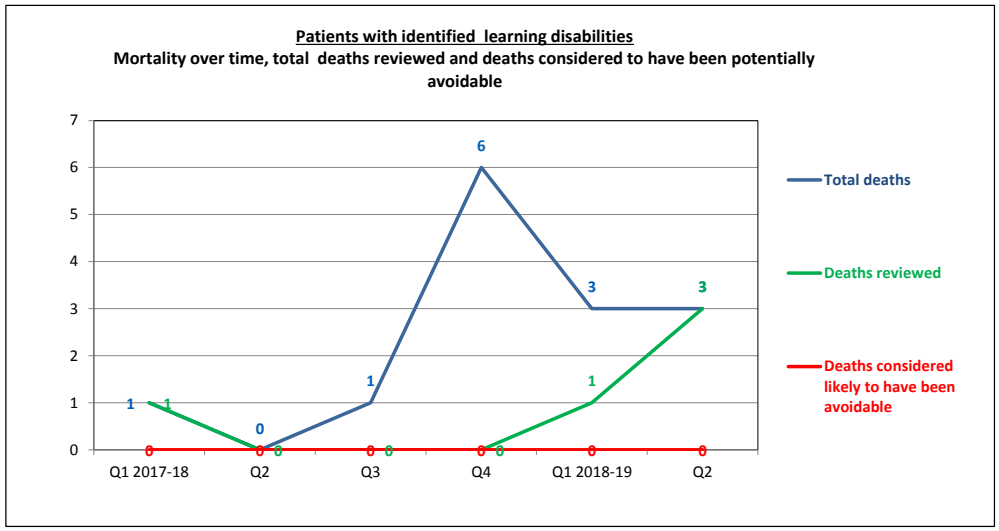
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 04/03/2019)

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	2018-19	Q2

Total number of deaths in scope		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	2	1	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	3	3	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
6	8	4	1	0	0



The LeDeR (learning disability mortality review) 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.
Prior to the national requirement to review learning disability deaths using the national LeDeR methodology, the deaths were reviewed by the learning disability nurse and Head of nursing for safeguarding who enter their review findings on the mortality database.
As the feedback from the wider external LeDeR has not yet been received, the internal reviews are being continued in order to mitigate against any risk.

7 Day Hospital Services (7DS) Board Assurance Framework

Meeting information:			
Date of Meeting:	2nd April 2019	Agenda Item:	11
Meeting:	Trust Board	Reporting Officer:	Dr 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?	

Summary:

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

The 7 Day Hospital Services (7DS) Programme aims to deliver improvements for patients by supporting providers of acute services to tackle variation in outcomes for patients admitted to hospitals in an emergency. Overall there are 10 clinical standards for 7DS, of which four clinical standards have been made priorities for delivery by NHS England (NHSE) and NHS Improvement (NHSI).

A new measurement system and process for 7DS was introduced in November 2018 to ensure that providers can produce a single consistent report for the dual purpose of assurance from their own boards and national reporting. The new board assurance framework is being implemented gradually. As part of the trial period, ESHT submitted an initial self-assessment to the regional NHSE and NHSI team on 28 February 2019.

Overall ESHT has met the standard for access to consultant-directed diagnostics (clinical standard 5), however the Trust self-assessment from February 2019 indicates that the Trust has not met the standards overall for initial consultant assessment (clinical standard 2), access to interventions (clinical standard 6), and ongoing consultant-directed review (clinical standard 8).

There are plans identified to improve delivery against the remaining three priority standards, with the Trust expected to be compliant with access to interventions (clinical standard 6) by the end of April 2019. The Trust also continues to develop divisional improvement plans for improving compliance against clinical standards 2 and 8 (first consultant review within 14 hours, and ongoing consultant review).

This paper summarises the self-assessment that was submitted, and outlines the work undertaken at ESHT in relation to 7DS to enable the Trust board to confirm their assurance of the assessment of delivery.

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

N/A

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

The board is asked to note the self-assessment against the 7DS clinical standards that was submitted in February 2019 and progress that is being made to improve delivery of the priority 7DS clinical standards at ESHT.

7 Day Hospital Services (7DS) Board Assurance Framework

1. Introduction

- The 7 Day Hospital Services (7DS) Programme aims to deliver improvements for patients by supporting providers of acute services to tackle variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England.

- Overall there are 10 clinical standards for 7DS proposed by the Academy of Medical Royal Colleges. Four of those clinical standards have been made priorities, for delivery by April 2020 by NHSE and NHSI.

- To enable tracking of progress in achieving the four priority 7DS clinical standards, ESHT has submitted a self-assessment survey to NHS England since 2016, with the most recent survey completed in April 2018.

- In November 2018, NHS England and NHS Improvement introduced a new measurement system and process for 7DS that replaced the previous self-assessment survey. The new self-assessment template aims to ensure that providers can produce a single consistent report for the dual purpose of assurance from their own boards and national reporting.

- The new process involves a single template for providers to record their self-assessments of 7DS delivery, and a board assurance framework for provider boards to provide evidence-based assurance of their organisation's delivery of 7DS. The new process requires provider boards to self-assess performance twice per year, once in spring and autumn.

- The new board assurance framework is being implemented gradually, with a trial period followed by full implementation from March 2019. As part of the trial period, ESHT submitted an initial self-assessment to the regional NHS England and NHS Improvement team on 28 February 2019.

- This paper provides a summary of the self-assessment that was submitted, and provides an overview of the work undertaken at ESHT in relation to 7DS to enable the Trust board to confirm their assurance of the assessment of delivery.

2. Priority 7DS clinical standards and how achievement is measured

- The four priority standards ensure patients admitted in an emergency receive the same high quality care at any time of day on any day of the week by ensuring that patients have access to initial consultant assessment (clinical standard 2), access to diagnostics and interventions (clinical standards 5 and 6), and ongoing consultant-directed review (clinical standard 8).

- Achievement of each standard requires meeting the level of care for at least 90% of patients admitted in an emergency. Self-assessment of achievement must be supported by local evidence, and be formally assured by the Trust Board.

- Published guidance on the 7DS board assurance framework requires the self-assessment to be evidenced by local data. An overview of the required sources of evidence for the priority clinical standards is provided below:

Clinical standard 2 – First consultant review within 14 hours Three sources of evidence: i) Triangulation of consultant job plans to deliver 7DS ii) Local audits to provide evidence iii) Reference to wider performance and experience measures	**Clinical standard 5 – Access to consultant-directed diagnostics** Assessment based on weekday and weekend availability of six diagnostic tests to appropriate timelines, either on site or by formal arrangement with another provider
Clinical standard 6 – Access to consultant-led interventions Assessment based on weekday and weekend availability of nine interventions on a 24-hour basis,	**Clinical standard 8 – Ongoing consultant-directed review** Four sources of evidence: i) Triangulation of consultant job plans to deliver 7DS

either on site or by a formal arrangement with another provider	ii) Evidence of robust multi-disciplinary (MDT) and escalation protocols iii) Local audits to provide evidence iv) Reference to wider performance and experience measures

- The template enables providers to record an assessment of 7DS delivery in each of the four priority standards for both weekdays and weekends, by selecting from a list of pre-determined options that generate an automatic calculation of the overall score.
- The measurement template also captures detail on 7DS in urgent network specialist services and all of the other 7DS clinical standards.

3. Assessment of achievement against the 7DS priority clinical standards at ESHT

- This section provides an overview of the self-assessment against achievement of the priority 7DS clinical standards that was submitted to NHS England and NHS Improvement in February 2019. The completed self-assessment template can be found in the appendix to this paper and a summary has been provided below.

Clinical Standard	Weekday	Weekend	Overall Score
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	**Standard Not Met**
Clinical Standard 8	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	**Standard Not Met**
	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

Clinical Standard	Diagnostic	Weekday	Weekend	Overall Score
Clinical Standard 5	Microbiology	Yes available on site	Yes available on site	**Standard Met**
	Computerised Tomography (CT)	Yes available on site	Yes available on site	
	Ultrasound	Yes available on site	Yes available on site	
	Echocardiography	Yes available on site	Yes available on site	
	Magnetic Resonance Imaging (MRI)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
	Upper GI endoscopy	No the test is only available on or off site via informal arrangement	No the test is only available on or off site via informal arrangement	

Clinical Standard	Intervention	Weekday	Weekend	Overall Score
Clinical Standard 6	Critical Care	Yes available on site	Yes available on site	**Standard Not Met**
	Interventional Radiology	Yes available on site	Yes available on site	
	Interventional Endoscopy	No the intervention is not available	No the intervention is not available	
	Emergency Surgery	Yes available on site	Yes available on site	
	Emergency Renal Replacement Therapy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
	Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
	Stroke Thrombolysis	Yes available on site	Yes available on site	
	Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
	Cardiac Pacing	Yes available on site	Yes available on site	

3.1. Clinical standard 2: First consultant review within 14 hours

ESHT has not met standard 2 overall. ESHT has consultant job plans in place across medicine and general surgical specialities to deliver compliance with this standard during weekdays. However the formalised arrangements for consultant cover in a number of surgical specialities currently provide insufficient cover to deliver review within 14 hours at weekends.

Mitigations:

- ENT is unable to staff a 7/7 consultant rota due to recruitment difficulties. This is currently being mitigated by employing an associate specialist and a locum.
- Urology operates a consultant of the day rota. The commitments of the daily consultant are currently being adjusted to ensure senior review within 14 hours 7 days per week.
- Introduction of the Nerve Centre (live bed state system) across the Trust, expected from spring 2019, will support tracking of patients and their review within 14 hours, provide patient and task lists for medical staff, and provide a robust mechanism for monitoring performance against this clinical standard.

Improvements made so far:

- An electronic record has been in use from December 2018 on our Acute Medical Unit (AMU) at EDGH to enable more reliable tracking of patients referred, the time of their admission clerking and the time of consultant review.
- From November 2018, we have monitored the rate of review within 14 hour standard, by ward, on a monthly basis as part of the “Excellence in Care” programme. Trust performance was 91.7% (433/494) in November, and 91.9% in December.

3.2. Clinical Standard 8: Ongoing consultant-directed review

ESHT has not met standard 8 overall. Twice daily review is standard practice in our intensive care and high dependency units on both sites which delivers compliance with this standard for patients with high dependency needs. Specialty teams at ESHT also conduct daily multidisciplinary consultant-led board rounds on our assessment units and acute inpatient wards during weekdays. However ESHT is not compliant with standard 8 at weekends in a number of specialities where the formalised arrangement for consultant cover at weekends does not include a consultant-led ward round. Documentation of need for medical review and delegation of consultant review is variable across specialities and wards, and remains poor in some.

Mitigations:

- Variation in Board Round practice has been audited and education and support is being targeted towards those clinical areas and specialities that are less developed. ESHT has piloted a project to improve documentation of delegation in two specialities in 2018. Educational work has been undertaken across all specialities to improve documentation of daily review and review delegation.
- The Nerve Centre system will incorporate a more reliable mechanism to document when a consultant-led review has taken place, and provide a robust mechanism to document delegated review of inpatients.

3.3. Clinical standard 5: Access to consultant-directed diagnostics

ESHT has met standard 5 overall. ESHT is currently not compliant with delivering the standard for upper GI endoscopy during weekdays and weekends, however this has not affected overall compliance against standard 5 as the diagnostic tests are weighted on the frequency of use for patients admitted in an emergency, with upper GI endoscopy accounting for 2.2% of requests. Plans are in place to allow gastroenterologists to provide a cross-site 7 day GI bleeding rota from 15 April 2019, following which the Trust will be fully compliant for this standard for all diagnostics.

3.4. Clinical standard 6: Access to consultant-led interventions

ESHT has not met standard 6 overall. Compliance against clinical standard 6 is based on a combination of weekday and weekend assessments with equal weighting to availability at weekdays and weekends. To achieve compliance, the Trust must comply with 17 out of 18 instances.

The plans in place to provide a cross-site 7 day GI bleeding rota from 15 April 2019, as outlined above for standard 5, will also enable the Trust to achieve compliance for standard 6 overall.

4. Recommendations and next steps

The Trust board is asked to note the progress that is being made in delivering the priority 7DS clinical standards at ESHT.

Although the Trust self-assessment from February 2019 indicates that the Trust has not met the standards overall for initial consultant assessment (clinical standard 2), access to interventions (clinical standard 6), and ongoing consultant-directed review (clinical standard 8), there are plans identified to improve delivery.

The Trust improvement plan for 7DS includes:

- Continuing to develop divisional improvement plans for delivering against the 7DS standards. Compliance against the 7DS standards at divisional level have been completed as part of the initial self-assessment for the trial period, and the next steps will involve identifying specific actions to improve compliance against clinical standards 2 and 8 (first consultant review within 14 hours, and ongoing consultant review).
- Improving quality of the data collected as part of the Excellence in Care programme, so that there is a robust mechanism to monitor delivery of clinical standard 2 by speciality and division
- Using Nerve Centre as a reliable mechanism to improve delivery against standards 2 and 8 by:
    - Providing patient and task lists for medical staff to support prioritisation and delivery of consultant-led review within 14 hours
    - Enabling documentation of when a consultant-led review has taken place, and when the review of inpatients has been delegated

Katey Ma
Head of Clinical and Quality Improvement

Dr David Walker
Medical Director

East Sussex Healthcare NHS Trust: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2018/19

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	During weekdays, ESHT has consultant job plans in place across medicine and general surgical specialities to deliver compliance with clinical standard 2. • All medical specialties participating in the general medical acute rota have in place consultant or senior staff rotas to enable review of medical patients within 14 hours, using a combination of GIM consultant of the day and AMU consultants, with on-site cover provided from 0900 to 2000. • General surgery has a consultant of the day on the Surgical Assessment Unit (SAU), available to see patients from 0800 to 2000. ESHT is not compliant with standard 2 at weekends in a number of specialties where the formalised arrangement for consultant cover provides insufficient cover in order to deliver review within 14 hours. • ENT is unable to staff a 7/7 consultant rota due to recruitment difficulties. This is currently being mitigated by employing an associate specialist and a locum. • Urology operates a consultant of the day rota. The commitments of the daily consultant are currently being adjusted to ensure senior review within 14 hours 7 days per week. • An Excel based electronic record has been in use from December 2018 on our Acute Medical Unit (AMU) at EDGH to enable more reliable tracking of patients referred, the time of their admission clerking and the time of consultant review. • From November 2018, we have monitored the rate of review within 14 hour standard, by ward, on a monthly basis as part of the "Excellence in Care" programme. Trust performance was 91.7% (433/494) in November, and 91.9% in December.	Yes, the standard is met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	Endoscopy is currently available on site 0800 to 1800 during weekdays, but there is no arrangement out of hours. During weekends cover is available from 0800 to 1200 only. There are plans to reduce commitment to acute GIM rota from 15 April 2019, which will allow gastroenterologists to provide a cross site 7/7 GI bleeding rota and enable the Trust to be compliant with this standard.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Upper GI endoscopy	No the test is only available on or off site via informal arrangement	No the test is only available on or off site via informal arrangement	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Not Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	No the intervention is only available on or off site via informal arrangement	No the intervention is only available on or off site via informal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	Endoscopy is currently available on site 0800 to 1800 during weekdays, but there is no arrangement out of hours. During weekends cover is available from 0800 to 1200 only. There are plans to reduce commitment to acute GIM rota from 15 April 2019, which will allow gastroenterologists to provide a cross site 7/7 GI bleeding rota and enable the Trust to be compliant with this standard.	Emergency Renal Replacement Therapy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	• Twice daily review is standard in ITU/HDU at both sites and recorded on EPR. • Daily multidisciplinary consultant-led board rounds are in place on admission and assessment units and on acute inpatient wards, as the Trust is operating the SAFER approach to inpatient care. • Cardiology has a consultant of the day, covering CCU at each site, and an alternating site acute primary angioplasty rota provides 24/7 cover. At weekends, there is currently no cardiology consultant cover at Conquest to provide ward rounds on the CCU. ESHT is in the process of reviewing the cardiology pathway. • ESHT is not compliant with standard 8 at weekends in a number of specialties where the formalised arrangement for consultant cover does not include a consultant-led ward round. Documentation of need for medical review and delegation of consultant review is variable across specialties and wards, and remains poor in some. Improvements to be implemented: • Variation in Board Round practice has been audited and education and support is being targeted towards those clinical areas and specialties that are less developed. ESHT has piloted a project to improve documentation of delegation in 2 specialties in 2018. Educational work undertaken across all specialties in improved documentation of daily review and review delegation. • The Nerve Centre clinical management system, which is currently in set-up phase, will incorporate a more reliable record of review and review delegation and provide patient and task lists for medical staff.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Standard 1 – Patient experience • Trust admission documentation (IPD) incorporates formal confirmation of discussion of diagnosis, investigation and treatment plan. 7DS national audits have assessed this annually, and quality of DNACPR form content has been monitored for several years. • From April 2019, the DNACPR form will be replaced by the combination of RESPECT documents and Treatment Escalation Plans (TEPs), which also document discussion with patient, family and others. Training is ongoing for RESPECT and TEPs in preparation for their formal introduction in April. Standard 3 – MDT review • Assessment of all acute admissions by nursing and medical staff 7/7 incorporates assessment of complex needs. Patients with potential complex needs are assessed at entry points (CDU, AAU, MAU, SAU) by HIT Team (Social Care, Physio, OT) 7/7. • MDT meeting held daily on AAU and AMU but not currently 7/7. • Post take ward round proforma incorporates specific sections for EDD, discharge criteria and escalation/ceiling of care but this is not universally completed. • Medicines reconciliation occurs within 24 hours. Standard 4 – Shift handovers • Evening Shift handovers are multidisciplinary (Medical, Surgical, Anaesthetics, Nursing, Gynae, Paediatrics and Site management team). Mainly Led by SpRs. Some led by consultant. • Morning shift handovers led by consultant in some, but not all, specialties. • Documentation not currently uniform across Trust

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	No, the standard is not met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Cardiology has a consultant of the day, covering CCU at each site, and an alternating site acute primary angioplasty rota provides 24/7 cover. At weekends, there is currently no cardiology consultant cover at Conquest to provide ward rounds on the CCU.

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

East Sussex Integrated System Governance

Meeting information:			
Date of Meeting:	2nd April 2019	Agenda Item:	12
Meeting:	Trust Board	Reporting Officer:	Dr Adrian Bull, CEO

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 Better Together governance structure was paused during 2018/19 to enable key focus on in-year financial recovery. This has also provided an opportunity to review and refresh the approach to our integrated system governance.

The East Sussex Better Together governance structure is attached as Appendix 2 and Appendix 1 provides an overview of the revised system governance structure. The new structure includes previous alliance members with the addition of High Wealds, Lewes and Havens CCG. It combines financial recovery, business as usual and the three key strategic programmes (urgent care, community services and planned care) into a single, streamlined partnership approach.

The overarching East Sussex Health and Care Executive will hold our system individually, organisationally and collectively to account for delivery. The Executive includes representatives from commissioners, Sussex Partnership Foundation Trust, GP Federations, the Local Medical Committee and our Trust. High level milestones and metrics are being set and a system PMO function has been established and track measurable progress and benefits realisation.

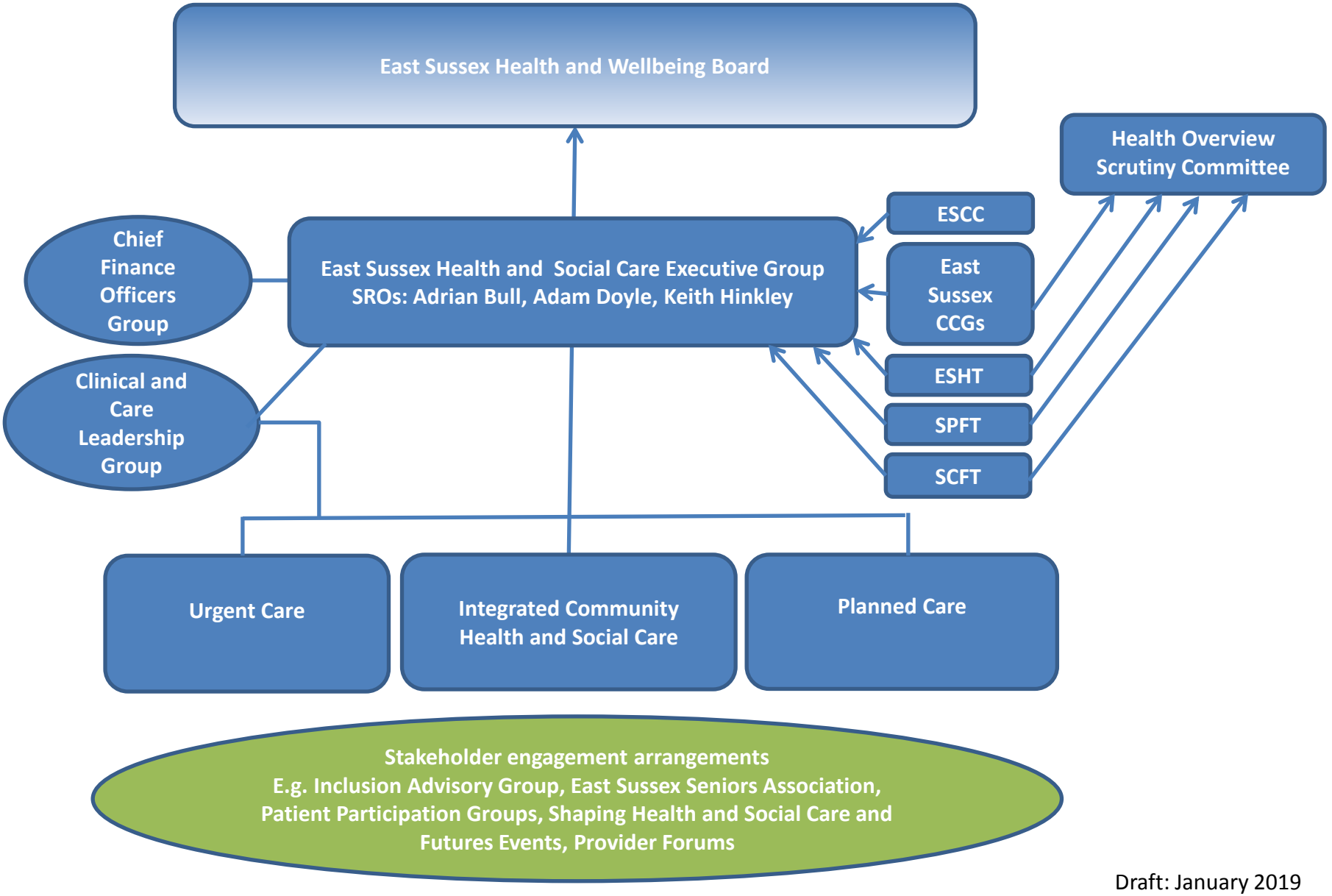
2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

East Sussex Health and Care Executive Group – 6 December 2018

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

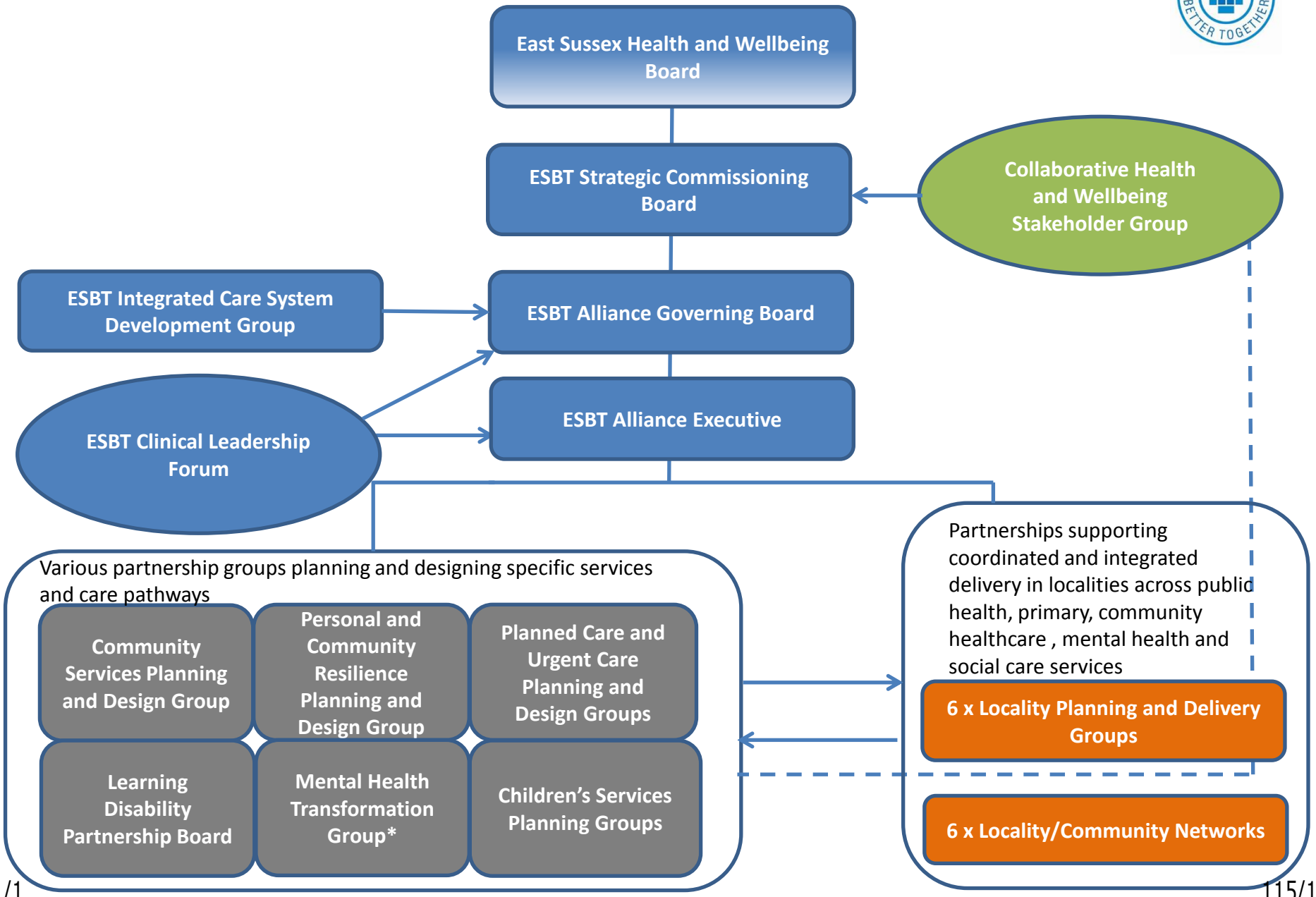
The Board is asked to review and endorse the revised integrated system governance structure outlined in Appendix 1.

DRAFT Suggested East Sussex Health and Social Care Transformation System Governance



Draft: January 2019

Appendix 2 Previous ESBT system governance structure



2019/20 Business Planning Update as at 15/3/19

Meeting information:			
Date of Meeting:	2nd April 2019	Agenda Item:	13
Meeting:	Trust Board	Reporting Officer: Catherine Ashton, Director of Strategy, Innovation and Planning	

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

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

Summary:

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

The paper provides an update on the progress with the Trust's annual business planning process. The next steps are:

- To finalise the activity, financial and workforce plans and align to the STP and system plans
- Director of Finance / Chief operating officer to sign off budgets with Divisional and Corporate Leads by 31/3/19.
- Final operational plan submission to NHSI/E due on the 4/4/19 and publication of Trust plan by 30/4/19

Risk	Mitigating Action
Significant divisional cost pressure requests exceeding the proposed budget	Executives to review and sign off all cost pressures, and formal sign off of 19/20 budgets with divisions and DoF/COO. Robust maintenance of the business case approvals process to ensure all investments are in line with the Trust plan.
Delivery of the 18/19 control total to support the 19/20 position	Ensure delivery of the 18/19 plan
Delivery of the CIP target	Continue development of CIPs and convert the pipeline into profiled schemes by Q1
Capital remains constrained	Continue to manage capital through the CRG
Contractual value	Continue to work with the CCG to resolve differences

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

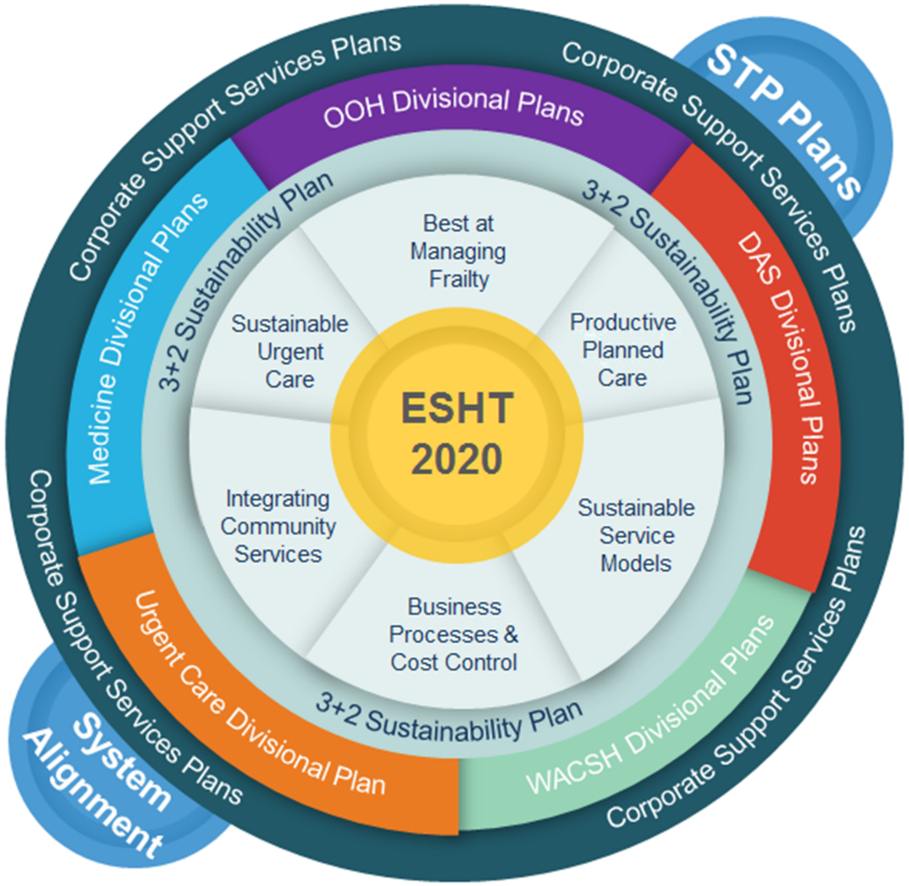
Executive Directors and Trust Board Seminar 27/2/19; Senior Leaders Forum 14/3/19

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

The Trust Board are asked to note the update.

2019/20 Business Planning Progress as at 15/3/19

NHS East Sussex Healthcare NHS Trust



Control Total Deficit Financial Plan
£34 million

Patient Activity Baseline Plan*

- **109,102 First Outpatient Appointments**
- **296,708 Follow up Outpatient Appointments**
- **34,040 Elective Daycases**
- **6,539 Elective Cases**
- **53,758 Non-Elective/Emergencies****

*Subject to finalisation of growth rate assumptions
**Growth rate assumptions based on 3% to be increased to 6%, subject to discussions with CCGs based on trend over past 2 years

- Divisions and Corporate team business plans discussed at Seminar on 27/2/19:
  - Priorities identified and summarised below
  - Activity, income and expenditure budgets being finalised
  - Budget sign off with Director of Finance and Chief Operating Officer by 31/3/19
  - Development of Cost Improvement Plans in progress
- NHSI Business Planning challenge session held on 6/3/19 to feedback on Trust's draft plan submitted in February 2019. Actions in progress
- Discussions with CCGs in progress to align Trust and system operational plans
- Final Trust Operational Plan submission to NHSI/E by 4/4/19

Out of Hospital Division Plan on a Page Priorities 2019/20

NHS
East Sussex Healthcare
NHS Trust

Priorities
Continuing the Transformation Journey

- ❖Rebasing Community Services
- ❖Re-alignment of ESBT and Block contract services
- ❖Implementation of operating model – integration with ESCC
- ❖End to end pathway development – Stroke, MSK/T&O and Frailty
- ❖Rehabilitation strategy
- ❖Digital strategy – S1 business case
- ❖Financial sustainability
- ❖Staff and citizen engagement

Pharmacy Department Priorities 19/20

Hospital Pharmacy Transformation Program (Year 3)

Pharmacy efficiency and effectiveness (Lord Carter Report)

- Support for patient flow and discharge process
  - 7 Day Clinical Pharmacy Service
  - Further support for ward level dispensing (COWs)
  - Roll out of Pharmoutcomes referral system to all local Community Pharmacies
- Enhancing Digital Systems to maximise efficiency
  - EPMA
  - Enhanced eTrading
  - Falsified Medicine Directive Compliance (3d scanning & automation)
- Review ESHT Aseptic services within local and national context
- Ensure best use of resources with respect to medicines use
  - Biosimilar switching
  - Collaborative supply chain efficiencies

Integrated Medicines Optimisation Program

ESHT & CCG Pharmacy teams working collaboratively on MO projects.

Three shared priority areas for 2019-20:

- Diabetes
  - New Consultant Pharmacist post – joint ESHT/CCG appointment
  - Evidence based prescribing guidance and monitoring – ensuring best practice
  - Education and training
- Pain management
  - Evidence based guidelines and formulary review
  - Actions to address controlled drug dependence, abuse, security and safety issues
- Outpatient prescribing
  - Timely and accurate transfer of information to GPs
  - Review of most cost effective supply route (internal, FP10 etc.)
  - Actions to address shared care/interface issues

Medicine Division Plan on a Page Priorities 2019/20

NHS
East Sussex Healthcare
NHS Trust

Overall Divisional Sustainability Priorities and Programmes

Productive Planned Care	Best at Managing Frailty	Sustainable Urgent Care	Sustainable Service Models
• Medical Day Unit • Acute Medicine Operational Flow	Frailty Plans	• GI Bleed Rota • AEC Expansion at Conquest	• Dermatology Sustainability & Redesign • Gastroenterology Service Model Review

Speciality Grouping Programmes and Priorities

Acute Medicine & Elderly Care Programmes and Priorities

Productive Planned Care	• Maintain operational flow from Acute Medicine to specialty wards.
Best at Managing Frailty	• 7 Day Palliative Care / End of Life Service • Clinical Pathways with clear KPI's (innovation apply the stroke model of care and pathway KPI's)
Sustainable Urgent Care	• AEC Expansion at Conquest • 7 Day Acute Medicine • Nurse-led ambulatory pathways • To implement twice daily board rounds
Integrating Community Services	• Frailty work streams must work across all boundaries. • Discharge destinations for frail patients who don't require acute admission.
Sustainable Service Models	• Investment in Acute frailty at Front of House • Investment in Frailty MDT in the acute setting
Business Processes & Cost Controls	• Invest to save • Recruitment • Demand and Capacity • Workforce Review • Frailty to be managed independently
Quality & Safety	• Reduce LOS • Consultant daily ward rounds

Cardiovascular Programmes and Priorities

Productive Planned Care	• Reduction of LOS • RTT Performance • Nurse led pathways to be fully utilised • Cath lab utilisation • Right sized cardiology ward s • Medical Day Unit for endocrinology patients
Sustainable Urgent Care	• Cardiology PCI Rota & Pathways • Sustainable Stroke Rotas • Thrombectomy Pathway • Thrombolysis On-Call Rotas
Integrating Community Services	• Integrated Diabetes Service • Further reduction in Stroke LoS • Community Cardiology Model
Sustainable Service Models	• Transformation of Cardiology • Review vascular pathways
Business Processes & Cost Controls	• 3% Efficiency • Medical Rotas • Workforce Redesign • Demand & Capacity • Stroke speciality code.
Quality & Safety	• SSNAP Audit • Meeting DM01 Targets • Practice Educator roles introduced in Cardiology • Increase in vascular lab services.

Specialist Medicine Programmes and Priorities

Productive Planned Care	• Medical Day Unit & Elective Pathways • Further development of Nurse Led Clinics • Reduction in LOS • Endoscopy utilisation
Sustainable Urgent Care	• GI Bleed Rota • GIM Medical Rota
Integrating Community Services	• Integrating Dermatology service with Community Providers • Review Neurology Pathways
Sustainable Service Models	• Dermatology Sustainability & Redesign • Gastroenterology Service Model Review
Business Processes & Cost Controls	• 3% Efficiency • Demand & Capacity • Workforce Review • RTT Performance
Quality & Safety	• Cancer Quality Improvement (lung) • Implementation of GI bleed rota • Implementation of 7 day specialist palliative care

Divisional Plans on a Page Programmes and Priorities 2019/20

East Sussex Healthcare NHS Trust

Diagnostic, Anaesthetic and Surgery Division

Quality & Safety

- **Enhancing the patient experience**
  - Ongoing training in fundamentals of care (Getting back to basics programme)
  - Improving patient outcomes (reducing falls and PU)
  - Learning from incidents
  - Enhancing patient pathways
- **Enhancing staff experience and engagement**
  - Continued monthly Network Sessions
  - Development of new roles & ways of working

Sustainable Service Models

- Redesign of ENT service to ensure clinical and financial sustainability
- Redesign of HSDU service
- Clinically led redesign of Ophthalmology service, inc. Estates Rationalisation
- Redesign of patient pathways for Sleep service, inc. relocation to an area with established night service

Productive Planned Care

- Increase day case activity for Breast surgery
- Maximise capacity and productivity of ENT theatre lists at Uckfield and EDGH
- Theatre utilisation and improving productivity.
- Outpatients productivity
- Elective inpatient pathway improvements.
- Development of a vision for private patient activity in the Trust.

Sustainable Urgent Care

- Anaesthetics pressure with on-call commitments and support to ITU
- On-call rota to cover ENT services

Best at Managing Frailty

- Orthogeriatric service
- Surgical frailty liaison service

Integrating Community Services

- 7 day services
- T&O collaborative working with MSK services.
- Rehabilitation plan for T&O (working with OOH)

Business Process & Cost Control

- Reduce agency and locum staff
- Recruitment and retention
- Job Planning
- Agree local tariff with CCG for provision of complex sleep studies
- Private patient activity meets current forecast income and generate further income accordingly

Women, Children and Sexual Health Division

Quality & Safety

- Maternity staffing review to support normalising better births implementation
- SSPAU clinical model to improve access for children through a 23 hour model
- Review of gynaecology service model

Sustainable Service Models

- Review of Gynaecology service pathways (Four Eyes report)
- Maternity footprint review at Conquest
- Normalising Birth/ Better Births Agenda
- Acute Paediatrics , clinical model for SSPAU
- Sexual Health Service – review of commissioned service

Productive Planned Care

- Gynae theatre capacity and utilisation
- Demand and Capacity review – Midwife and Consultant led antenatal clinics
- Maternity Day Unit review cross site

Sustainable Urgent Care

- Acute Paediatrics APNP service progression
- Integration EDGH middle grade night rota

Integrating Community Services

- Acute Paediatrics – review Outreach Nursing service and specification
- Acute Paediatrics, streamline pathways to integrate transition services and bring together Specialist Nurses
- Scope opportunities for the health visiting service
- Link with CAHMS & Community Paeds/Scott Unit(ASD/ADHD pathway)

Business Process & Cost Control

- Workforce planning and talent management
- Job Planning
- Apprenticeship schemes
- Review of skill mix within Sexual Health Service, in line with new contract
- Audiology tariff
- Procurement of a maternity system which fits the needs of the service

Urgent Care Division

Quality & Safety

- Consultant lead handovers 7 days a week
- Regular board rounds in ED

Sustainable Service Models

- Review of site management and discharge team configurations.

Sustainable Urgent Care

- Urgent Treatment Centres (CQ & EGDH)
- Achieve 4 hour standard
- Expansion of nerve centre to include ED module

Integrating Community Services

- Stranded patient app helping to identify patients for Therapies and ASC

Business Process & Cost Control

- Recruitment and retention – Cons Twilight.
- Reduce locum staff
- Job planning
- Adjustment to training delivery for ED staff
- Review of clinical supervision days
- Stock controls in A&E

Corporate Services Plans on a Page Priorities 2019/20

NHS East Sussex Healthcare NHS Trust

Outpatient/Clinical Administration

Productive Planned Care

- Self service kiosks in T&O at EDGH & Conquest
- Patient Portal – implement software and engage patients
- E-forms for Outcome , waiting lists & clinical documentation

Sustainable Service Models

- Outpatients Transformation Programme
- Health Records Strategy/Scanning/Estate/Third party
- Medical Secretarial Service Redesign

Business Processes & Cost Controls

- BigHand – implement speech recognition and improve IG compliance
- Outsource letters from inpatients, cardiology and endoscopy to be more cost effective
- eRS – transition to BAU and expand, including Advice & Guidance
- Refurbishment reception areas
- New call mgt system for OPs
- Bookwise

Estates & Facilities Modernisation Programme

Premises

- Conquest residences
- EDGH industrial area
- 6 facet survey
- GP developments
- St Anne's business case
- Meeting room bookings
- Review of SIFT funding allocations and requirements
- Roll out of cleaning trolleys in all areas
- Review efficiency of CCTV systems

Service Development Opportunities

- Review patient meal ordering solutions and source digital solution
- Work with dietitians and clinical teams to support improvements in nutrition and hydration
- Improve out of hours catering services for staff
- Car parking management systems review

Strategic Projects

- EPC
- Backlog maintenance review
- St Anne's business case
- Residential business case
- Construction procurement models; P22 and Frameworks

Estates Re-provision

- EDGH industrial area SOC
- EPC
- Residential

18-19 Capital Projects over £250K carried forward to 19/20

- Backlog
- MRI
- Ambulatory care
- UIS
- Conquest main entrance

Outpatients Transformation Programme

To enable our patients to have timely access to advice, diagnostics and treatment that improves and/or maintains optimal health, supporting a positive experience

Greater Productivity in existing services

Improve Utilisation
Reduce DNAs
Reduce cancellations

Maximise capacity

- Reduction in frequent attenders
- Referrals without subsequent OPA
- Procedures not commissioned

Transform & Redesign

Introduce new processes and pathways including one stop and virtual clinics

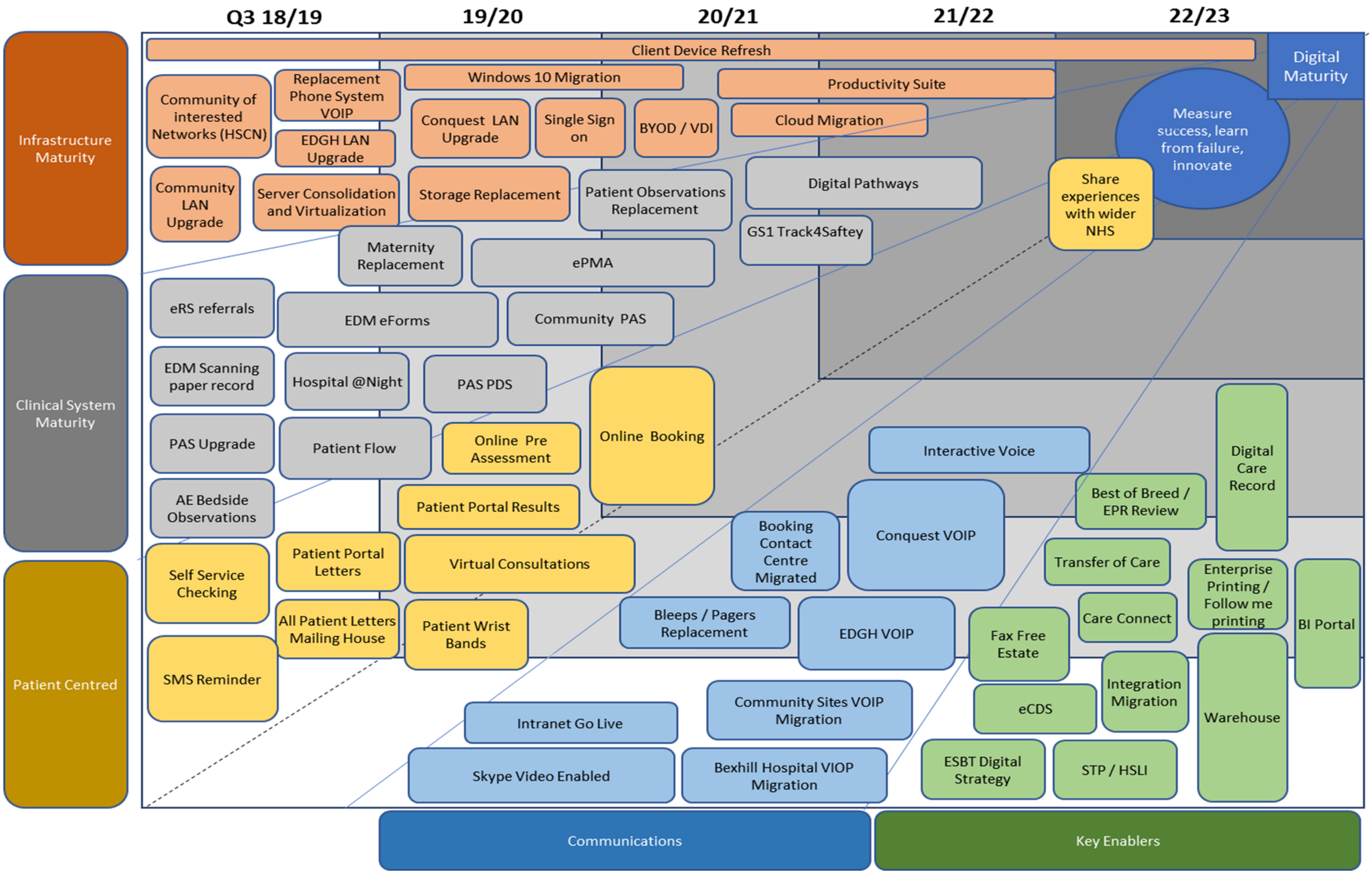
Embrace digital capabilities

- OPA mgt solution for patients
- Self service check in
- Voice recognition for OP letters
- Patient Portal
- Virtual #clinic
- Chronic Health Mgt Apps

Digital Department Plan on a Page Priorities 2019/20

NHS
East Sussex Healthcare
NHS Trust

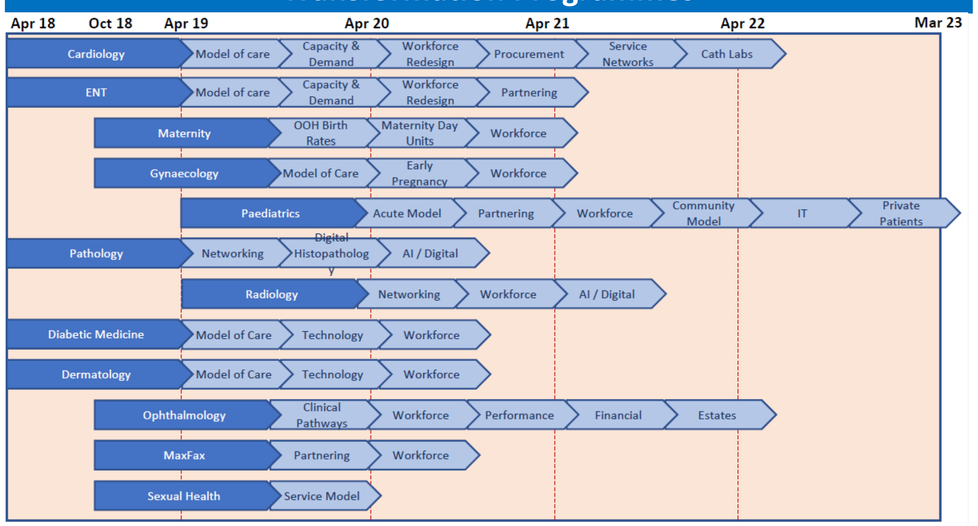
Five Year Digital Plan



Strategy, Innovation, Improvement & Planning 2019/20

NHS
East Sussex Healthcare
NHS Trust

Transformation Programmes



QI Training Programme

We are an organisation focused on embedding a continuous improvement approach, and we offer a range of QI training courses that vary in duration and depth of content.

Pop Up QI
1 hour introductory session
AVAILABLE NOW!

Bitesize QI
4 hour session
Focus on the principles of quality improvement and practical application of tools and techniques
STARTS APRIL 2019

QSIR Fundamentals
1 day workshop
Introduction to the 8 modules within the QSIR programme covering quality, service improvement and redesign tools and techniques
STARTS JUNE 2019

QSIR Practitioner
5 day course with monthly workshops
Application of tried and tested approaches, tools and techniques for designing more efficient and productive services
COHORT 1 STARTS JUNE 2019

Embedding Quality Improvement

QI course offered

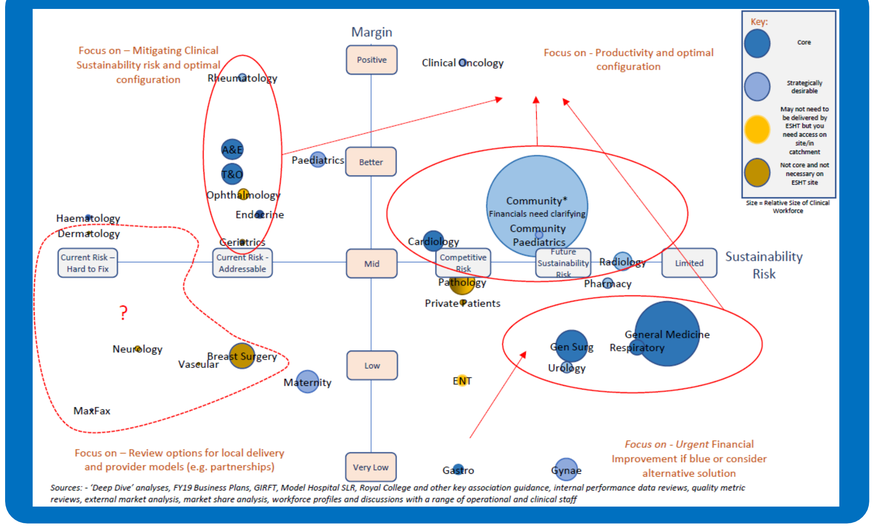
Pop Up QI
1 hour introductory session

Bitesize QI
4 hour in-depth session

QSIR Practitioner
5 day course with monthly workshops

QSIR College
In house training faculty

ESHT Sustainability Matrix



Clinical Research Programme

Priority	Summary
Embedding Research	Advise on implementation of Research Escalator within job planning and IPR - to embed a research culture in the workplace – appropriate to role.
Increase opportunity for participation	Refresh extranet page and update regularly. Arrange events across the Trust to celebrate National Clinical Trials day in May. All new consultants to be appraised of research opportunities appropriate to their practice.
Improve research governance standards.	Restructure and employ core governance posts X 2. Commence monthly reporting of performance. Audit 10% of recruiting studies per annum.

Quality Improvement Priorities 2018/19

Meeting information:			
Date of Meeting:	2nd April 2019	Agenda Item:	14
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth, Director of Nursing

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

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

Summary:

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

The Trust Quality Account (QA)is published by 30 June every year, to report on the quality of services offered by ESHT. The QA is both retrospective and prospective, and includes within it:

- **A review of improvements that have been made to our services in the previous financial year.** For 2018/19, the Trust identified eight quality improvement priorities. The Trust is on track to fully deliver three out of eight priorities, with partial achievement of the others.
- **An outline of the Trust priorities for improvement in the year ahead along with a commitment about how those improvements will be delivered and monitored over the year.** For 2019/20, the Trust is proposing four quality improvement priorities which are aligned with the strategic priorities of the organisation.

The process for developing the QA is on track for publication by 30 June 2019. The Board will receive a finalised version of the QA for review prior to publication.

This paper provides a summary of progress with developing the 2018/19 QA, including an outline of progress with delivering the 2018/19 improvement priorities and an outline of the proposed quality improvement priorities for 2019/20.

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

Quality & Safety Committee – 24 January 2019 & 21 March 2019

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

The Board is asked to note the progress with developing the Quality Account report for 2018/19, including the progress within implementing 2018/19 improvement priorities, and the improvement priorities proposed to be taken forward in 2019/20.

1. Introduction

The Quality Account (QA) is a mandatory annual report to the public on the quality of services offered by ESHT, which the Trust is required to publish by 30 June every year. Included within the QA is a review of improvements that have been made to our services in the previous financial year, and our priorities for improvement in the year ahead.

The process for developing the QA report requires identification of at least three priority areas where the Trust plans to improve the quality of our services, which have been determined through discussion and consultation with internal and external stakeholders. The priorities must be measureable and reportable, and should be focused on the three domains of quality (patient safety, patient experience, and clinical effectiveness) with at least one priority assigned to each.

This paper provides a summary of progress with developing the 2018/19 QA, including an outline of progress with delivering the 2018/19 improvement priorities and an outline of the proposed quality improvement priorities for 2019/20.

2. Progress with delivering the 2018/19 improvement priorities

The 2017/18 QA identified eight quality improvement priorities, which are summarised in the table below. The Trust is expected to fully deliver three out of eight priorities in 2018/19. Plans are in place to mitigate delivery against the remaining five priorities which are partially achieved. Although the set targets for these priorities that are currently only partially achieved have not been delivered overall, there has been demonstrable improvement from the original baselines which is reported to the Q&SC.

Quality Domain	Quality Improvement Priority 2018/19		Current Status
Patient Safety	1.	Improving the early recognition, escalation and management of the deteriorating patient	*Partially achieved*
	2.	Continue to reduce the number of avoidable falls	*Partially achieved*
	3.	Continue our focus on reducing avoidable grade 3 and 4 pressure ulcers	*Partially achieved*
Clinical Effectiveness	4.	Working towards providing consistent high quality care for our patients seven days a week	*Partially achieved*
	5.	Continued implementation of the Excellence in Care Programme	*On track for full achievement*
	6.	Safe and effective discharge and improving our patients' experience of getting home	*On track for full achievement*
Patient Experience	7.	Continue to improve end of life care by improving processes and documentation	*On track for full achievement*
	8.	Improving the experience of young people in hospital	*Partially achieved*

3. The process for developing the improvement priorities for 2019/20

A long list of improvement priorities were initially derived from safety and quality indicators where the Trust's performance over the past year could be improved, and included improvement priorities from the previous year where it was felt that there was a need for continued or renewed focus. The initial long list of priorities was considered by the Executive Directors in February 2019 and refined to the shortened list of proposed priorities that are presented in this paper.

To support the development of improvement priorities for the year ahead, discussion and consultation with external stakeholders has been undertaken at a variety of forums throughout February and March, including at the Eastbourne, Hailsham and Seaford Patient Participation Group meeting in February, and at an East Sussex Seniors Association meeting in March. Participants at these forums have also been given the opportunity to provide further written feedback on the proposed priorities. Further discussions with external stakeholders are also planned at a Healthwatch Advisory Group meeting in March.

The focus of the external engagement events has been to gauge opinion as to what is important to the public relating to the suggested patient experience improvement priority, and use the feedback to help shape and refine the specific issue or areas of concern where it is felt there is a need to concentrate efforts for improvement.

Internal staff engagement events are also planned throughout March and April 2019 to raise awareness of the QA and provide the opportunity for staff to participate in developing and refining the content of the improvement priorities that have been proposed.

4. Proposed Quality Account Priorities for 2019/20

For 2019/20, the Trust is proposing four quality improvement priorities which are aligned with the strategic priorities of the Trust. In addition to the improvement priorities for 2019/20, the Trust will continue to address a number of on-going continuous improvement priorities, as part of the Trust Quality Strategy.

Quality Domain	Priority for Improvement 2019/20
Patient Safety	• Continue to improve the management of the deteriorating patient
Clinical Effectiveness	• Improve compliance against the 7 day working standard for ongoing consultant-directed review • Continued implementation and development of the Excellence in Care Programme
Patient Experience	• Improve communication so that patients feel better informed about their care and treatment

The following section provides the rationale for choosing the proposed priority areas.

4.1. Continue to improve the management of the deteriorating patient

Early detection and treatment of physiological deterioration has been shown to improve the clinical outcomes for patients, and was made an improvement priority for the Trust in 2018/19.

The priority in 2018/19 focused specifically on supporting the early recognition and prompt treatment of suspected sepsis, acute kidney injury (AKI) and improving processes for escalation. As part of the work completed in 2018/19, the Trust has made considerable improvements, including:

- Improvement in the recognition, diagnosis and treatment of sepsis which has led to a reduction in mortality rates at ESHT
- A revised the pathway for AKI, which is in the process of being ratified
- Introduction of a new Treatment Escalation Planning (TEP) tool from 1 April 2019, which will assist clinical staff with appropriate planning of ongoing care

While the TEP tool will be introduced across the Trust from April 2019, the priority for 2019/20 will be to ensure that use of the TEP tool is embedded into clinical practice and used consistently as an aid to improve management of deterioration and document ceilings of treatment. The new ReSPECT process is also being launched in April and will support this process and the ongoing work regarding End of Life Care.

4.2. Improve compliance against the 7 day working standard for ongoing consultant-directed review

The 7 Day Hospital Services (7DS) Programme aims to deliver improvements for patients by supporting providers of acute services to tackle variation in outcomes for patients admitted to hospitals in an emergency. Overall there are ten clinical standards for 7DS, of which four clinical standards have been made priorities for delivery by NHS England (NHSE) and NHS Improvement (NHSI). Improvement in delivery against the four priority 7DS clinical standards was identified as an improvement priority in 2018/19, and the Trust has made progress in improving delivery against the four priority 7DS clinical standards throughout the year.

The Trust has not met the standard overall for ongoing consultant-directed review (clinical standard 8), with particular challenge at weekends in a number of specialities where the formalised arrangement for consultant cover does not include a consultant-led ward round. Documentation of need for medical review and delegation of consultant review is variable across specialities and wards, and remains poor in some. The priority for 2019/20 will be to ensure that continued progress is made to deliver on the standard for ongoing consultant-directed review during weekdays and weekends, so that the Trust can deliver on its aim to meet all priority clinical standards by 2020/21.

4.3. Continued implementation of the Excellence in Care Programme

The Trust first identified the introduction of a departmental accreditation programme as a priority in 2017/18, which evolved to become the Excellence in Care Programme in 2018/19. Over the past two years the Trust has made significant progress in developing a comprehensive dashboard to provide one source of data to enable ward teams and divisions to review, analyse and understand a range of metrics which align with national guidance and local policy. In 2018/19, progress has been made in defining the measures for access and delivery, and leadership and culture, and the quality and safety measures within the Excellence in Care dashboard have been refined and made available to all inpatient wards across the Trust.

The overall aim of the Excellence in Care programme is to provide one source of robust data to enable ward teams to monitor consistency in care and identify areas for improvement. It is in essence a dashboard with four specific domains (of which Quality is one) and a large number of KPIs. The priority for 2019/20 will be to ensure that standards for all domains within the dashboard are clearly defined, and that ward teams are supported to implement improvements. Considerable technical support is now required due to a change in focus and also a change in the software used for the programme.

4.4. Improve communication so that patients feel informed about their care

Data from the national inpatient survey, our own internal complaints and inpatient questionnaires highlight a number of areas regarding communication and information provided to patients where we can make improvements. This includes how we involve patients in making decisions about their care, and the information provided to patients when they are being discharged from our services.

The Trust recognises that there are a number of areas in the patient journey where communication could be improved. The priority for 2019/20 will be to work with patients and staff to review the current systems in place and identify the opportunities to re-design and improve how we communicate with patients so that they are fully informed about their care. A quality improvement approach will be adopted to identify the specific areas to target, test new approaches and ensure improvements are sustained.

5. Recommendations and next steps

The Board is asked to note the progress that is being made in developing the 2018/19 Quality Account (QA) and the proposed improvement priorities that have been identified for 2019/20. The Board will receive a finalised version of the QA for review prior to publication in June 2019.

Katey Ma
Head of Clinical and Quality Improvement

Minimising Mixed Sex Accommodation – Annual Declaration

Meeting information:			
Date of Meeting:	2 April 2019	Agenda Item:	15
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth, Director of Nursing

Purpose of paper: (Please tick)			
Assurance	☒	Decision	

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

Executive Summary:

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

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

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

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

The Operating Framework 2012/13 states that:

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

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

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

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

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

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

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

Patient Experience Group
Quality and Safety Committee – 21 March 2019

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

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

Our commitment to minimizing mixed sex accommodation

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

What does this mean for patients?

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

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

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

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

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

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

How will we measure success?

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

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

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

Vikki Carruth
Director of Nursing

31 March 2019

NHS Provider Licence Conditions - Annual Self-Certification

Meeting information:			
Date of Meeting:	2nd April 2019	Agenda Item:	17
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? No	

Summary:

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

Each year NHS trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence and that they have complied with governance requirements. We need to self-certify the following after the end of each financial year end:

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

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

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

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

Audit Committee reviewed the Draft Annual Governance Statement 27 March 2019

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

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

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

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

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

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

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

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

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

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

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

A

APPENDIX ONE

Compliance with the Provider Licence Conditions

SECTION 1: GENERAL CONDITIONS

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

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
G4	Fit and Proper Persons (FPP)	This condition prevents licensees from allowing unfit persons to become or continue as Governors or Directors (or those performing similar or equivalent functions).	All members of the Board and their deputies who may 'act up' into a Board role have been subject to a Disclosure & Barring Service (DBS) check. FPP checks are made upon appointment and Board memebrs are required to sign an annual declaration that they remain a FPP. The CQC reviewed the Trust's Fit and Proper Persons compliance in March 2018 and found the Trust to be compliant.	Director of Human Resources
G5	NHS Guidance	This condition requires licensees to have regard to any guidance that NHSI issues.	The Trust has had regard to NHSI guidance through submission of required annual and quarterly planning requirements, declarations and exception reporting.	Director of Finance Chief Operating Officer
G6	Systems for compliance with licence conditions and related obligations	This requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements.	The Trust has a robust governance framework in place as outlined in the Annual Governance Statement. The Board and its sub Committees (Audit Committee, Quality and Safety Committee, People and Organisational Development Committee and Finance and Investment Committee) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance. All Committees undertake a review of their annual work programme and effectiveness and revisions are made as required.	Chief Executive Director of Corporate Affairs

			The Trust has a Risk Management Strategy and processes are in place to enable identification, management and mitigation of current risk and anticipation of future risk. The Risks are identified through incident reporting, risk assessment reviews, clinical audits and other clinical and non- clinical reviews with a clearly defined process of escalation to risk registers. The Board Assurance Framework is reviewed by the Board and its sub committees. The Board has regard to the NHS Constitution, compliance with access targets has improved in 2018/19 and actions are in place to support delivery and achievement of trajectories.	
G7	Registration with the Care Quality Commission	This licence condition requires providers to be registered with the Care Quality Commission and to notify NHSI if registration is cancelled.	The Trust is registered with the Care Quality Commission without condition.	Chief Executive Director of Corporate Affairs
G8	Patient eligibility and selection criteria	This condition requires licence holders to set transparent eligibility and selection criteria for patients and to apply these in a transparent manner.	The Trust publishes descriptions of the services it provides and who the services are for on the Trust website. Eligibility is defined through commissioners' contracts and the choice framework. Assurance is gained through the patient's assessment stages to ensure that the appropriate services are provided.	Chief Operating Officer

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

SECTION 2 PRICING

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

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

SECTION 3: CHOICE AND COMPETITION

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

SECTION 5: CONTINUITY OF SERVICES

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

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

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

SECTION 6: NHS FOUNDATION TRUST CONDITIONS

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

FT4 Annual Corporate Governance Statement

1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS	Confirmed	As evidenced in the Annual Governance Statement
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Board reporting cycle and seminars allow new guidance to be brought to the Boards attention as required
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Governance framework in place. Clarity of reporting , highlighted in 2020 document and communicated across the organisation. Reviewing accountabilities across the organisation and developing new Accountability Framework. Annual review of committee structure and effectiveness in place. Revisions made if review highlights any requirements.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Annual Governance Statement, Quality account along with Annual Report document compliance with regulatory requirements and the Trust's governance and risk framework. Robust external and internal audit processes in place with escalation of any concerns on key internal controls and processes. Regular board and sub-committee meetings includeoversight of performance information, financial information, the corporate risk register and workforce. Improvement in meeting NHS Constitutional requirements, particulary A&E 4 hour standard. Challenges remain in meeting 62 day cancer requirement, actions in place to support improvement. CQC inspection demonstrated significant improvement in well led domain. Trust removed from Special Measures for Quality following Mar-18 inspection. Trust was placed in financial special measures in 2016 and a Financial Recovery Plan is in place.

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Wednesday 28th November 2018 at 1300 Video-conferenced between the St Mary's Boardroom, EDGH and Room 10, Education Centre, Conquest

Present: Mrs Nicola Webber, Non-Executive Director (Chair)
Mr Barry Nealon, Non-Executive Director

In attendance: Mr Jonathan Reid, Director of Finance
Mrs Lynette Wells, Director of Corporate Affairs
Mr Stephen Hoaen, Head of Financial Services
Mrs Jo Lambourne, Principal Auditor, TIAA
Dr Simon Merritt, Clinical Lead, Medical Division (for item 060/18 only)
Mr Adrian Mills, Audit Manager, TIAA
Ms Saba Sadiq Deputy Director of Finance
Mr Darren Wells, Engagement Lead, Grant Thornton
Mr Pete Palmer, Assistant Company Secretary (minutes)

Action

056/18 Welcome and Apologies for Absence

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

Dr Adrian Bull, Chief Executive
Ms Vikki Carruth, Director of Nursing
Mr Chris Lovegrove, Counterfraud Manager, TIAA
Mrs Emma Moore, Clinical Effectiveness Lead
Mr Mike Townsend, TIAA
Dr David Walker, Medical Director

057/18 Minutes of the meeting held on 25th July 2018

The minutes of the meeting held on 25th July 2018 were reviewed and agreed as an accurate record.

058/18 Matters Arising

There were no matters arising from the previous minutes.

059/18 Board Assurance Framework and High Level Risk Register

Mrs Wells apologised for an issue with the Risk Register where the full text of updates in some boxes was not visible, noting that the issue would be resolved for future submissions to the Committee.

Mrs Wells explained the Trust's Senior Leader's Forum (SLF) reviewed the Risk Register on a quarterly basis. She reported that the Board Assurance Framework (BAF) had been reviewed at the recent meeting of the Quality and Safety Committee who had accepted two recommended updates:

- 2.1.3 concerning monitoring of follow up appointments. Mrs Wells reported that a tracking system had been introduced and was becoming embedded. She proposed that the rating should be

moved from amber to green.

- 4.2.1 concerning available capital resources. Mrs Wells proposed that this rating should be changed from amber to red due to the significant pressure on capital within the organisation.

The Committee supported the proposed ratings changes.

Mr Wells asked why the risk concerning cybersecurity risk had been reduced and Mr Reid explained that the Trust had initially assigned a high level of risk to cybersecurity. Following external reviews the Trust was assured that a good programme of protection had been implemented, and he noted that the STP's cybersecurity lead was employed by the Trust. The risk had been reduced from 20 to 15 as a result of this assurance. Mrs Webber requested that narrative describing the reasons for changes to scores be included on the Risk Register in the future. Mrs Wells would pass this to the Risk Management team. **LW**

Mr Nealon asked whether Brexit and the consequences of leaving the EU with no deal should be included on the register. Mr Reid explained that a paper setting out the workforce consequences of Brexit was being written, and that a review of procurement and the Trust's supply chain would be concluded by the end of the year. The outcomes from these reports would help to inform the decision about including a Brexit risk on the Risk Register.

Mrs Webber asked how ratings on the register were decided, specifically asking about a risk concerning fire in the organisation. Mrs Wells explained that risks are scored using a framework and the rating was decided based on the level of assurance received about the control of risks. The fire risk was regularly reviewed during monthly meeting with the estates and facilities team. Mrs Wells added that all revisions to the BAF were discussed at Board meetings in public, and that ratings couldn't be changed without the approval of the Board.

Mr Wells asked why the quality approval programme was rated as green, while other risks relating to quality were less well rated. Mrs Wells explained that the initial risk related specifically to the CQC's fundamental standards and had been added following a previous inspection. The latest inspection had seen a good outcome for the Trust with a rating of 'Requires Improvement' based on areas that hadn't been re-inspected. The risk would remain on the Register until the Trust's CQC rating changed from 'Requires Improvement' to 'Good'.

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

060/18 Medicine Division Clinical Audit and Risk Register Review

Dr Merritt reported that the Medicine Division held monthly governance meetings where they reviewed audits, complaints, lessons learned and the Division's risk register. Heads of nursing for specific areas presented mitigations that had been made to address issues and consultants attended the meeting if required. Risks were regularly discussed by divisional leaders and Dr Merritt felt that governance processes worked well within the Division.

Dr Merritt reported that, due to staff shortages, the division had a long standing issue with the treatment of foot conditions relating to diabetes. The issue was being addressed in conjunction with commissioners and the Out of Hospital Division with significant improvements being realised. The Trust had engaged Medacs to assist with recruiting in problematic areas, but Medicine had not yet benefitted from this initiative.

Mrs Webber asked whether the Division was fully engaged in addressing risk, as information about some of the risks on the register had been chased for some time without response. Dr Merritt explained that work was being undertaken by divisional leaders to review the risk register and cleanse areas where risks were no longer applicable or where recommendations were no longer relevant.

Dr Merritt reported that the Division was completing all of its nationally mandated audits. In respect of local audits staff were not directed to audit specific areas and tended to audits areas where their specific interests lay. He advised that the Division might take a more proscriptive approach to audit in the future to ensure that areas of concern were looked at. He noted that the Division had issues with unfinished audits, often when junior doctors left the Trust.

Mrs Webber asked whether the issues being seen by the Division were also being seen by other divisions. Mrs Wells explained that the Trust's Clinical Audit Forum would have a good understanding of audit trends within the organisation and Mrs Moore could update at a future meeting. She added that she was delighted that the national diabetes would be completed, after years of not being able to do so due to not having the required software.

Dr Merritt noted that the division had a further issue with ensuring the recommendations from audit were followed up as often the person completing the audit then left the organisation shortly afterwards. He suggested that in the future, recommendations should be discussed during divisional audit meetings to ensure that they were followed up on and remained relevant. Mr Mills noted that audit outcomes issued by tiaa were prioritised in order to ensure that high priority items recommendations were not overlooked. Mrs Webber noted that following up on audit recommendations was a potentially Trustwide issue, and asked that Mrs Moore comment on the issue at the next meeting of the Audit Committee. **EM**

The Committee noted the report

061/18 Clinical Audit Update

Mrs Moore was unwell and therefore the paper was noted. Mrs Wells asked those present to send her any comments on the paper, which would be passed to Mrs Moore.

Mr Nealon asked whether the Trust was in breach of national requirements for level one audits. Mr Reid advised that the summary of the report confirmed that all mandatory priority one audits were being undertaken by the Trust.

062/18 Internal Audit

i) Progress Report

Mr Mills explained that internal audit's annual plan had been updated as planned audits of income, and the STP were no longer required. Audits of Waiting List Initiatives, cost improvement planning and the Data Quality Framework had been added to the annual plan. He updated that outcomes from an audit of delayed transfers of care had led to the scope of the audit being extended.

The Committee approved the proposed changes to the internal audit annual plan 2018/19.

Mr Mills updated that four final audit reports had been issued since the previous meeting of the Audit Committee; one gave substantial assurance and three gave reasonable assurance (though one of these was borderline substantial). Mr Mills commented on the continued positive trajectory that was being seen from internal audits. He noted that a recent audit of Freedom to Speak Up within the Trust had identified robust processes in place and clearly demonstrated openness. He added that it was evident the Trust now had a management culture that listened to, and valued, contributions of staff.

Mrs Webber asked whether re-auditing took place where issues were identified, and Mr Mills confirmed that this was the case. Action plans were agreed with teams, and evidence that these had been carried out was sought with re-audit undertaken if necessary.

In response to a question from Mrs Wells, Mr Mills explained that a draft audit of management of medical devices within the organisation had been given limited assurance. An exercise of rationalisation between a database of equipment held by EME and one held by the Finance team was being undertaken to ensure that they were fully aligned.

Mr Nealon noted that the Trust would be asking the CCG for £8million of additional income following a detailed piece of work undertaken by the internal audit team to review Trust income in 2017/18. Mr Reid explained that the request for additional income was justified and well evidenced. Mr Mills agreed, explained the robust and comprehensive system mapping had been undertaken leading to assurance about the level of income being claimed.

ii) Audit Tracker

Mr Mills reported that tiaa had updated the format of the audit tracker following the introduction of a new system. The report comprised three sections: recommendations to be closed down with committee's approval; overdue recommendations; and outstanding but not overdue recommendations. He reported that 38 recommendations were being recommended for closure to the Audit Committee. He noted that updates would continue to be sought on overdue recommendations.

Mr Nealon asked whether any of the outstanding recommendations were of sufficient concern to effect the level of assurance offered by auditors at year end. Mr Mills replied that some delay in responding to recommendations was expected, and didn't anticipate that they would affect the level of assurance offered.

Mr Reid suggested that the Executive team should review the list of recommendations in order to ensure that they were managed appropriately. **JR**

The Audit Committee approved the recommendations for closure.

063/18 Local Counter Fraud Service Progress Report

Mr Lovegrove was unable to attend the meeting. Mr Reid reported that four new referrals had been received by LCFS. A recent staff survey had been completed and the results would be shared with the Audit Committee. LCFS continue to attend Trust inductions to provide training to new starters. He reported that Mr Lovegrove met with himself and the Director of Human resources on a monthly basis to provide assurance about progress.

Mrs Webber asked whether the Trust invested money in investigating incidents. Mr Reid explained that LCFS undertook enquiries when issues were referred to them. Themes that emerged from these enquiries drove the Trust to consider the processes that were in place and how they could be improved in order to prevent incident recurring. Mrs Wells explained that issues were thoroughly investigated in conjunction with the Human Resources team, and were prosecuted if necessary.

064/18 External Audit

Mr Wells reported that the annual audit of charitable funds had been completed and submitted.

The risk assessment for financial statements audit had commenced. This would be presented in February, leading to the auditor's value for money conclusion for the year. He explained that the auditors were starting from an adverse value for money conclusion and would take a pragmatic approach to the audit given the current level of scrutiny undertaken by regulators.

Mr Nealon asked about the going concern statement at the end of the financial year. Mr Reid explained that the Trust Board would evaluate this and it would be supported by evidence and be subject to audit. The improved financial position would form demonstrable evidence of improvement and the acceptance of a five year financial recovery plan by NHSI would offer further assurance of progress.

065/18 Information Governance

Mrs Wells presented a comprehensive report on information governance within the organisation. She explained that the Trust had evaluated itself against an Information Governance Toolkit for many years and that this had now been replaced by the Data Security and Protection Toolkit (DSPT). This was an online self-assessment tool that allowed organisations to measure their performance against the National Data Guardian's 10 data security standards.

Over 200 data flows within the organisation had been mapped to ensure that they used data legitimately, and Mrs Wells gave assurance to the Committee of the Executive team's confidence in the outcomes from the exercise. Internal audit were undertaking a two part audit of the Trust's performance, with follow up work being undertaken where areas had been identified as being non-compliant.

Mrs Webber asked whether the Committee should wait until internal audit had completed their audit prior to approving the report. Mr Nealon asked for confirmation about who was providing assurance about the data mapping to the Committee. Mrs Wells confirmed that she had looked at the data in detail, explaining that it also had been approved by the Trust's Information Governance Steering Group which was chaired by Mr Reid. Internal audit would not be reviewing the data flows during their audit. It was noted that a list of data flows that had been mapped was included as an appendix to the report. The Committee noted that the mapping had been undertaken and this had been scrutinised by the Steering Group.

Mrs Webber noted that some of the graphs within the report were missing keys and asked if this could be rectified in future reports. **PP**

Mrs Webber asked why not all data protection officer investigations were undertaken by the information governance team. Mrs Wells explained that is was not always appropriate for the team to investigate and sometimes incidents were passed directly to HR to investigate.

Mrs Wells confirmed that the Trust had no incidents currently under investigation by the Information Commissioner's Office.

The Committee noted the proposal, and the requirement for signing of DSPT data prior to 31st March 2019.

066/18 Emergency Preparedness, Resilience & Response (EPRR) Policy

Mr Claxton, Emergency Planning Lead, was unable to attend and Mr Reid presented a refreshed and updated policy. Mrs Webber noted that the policy included a lot of actions for departments to undertake and asked if compliance was audited. Mr Reid confirmed that limited audit of compliance was undertaken, and that a new EPRR lead and EPRR officer had been employed to improve compliance and to systematically review processes and procedures. Once new processes had been embedded then internal audit would be asked to review EPRR.

It was agreed that EPRR should report to the Audit Committee on a bi-annual basis and this would be added to the work programme. **PP**

Mr Nealon asked who was responsible for EPRR within the Trust. Mrs Wells explained that a line of responsibility ran from the Chief Operating Officer to the Chief Executive and then to the Trust Board. The Trust had previously had a NED designated as responsible for EPRR and she would confirm whether a successor needed to be appointed. **LW**

The Committee noted and supported the refreshed EPRR policy.

067/18 Tenders and Waivers

Mrs Wells asked for clarification about how waivers were approved by the Trust. Mr Reid explained that he authorised those below £75k and then increasing thresholds required Chief Executive and then Trust Board approval. He explained that internal audit had undertaken a review of waivers which had indicated that they were inconsistently applied. As a result a more rigorous process had been introduced with greater levels of tender waivering being seen. He noted that a lot of the waivering related to transactions with other NHS organisations.

Mrs Webber raised concerns about the value and number of waivers by the DAS Division. She also queried a waiver concerning a local supplier. Mr Reid reported that work was being undertaken with estates to ensure procurement processes were effectively applied.

Mrs Webber asked if a system wide approach could be taken with other Trusts in order to buy equipment at reduced prices. Mr Reid explained that he hoped to see an increase in joined up procurement across the STP, but that most purchasing was done centrally by NHS Supply.

Mrs Webber asked what improvements in tenders and waivers the Audit Committee could hope to see over the coming 3-6 months. Mr Reid explained that the procurement team were focussed on ensuring waivers were only given where appropriate and that there had already been some improvements.

It was agreed that the report to the Audit Committee would be updated to include:

- Highlighting of sole suppliers
- Highlighting of unnecessarily issued waivers
- Enhanced information about direct awards
- Trends were identified as useful and to remain in the report. **SS**

Mr Mills agreed to review the internal audit report on thematic waivering and report back to the Committee if any further issues had been identified. **AM**
Mr Wells noted that he had seen another Trust RAG rate their waivers and agreed to send an example of this to Ms Sadiq. **DW**

068/18 Review of Losses and Special Payments

Mr Hoaen presented the report, explaining that no items of concern were included. He explained that the write off of pharmacy stock remained the biggest value. He anticipated that this would increase in Month 7 due to a recent £160k pharmacy write off.

Mr Nealon asked whether there was a Trust policy for writing off debts. Mr Hoaen explained that the Trust initially employed a professional debt controller and would then escalate to a debt collection agency if required. Once this process had been exhausted, the Trust would consider writing off non-NHS debt, while inter-NHS debts would only be written off following a formal NHS process.

Mrs Webber requested that existing levels of arrears for the Trust be quantified and reported back to the Audit Committee. She also asked that information about debt write offs be reported in order for the Committee to identify any potentially material future risks. **SS**

069/18 Review of Corporate Governance Documents.

Mr Reid reported that the Trust's Corporate Governance documents were reviewed on an annual basis. He explained that no major changes had been made to the governing documents, noting that references to approved suppliers had been removed.

Mrs Webber asked for confirmation that the documents remained relevant under the T3 process and Mr Hoaen confirmed that this was the case. He explained that the T3 process was a temporary process for 3-6 months and that the governing documents sat above this process.

Mrs Wells noted that the Audit Committee were being asked to recommend the changes to the Trust Board. No changes had been made to the Standing Orders.

Mr Reid explained that internal audit would be asked to compare the Trust's documents with those of other organisations in 2019 to see if they could be improved. The Trust's current internal audit team would not be involved in the audit.

The Committee recommended the changes to the Corporate Governance Documents to the Trust Board.

The Committee approved the proposal for the Corporate Governance Documents to be audited by tiaa in 2019.

070/18 Date of Next Meeting

The next meeting of the Audit Committee would be held on:
Thursday, 31st January 2019, 1300-1500, Committee Room, Conquest

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE & ORGANISATIONAL DEVELOPMENT (POD) COMMITTEE

Minutes of the People & Organisational Development (POD) Committee held on
Thursday 24th January 2019
10:00 – 12:00
Committee Room, Conquest Hospital

Present:
Mrs Miranda Kavanagh, Non-Executive Director (MK) – Chair
Dr Adrian Bull, Chief Executive (AB)
Ms Monica Green, Director of HR (MG)
Mrs Moira Tenney, Deputy Director of HR (MT)
Mrs Lorraine Mason, Assistant Director of HR - OD (LM)
Mrs Dawn Urquhart, Assistant Director HR, Education (DU)
Ms Emma Chambers, Interim Assistant Director of Nursing (EC)
Mrs Lynette Wells, Director of Corporate Affairs (LW)
Mrs Brenda Lynes O'Meara – Associate Director of Operations (BLO)
Mr Pravin Sangle, Associate Specialist (PS)
Mr Jamal Zaidi, Associate Medical Director – Workforce (JZ)
Mrs Michelle Elphick, Associate Director of Operations (ME)
Ms Penny Wright, Head of Workforce Planning (PW)
Ms Anne-Marie Newsholme, Lead Healthcare Scientist (AMN)
Jo Gahan, Head of Operational HR (JG)

In Attendance:
Ms Janet Botting, Acting Medical Staffing Manager (JB)
Tina Lloyd, Assistant Director of Nursing (TL)
Mrs Nicky Hughes, EA to Director of HR (NH) (minutes)

No	Item	Action
1	**Welcome, introductions and apologies for absence** The Chair welcomed all to the meeting and noted a quorum was present. Apologies for absence were received from: Mr Jonathan Reid, Finance Director Mr Salim Shubber, Director of Medical Education Mrs Vikki Carruth, Director of Nursing Ms Nadia Muhi-Iddin, Guardian of Safe Working Mrs Kim Novis, Equality & Human Rights Lead Ms Karen Manson, Non-Executive Director (KM) Dr David Walker, Medical Director (DW) Mrs Joe Chadwick-Bell Chief Operating Officer (JCB) Mrs Lesley Houston, Deputy GM – Medicine (LH) Mrs Jan Humber, Staff Side Chair (JH)	

2	**Minutes and Matters Arising** **2.1 Minutes of the previous meeting held on 7th November 2018** The minutes were reviewed and agreed as an accurate reflection of the meeting. **2.2 Review of Action Tracker:** The outstanding items on the Action Tracker were reviewed: CQC Well Led The Deloittes Action Plan, following the Well Led review, was shared. It was noted that there had been some further updates. An accountability and governance review was being undertaken which would be shared at a future meeting. Apprenticeships Awareness To be discussed within the agenda. **Action: Closed** Stay Interviews LM provided an update on stay interviews, which had been undertaken in pilot areas. This would now be rolled out throughout the Trust and incorporated into the Retention Plan. **Action: Closed** POD Annual Report Future agendas and a review of the work planner had been undertaken. **Action: Closed**	
3	**National Update** 3.1 NHS Long Term Plan: Workforce implications MG provided a verbal overview of the NHS Long Term Plan. The plan acknowledges the key role of the staff in the NHS and the role that employers play in ensuring staff can deliver care to patients. It acknowledges where there are staff shortages and suggests ways in which this might be improved, for example increasing training places, composition of training and routes into training. It also talks about the development of new roles, the importance of ongoing development of staff and the NHS becoming a model employer. It was noted that all of the issues covered in the plan are regularly discussed at POD thus providing assurance to the Board. Key highlights: • Use of apprenticeship roles, new roles in nursing e.g. nurse associates • To address shortage in Primary Care particularly GPs • New ways of supporting doctors within their training • Trainee doctors becoming more generalist than specialist • Productive working to ensure that organisations were getting the most from their workforce • Adhering to Model Hospital recommendations and metrics • Career pathways and developments. Next Steps: • National Implementation plan to be drawn up in relation to the recommendations within the NHS Long Term Plan. To be produced by September this year.	

	• Sub-groups to be set up reporting into the Implementation Plan (Dental Medical Workforce, roles of Pharmacists and Professional Healthcare Scientists, leadership and development and talent management, technologies and skills) • The Budget would be set for Health Education England later in the year AB highlighted that it was the NHS' intention to expand the options for people to undertake their nurse degrees by correspondence, subject to having clinical placements and asked if this was something that the Trust could provide. MG replied that once further details had been obtained it would be something that the Trust would follow up. TL reported that the Trust has 4 trainee nurses who commenced in September 2018 (completion 2020) with another 6 to commence in January 2019. These trainee nurses were part of the Trust's employed workforce and were released one day a week to study. AB asked if the Trust was in a position to have a specific plan looking at the trajectory for nurse associates and other nurse trainee opportunities as well as accessible data of numbers increasing over the next 3 years. PW replied that the Strategic Capital Workforce Plan would detail this information as part of the Workforce Development Plan.	
4	**Workforce Capacity** 4.1 3+2 Workforce Plan PW provided a verbal overview of the 3+2 Workforce Plan, which had been submitted to NHSI. The Plan contains a blend of optimisation and transformation initiatives consisting of 6 programmes; sustainable urgent care, productive planned care, best at managing frailty, integrating community services, sustainable service models as well as business processes. A week by week retrospective workforce analytical review would be delivered. PW provided an explanation of the Developing Workforce Safeguards (DWS), which links in to the Trust's overarching strategic workforce and business planning work. It is a mandated national compliance framework for local adoption; it undertakes a gap analysis and reviews the current safer staffing practice against the use of evidence based tools. AB queried when the actual plan would be shared. MT replied that in terms of developing workforce safeguards, it would be presented to the Audit Committee in March 2019 to make a declaration (annual assurance statement). This would be the Trust's compliance tool on looking at models in nursing for establishment reviews etc. and providing assurance to NHSI of where we are in using those models against different staff groups. It was agreed that this should also be presented to POD. MK queried the capacity in the Trust to deliver this; do senior managers have the capacity (time and skills). PW replied that the department had already assessed this situation and confirmed that there were some good tools and working in place, which would help to deliver. MK referred to training for managers, would those programmes include modules and support of what was being asked for. MT replied not specifically at the moment but it would be highlighted through the Nursing Establishment Review and part of the Business Planning workshops.	**PW**

4.2 Settled Status for EU Staff

MT provided a verbal update of the Settled Status for EU Staff. Key highlights:

- The Government had decided to drop the £65 charge for those EU staff applying for settled status
- Announced process for applying and the new Visa arrangements in place
- 500 Trust staff registered as non-EU citizens
- Trust will engage with staff by providing events in February explaining the process of applications as well as advice
- Concerns around social unrest on Brexit day; need to be prepared.
- Direct engagement with staff to find out where they are in their journey living in the UK

MK queried whether the application for settled status was an onerous process. MT replied that it is about 3 questions on line, so not that difficult.

4.3 Agenda for Change Transformation Closure of Band 1

MT explained that the Agenda for Change Transformation Closure of Band 1 paper provided a brief overview of key items in terms of the pay reforms and change.

- To encourage more people to change to the standard terms and conditions; pay rates have been increased
- Pay progression to commence implementation from 1st April 2019
- Completion of complete toolkit in terms of readiness assessment
- Band 1 – ending pay banding - pay review group and sub-group have been set up for working through national guidance
- Job evaluation – all to move to Band 2 with a transition period
- National guidance states that we job descriptions should be re-written and to develop all Band 1 staff to become a Band 2.
- Target date 1st April 2019.

MK queried the reaction of the union. MT confirmed that they were all engaged.

4.4 Employee Relations Report

JG provided a verbal update of the current headlines from the Employee Relations Report for the period quarter 1 to quarter 2 (April to September 2018). There were 32 new formal incidents raised under the Trust workforce policies, 11 disciplinary hearings, 3 appeal hearings, 7 dismissals, 6 suspensions, no formal whistleblowing investigations and 2 ongoing employment tribunals. The average length of investigation was 12 weeks; a reduction on the last period.

Key issues being worked on as part of the HR improvement agenda from CQC feedback:

- Timeliness of process
- Keeping in touch and feedback

AB queried whether the Trust felt more satisfied re supporting members of staff going through suspensions and disciplinary procedures improvements. JG explained that HR had spent some considerable time with staff that had been through a HR processes to gain feedback on improving ways of working.

MK referred to the data on page 3 and queried the increase in cases compared to last year's figures and asked whether there was a reason that last year's figures were so low. JG explained that this involved in attempting to deal with cases informally and stated that HR continuously support managers to deal with cases informally, which is part of the ongoing learning.

	JZ queried that at the end of a fixed term contract would a person automatically be dismissed. JG stated that this is how it is classed under employment law but the Trust deals with this sensitively, taking appropriate steps as to why the fixed term contract has come to an end.	
5	**Workforce Efficiency Update** MG explained that the Workforce Efficiency Group reports into the Financial Improvement & Sustainability Committee (FISC) and the report had been updated earlier this week. New Workforce Efficiency Programme Manager has commenced. The information provided was around workforce spend, broken down by both substantive staff and all elements of temporary staff, mapping workforce spend against inpatient and outpatient activity to get some idea in fluctuations of workforce spend. This updated report would be circulated with the notes of this meeting. Overall workforce efficiency groups had been set up; medical staffing, AHPs, Nursing and Midwifery and Corporate. These groups are looking at workforce savings to be achieved with common elements being addressed e.g. job planning and linking activity to the work being undertaken looking at efficiencies. AB reinforced that this had been shared at FISC this week and the work programme was positive with good plans for next year. MK referred to page 47 CIP Performance Summary and highlighted that the rag ratings were inconsistent. Finance department to clarify. MK stated this was month 9 and some initiatives were well off plan and asked if these initiatives would be achieved by the end of the year. AB stated that the forecast for the overall CIP was to reach the target.	
6	**Workforce Development** <u>6.1 Action Plan from Training Needs Analysis (TNA)</u> DU explained that the action plan from the Training Needs Analysis had been developed to support the recommendations and results identified in the Training Needs Analysis undertaken last year. It also supports the objectives set out in ESHT 2020. DU provided a verbal summary of the Action Plan from Training Needs Analysis, which was an update of where the Trust is at present. MG reported that the Trust were concentrating on another review of some of the elements of mandatory training and mapping this across all staff groups. LW queried that there was an action missing and stated that one of the key issues with TNA is about attracting staff from outside; no action about how we communicate what we are doing was listed. DU to add to action plan. AB queried whether the Trust were giving as much support to HCPC colleagues as we were to registered nursing for their revalidation and support. DU replied that ongoing work was taking place addressing the need and would be added to the action plan.	

	6.2 Apprenticeships DU provided a verbal update on apprenticeships and explained that the Trust supports staff through apprenticeships. There are currently 129 learners with further staff due to start courses over the next few months. DU reported that there was a better understanding of what was required by the Trust and confidence around the positive use of the apprenticeship levy. AB and MK commended the work undertaken. 6.3 Workforce Learning & Development LM provided a verbal review of the Workforce Learning & Development report and stated that it was an opportunity to reflect on the aspect of the leadership and talent management strategy which is about building the capacity of our leaders to deliver trust objectives and innovation and transformation. The presentation outlined the range of leadership programmes/development opportunities available for staff, attendance to date, feedback from participants and the impact the programmes of the programme in relation to the achievement of our ESHT 2020 vision, meeting the requirements of the well led domain and feedback from the staff survey. The Leadership Pathway had been developed following a robust training needs analysis and involved a range of stakeholders. AB referred to the pie chart of attendees and requested additional data to be added reporting on how many staff members were relevant for these courses and what percentage had actually been taken up. AB commended the programme in place. JZ referred to medical leadership and asked if the Trust could formally encourage new consultants to become involved; no formal mentoring programme at the moment. LM stated that she was working on a framework and looking at new development opportunities.	
7	**Medical Engagement Update** Deferred to the March 2019 meeting. SAS doctors JZ referred to SAS doctors and stated that autonomous working programmes had improved and SAS charter was being implemented; launch day early March 2019. Appraisals had always been good at this Trust: over 95%. One area of challenge was job planning which was thought to be an engagement issue. The trajectory was increasing; hopefully within the next 3 months would be compliant.	
8	**Guardian of Safe Working (GOSW) Quarterly Report** JB provided a verbal overview of the Guardian of Safe Working Quarterly Report. Exception reports were continuing to decrease (from around 300 per month to 10) reason unknown but was possibly due to morale of the contracts. Guardian fines had increased by £388 for the quarter. A work pattern review had been initiated for the FY1 work pattern at Eastbourne, introducing night shifts. The next Junior Doctors Forum was due to take place on Monday 28th January.	

	MK queried the lack of exception reporting. JB replied that was possibly due to morale of the contracts and was under review by NHS employers. PS referred to a SAS meeting where a discussion took place regarding exception reports, anxiety was reported from the junior doctors and it was highlighted that handover time was used seeing the patient. AB reported that a Rota Oversight Group had been set up to look at and address problems across the Trust, taking appropriate action. AB suggested a report from this group to sit alongside the reporting of exception reports.	
9 **9.1** **9.2** **9.3**	**Items for Information:** Nursing Report Item noted. Workforce Report Item noted. **Minutes from sub-groups**: Organisational Development & Engagement Group Item noted. Education Steering Group Item noted. Workforce Resourcing Group Group had not met. HR Quality & Standards Group Item noted.	
10	**Any other business** None.	
11	**The next meeting of the Committee will take place on:** **Thursday 21st March 2019** **10:00 – 12:00** **St Mary's Boardroom, EDGH vc to Room 7, Education Centre, Conquest**	

Dates of 2019 Meetings:

Date	Time	Venue	Call for Papers Date	Submission Deadline
Thursday 21st March	10:00 – 12:00	St Mary's Boardroom EDGH vc Room 7 , Ed Centre, Conquest	22.02.19	08.03.19
Thursday 23rd May	10:00 – 12:00	Committee Room Conquest vc Sara Hampson Room, EDGH	26.04.19	10.05.19
Thursday 25th July	10:00 – 12:00	St Mary's Boardroom, EDGH vc Room 1, Ed Centre, Conquest	28.06.19	12.07.19
Thursday 12th September	14:30 – 16:30	Committee Room Conquest vc St Mary's Boardroom, EDGH	23.08.19	06.09.19
Thursday 21st November	10:00 – 12:00	St Mary's Boardroom EDGH vc Room 1, Ed Centre, Conquest	25.10.19	08.11.19